

A large, circular inset image showing a dental procedure. A dentist in a white coat and blue mask is working on a patient's teeth. A dental assistant in a white coat and blue mask is assisting. The patient is reclined in a dental chair. The background is a clinical setting with dental equipment.

Dental Workforce *resource pack*

A six step resource pack to aid the development of the dental workforce in response to local population needs



Six Steps is a framework for workforce planning developed by **NHS National Workforce Projects**. It is designed to provide an evidence based and effective model that can be adopted by any NHS or partner health and social care organisation. Using a model like Six Steps helps lead to sustainable workforce planning.

For more information on Six Steps and the work of NHS National Workforce Projects see the healthcare workforce portal www.healthcareworkforce.nhs.uk.

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Foreword

The Department of Health's Report of the Primary Care Workforce published in February 2004 identified an undersupply of dentists of some 10 percent which, if no remedial action was taken, would increase to between 16 percent to 21 percent by 2011.

The Department responded with two initiatives. To meet immediate requirements we succeeded with the Project 1,000 campaign of recruiting the equivalent of 1,453 dentists. For the longer term, the number of training places at dental schools in England was increased from 670 to 840 to provide for a 25 percent increase in the number of dentists qualifying here from 2009/2010 onwards.

There has also been a major expansion in the training of dental care professionals which, together with the regulatory changes undertaken by the General Dental Council, have greatly increased the scope for skill mix within the dental team.

In April 2006 the Government launched the first major reforms of primary care NHS dentistry since 1948. These were of particular significance to the demand side of the equation. Under the old system, dentists could set up practice where they wished and carry out as much or as little NHS dentistry as they wanted. This gave the NHS little control over how much dentistry was provided in different areas of the country whilst, under the new system, primary care trusts (PCTs) hold local budgets for dentistry and use these resources to commission an agreed annual level of service from local dentists.

These developments, which have resulted in more capacity and closer control over the use of resources, have had major implications for dental workforce planning. This resource pack offers an essential guide to this new environment. It identifies the relevant policy changes, the main stakeholders, the key data sources and the structure in which a plan could be drawn up.

I commend the pack to all those with responsibilities for workforce planning, training and education, and development of dental services in the strategic health authorities (SHAs), PCTs, dental schools and other education and training institutions.



Barry Cockcroft
Chief dental officer

Dental deaneries have traditionally been concerned with postgraduate training and education. Whilst this is still an aspect of their remit, local commissioning of dental services by PCTs will, potentially, change the workforce environment in which they function. Similarly, changes to the regulation of dental healthcare professionals will allow for more flexibility in the skill mix within the oral health workforce, whilst extending the requirements for professional development across all disciplines.

As part of a multiprofessional deanery within the directorate of workforce and education of an SHA, the dental deanery needs a framework within which to plan, commission and deliver the training and education needed by an oral health workforce developed in the light of locally commissioned, patient led services. Such a framework should encompass service commissioners, patients and providers, together with those charged with developing and delivering the workforce required.

Without this collaboration, workforce planning and service commissioning will exist in isolation from each other, to the detriment of both.

This resource pack provides such a framework and can support joint planning for, and delivery of, the dental workforce of the future.

Nick Ward

Dean of postgraduate dental education, North Western Deanery, NHS North West



Introduction

The present dental workforce is currently going through immense changes due to the advent of a new dental services contract and the restructuring of PCTs. NHS dental services are, for the first time, being commissioned by PCTs with a focus on patient led services that are based on need rather than demand.

However, access to NHS dental services has been of concern to the Government for some time and as a result services such as dental access centres and dental access teams have been developed. There are other concerns, such as improving general oral health, dealing with health inequalities, and integrating oral health services into general public health improvements.

Currently, mainly the dental practitioner is recognised as having the expert skills needed to treat oral disease and improve oral health. This can result in time and resources being spent on care that could be delivered by other members of the dental team, such as therapists and dental nurses, and/or health professionals and community workers such as health visitors, smoking cessation advisors, teachers and ethnic support group leaders.

Current workforce issues, therefore, have two facets. The first concerns meeting immediate access demands, whilst the latter involves visioning and developing a future workforce that is appropriately equipped with the skills, knowledge and competencies to deliver a patient led service. Whilst initially appearing as separate issues, both will ultimately interrelate. This resource pack has therefore been designed for use by all staff involved in planning and developing the *current* and *future* dental service workforce and is written in a language and structure that can be shared with all relevant agencies at all professional levels.

The resource pack contains workforce planning guides, together with frequently asked questions (FAQs) that have been developed to solve common issues and examples of innovative approaches to skill mix. A section on useful contacts and resources has also been included.

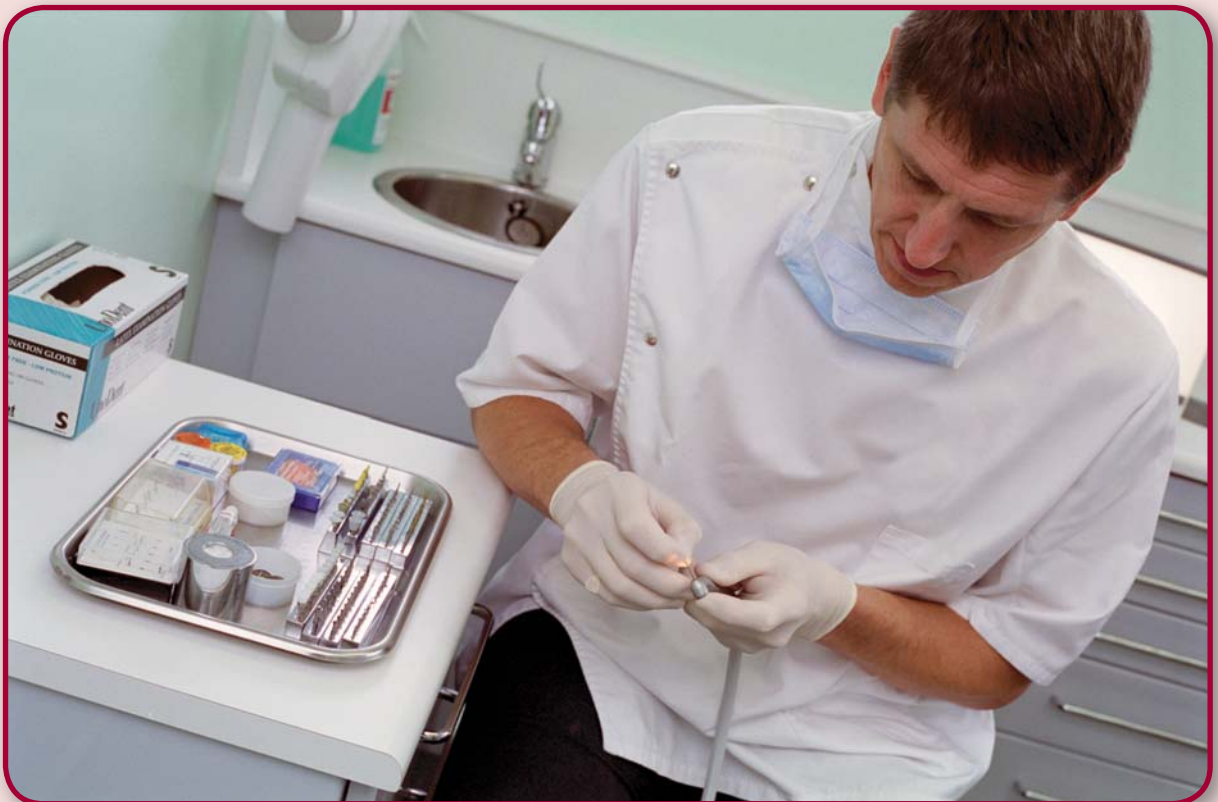
This resource pack aims to offer the best up to date view concerning workforce development within the field of dentistry. Whilst this pack contains reference to national policies and initiatives, it is not intended to cover all the work that is currently being undertaken in the provision of dental care but offers guidance on planning dental workforce development needs to support the commissioning of a range of services that will improve oral health as well as improve access.

We hope this guide will provide a functional framework that enables efficient development of a contemporary dental workforce, from a service provision perspective, according to the oral health needs of the local population.

Section One:

Background

Improving long term oral health and providing treatment for people with dental disease has a significant impact on NHS dental services. However, when planning the workforce to deliver this care it is important that it is not viewed in isolation of other changes and developments that are taking place within the NHS, for example improving working lives (IWL), agenda for change and the demographics of both the population and the health and social care workforce. Below are listed key service and workforce policies related to dental workforce planning which an effective workforce plan will need to consider. More information relating to each policy can be found in appendix 1.



Key Policies

Our Health, Our Care, Our Say: A New Direction for Community Services (2006)

Key points:

- Better prevention and earlier intervention for improved health and wellbeing
- More choice, control and a louder voice for service users
- Improved access to community services
- Tackling inequalities.

Choosing Better Oral Health – An Oral Health Plan for England (2005)

Key points:

- Help PCTs to prepare for commissioning NHS primary care dental services
- Emphasise a preventive approach involving fewer interventions.

Commissioning a Patient Led NHS (2005)

Key points:

- Focuses on the way healthcare services will be delivered in the future
- Outlines developments in commissioning.

National Service Framework for Children, Young People and Maternity Services (2004)

Key points:

- Stimulate long term and sustained improvement in children's health
- Ensure fair, high quality and integrated health and social care from pregnancy right through to adulthood.

Report of the Primary Care Dental Workforce Review (2004)

Makes recommendations for the development of the dental workforce.

Health and Social Care (Community Health and Standards) Act 2003

Key points:

- Legislated for far reaching reform of NHS dental services to provide for implementation of the lessons learned from the *Option for Change* pilot projects
- Under the Act, PCTs will assess local oral health needs in order to tackle long standing oral health inequalities.

NHS Dentistry: Options for Change (2002)

Contains recommendations to begin radical changes, designed to provide a first class NHS dental service, responsive to local needs.

Modernising NHS Dentistry: Implementing the NHS Plan (2000)

Outlines the commitment to improving NHS dental services as set out in the NHS Plan.

Demographic implications for workforce planning

The demographic shape of the western world is changing due to the combination of increased life expectancy, falling birth rates in developed countries and the effect of the baby boom generation coming towards retirement age.

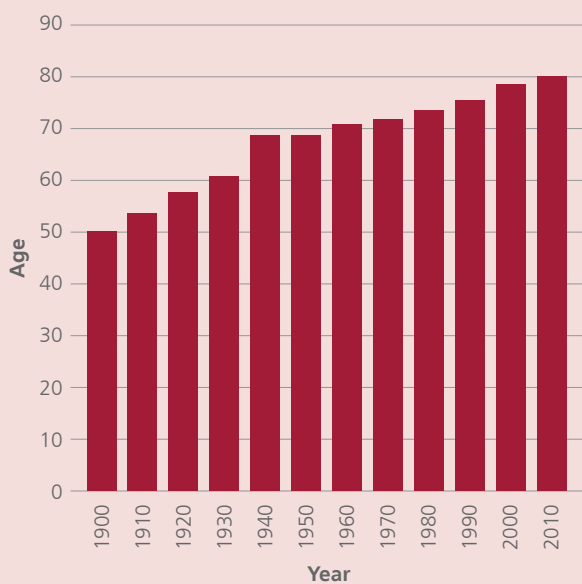


Figure 1: Demographic – Increased Life Expectancy in the UK (Source: Government Actuary Department, UK)

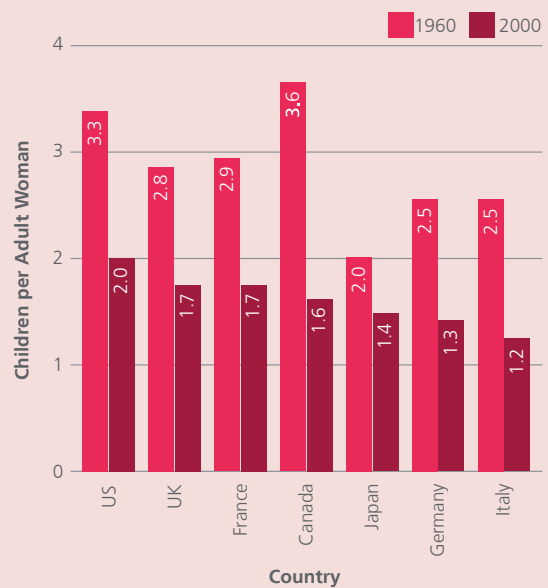


Figure 2: Birth Rates – Total Fertility Rate: 1960 and 2000 (Source: US National Centre for Health Statistics)

With each generation on average living longer than the last, and this trend continuing for the current generations, UK government actuary figures predict that a child born in 2000 has a life expectancy of 81 years¹. These figures are by their nature averages and in future years a significant portion of the population will be living well into their 90s and beyond.

¹ Source: Government Actuary Department, UK

These demographic issues will impact on the dental workforce in many ways. Broadly, demand from the elderly will increase as the growing elderly sector both retain their teeth and have higher expectations of dental services, simultaneously demand from the younger sector will decline (as there are fewer young people and they have better health - the 'no decay' generation).

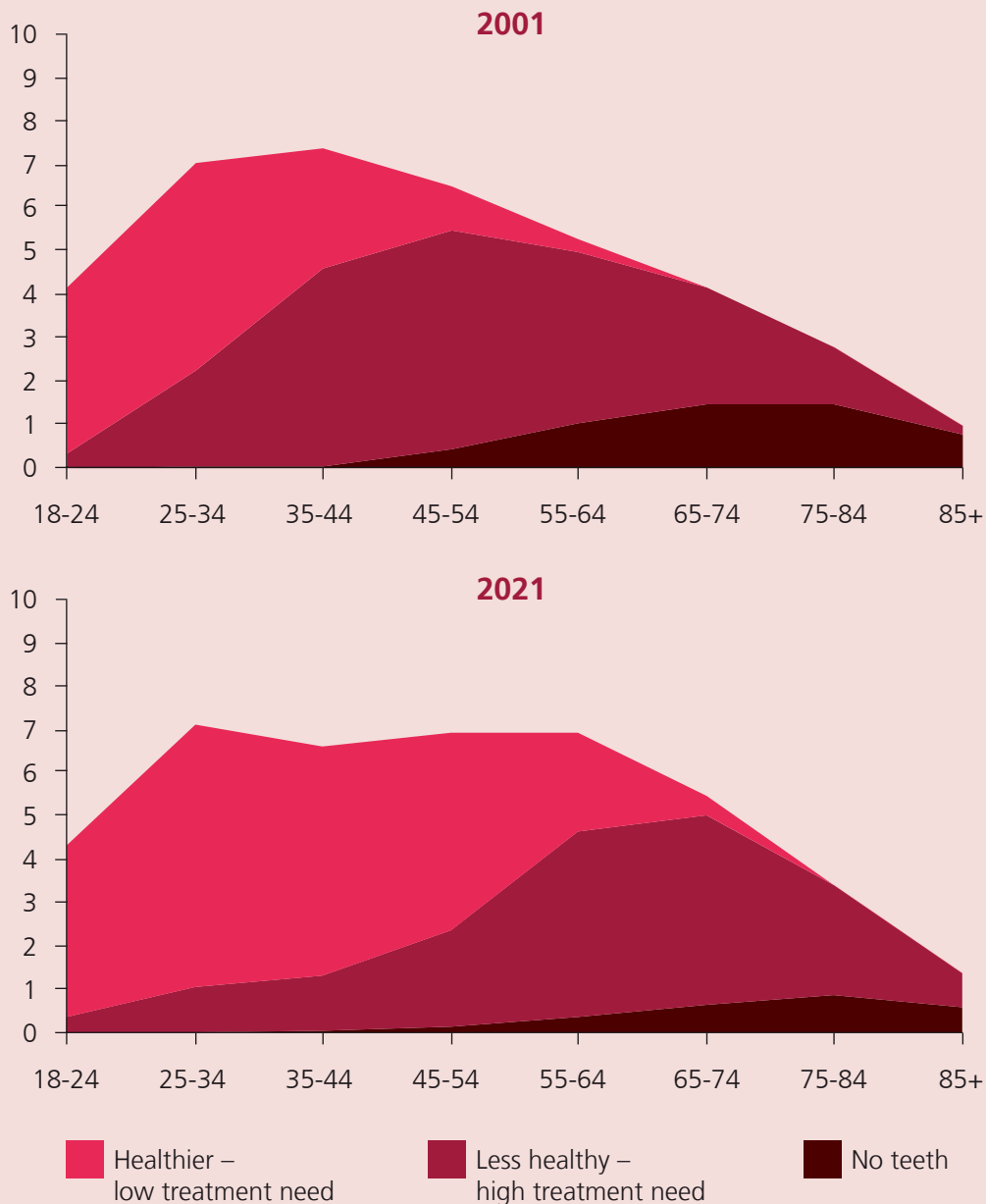


Figure 3: Baseline projections of adults in different dental health categories (source: Report of the Primary Care Dental Workforce Review)

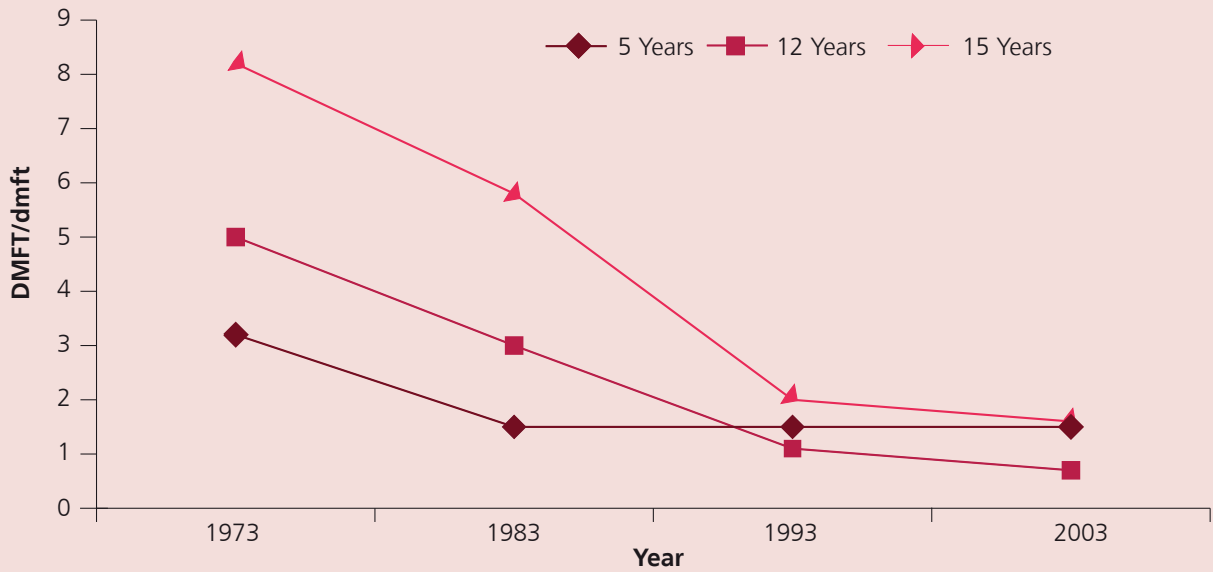


Figure 4: Average DMFT/dmft per child in England 1973 to 2003 (source: National Children’s Dental Health Surveys, Office of National Statistics, London)

In addition to the impact of increased life expectancy on the provision of dental care, the age of the workforce providing the service will also rise. The fall in birth rate will provide fewer young workers to the labour market than in previous generations whilst changes to the current pension arrangements include the expectation that people will work on past the current retirement age of 60.

The following graph shows the age range of the NHS staff changing from 2000 to 2010:

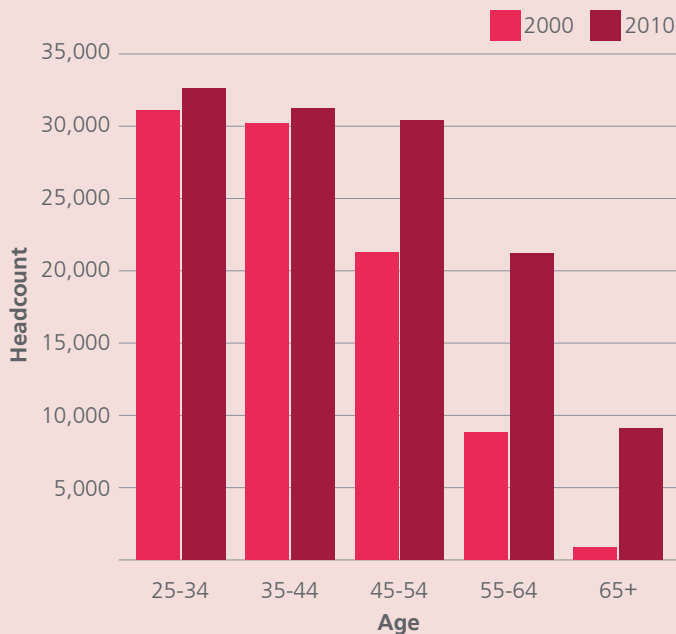


Figure 5: Age profile of the NHS medical workforce 2000 – 2010 (source: Source: NHS Health and Social Care Information Centre medical and dental workforce census 2000-2004)

At the present time, assessment shows that there is an under supply of dental time of approximately 9 percent of that required to meet demand. Assuming no interventions affect the supply of dental staff or the demand for their services, the following graph illustrates clearly that the under supply of dentistry is projected to increase markedly up to 2011. This gap between supply and demand is expected to persist but not grow at such a substantial rate between 2011 and 2021.

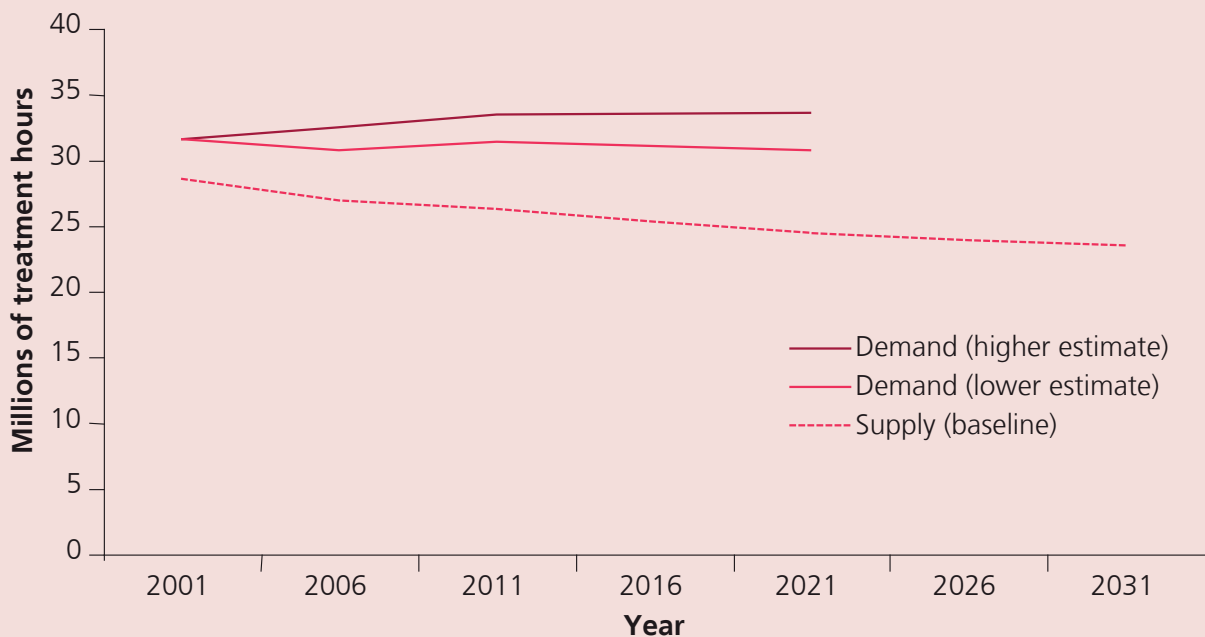


Figure 6: Project demand and supply for dentistry in England 2001-2036 (source: Report of the Primary Care Dental Workforce Review)

Therefore, a flexible workforce will be required that can be described in terms of skills and competence supported by General Dental Council (GDC) regulations, rather than rigid professional boundaries. Other current changes such as agenda for change, IWL and competence frameworks will combine to help organisations create and deliver this flexible workforce. Organisations will require long term plans that map out the effects of all these changes and work through the right skill mix for the delivery of services for the future within the resources available to commissioners. This long term plan then needs to inform and shape the workforce commissioning decisions, and local delivery plans within each organisation to bring about the workforce of the future.

Section Two:

Workforce planning issues

Before embarking on workforce planning, it is necessary to understand that this is part of a process that starts with the initiation of an oral health services strategy. This strategy should clearly set out what patient led dental service needs to be designed to deliver a service to address immediate access issues and continue to be developed into a robust service of the future. Only then can action be undertaken to plan the workforce.

Planning the workforce

The main emphases of dental workforce development are disease prevention and management, improving community based services and better integration of allied health care services.

When planning the workforce to address these, it is important to look at what dental professionals are needed now and whether the currently available workforce has the appropriate skills, knowledge and competence. Predictions can then be made concerning the likely future staffing requirements, based on appropriate use of skill mix, and the steps needed to meet that staffing need. The problem with some organisations' workforce planning models is that they concentrate on the workforce numbers in isolation, or vision the future without checking if the numbers will meet that need. Commissioners of dental services will have to identify what the workforce of the organisation will look like following the implementation of a range of initiatives such as the new NHS general dental service contract, agenda for change, IWL, *Commissioning a Patient Led NHS* and the changing workforce initiatives. Currently all these plans are being taken forward in isolation but the combined effect of these changes in the next five years will markedly change the number, structure and role of the dental workforce.



Organisational change

All organisations need to change over time. Organisational change may be necessary for a number of reasons and the way that change is managed will impact on the way the change is received by the people involved.

Organisational change can be an unsettling process for the staff involved and this element is often ignored in the process of redesigning the workforce to meet the changing service needs. The needs of staff are different as are their working styles, and reactions to change. These differences must be understood and recognised if there is to be a smooth transition from one way of working to another.



Role redesign

When planning the workforce to meet future service needs it is important that the organisation and the current workforce understand the impact of any changes to traditional roles and ways of working. As part of the change management process it is important that staff recognise the reason for the change and the benefits that change will bring. They will need to understand how any changes will impact on them personally and how it will improve patient care.

Effective role redesign must follow a set of fundamental principles:

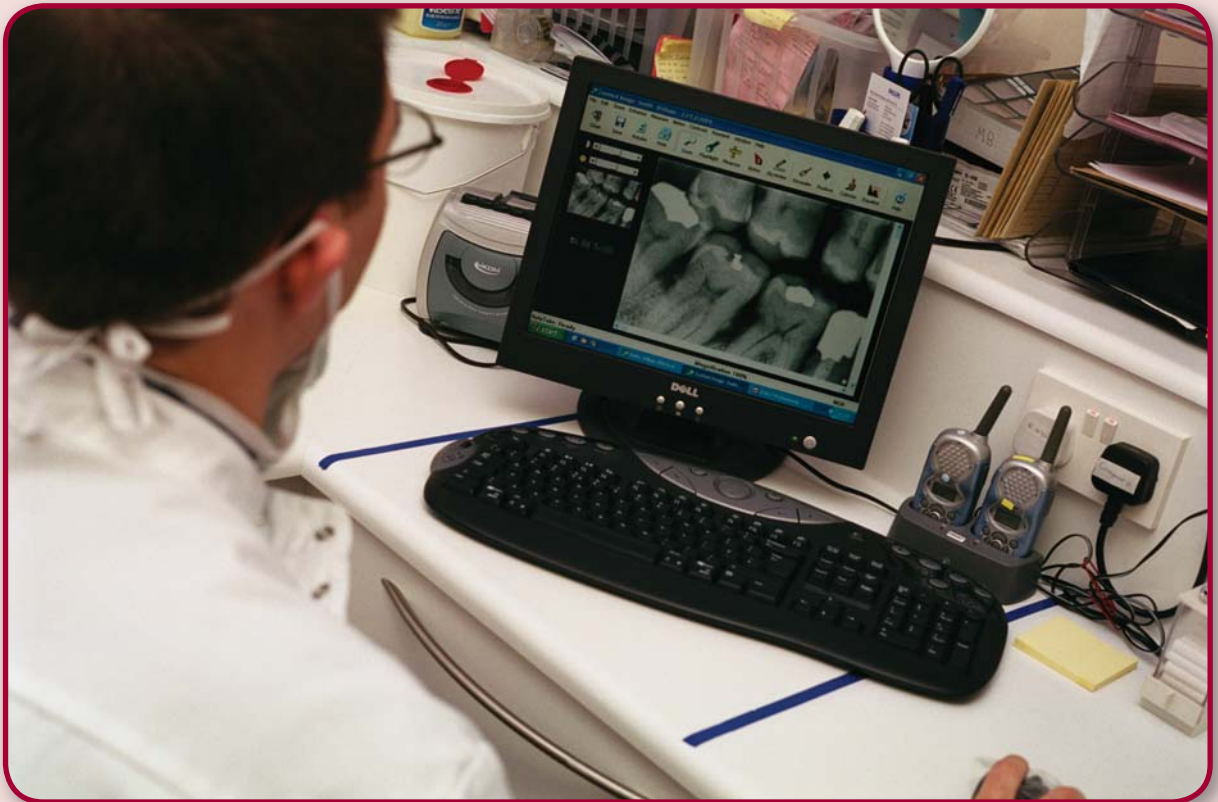
- The changes are based on the use of care systems, pathways and protocols linked to the development and delivery of services
- Any changes must ensure clarity, accountability and safety for the patient
- Assessment of the impact on changing or new roles on other roles and services provided has taken place and wider changes made if needed
- Close links are maintained with other relevant developments in human resources
- All role design takes account of the need for continuing personal and professional development and lifelong learning. Experience and training from one post should be recognised and accredited and used for development



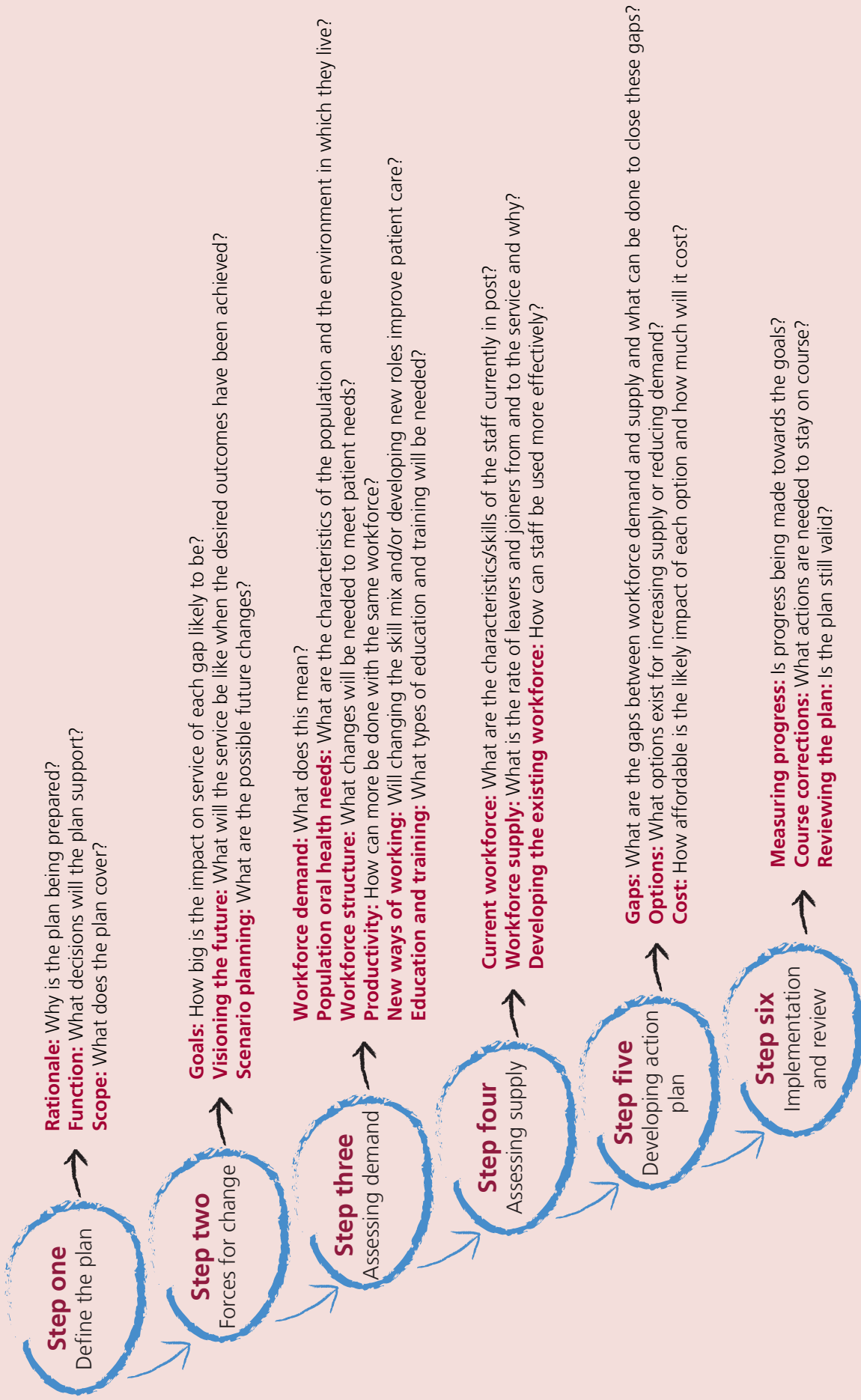
- Role redesign builds on growing evidence and experience of good practice.

It is crucial during the time of change that all parties recognise that role redesign is not a way of getting staff to do more work for less, nor is it a cost cutting exercise. In the current changes facing the NHS, role redesign needs to be used to contribute to the solution to the widening gap between service demand and delivery, which cannot be met by the current workforce structures and numbers.

For guides on personal and organisational development go to:
www.institute.nhs.uk/improvementguides.



Six step guide to planning the workforce



Step one: Defining the plan

- *Rationale: Why is the plan being prepared?*

This establishes who initiated the planning process, the reasons for initiating the plan, who will be involved in the planning process and what the plan aims to achieve. However, before starting the planning process it is important that organisations know the drivers behind the planning process. Some of the drivers for dental services can be found in section one of this pack.

- *Function: What decisions will the plan support?*

This considers the decisions that need to be made by the planning organisation, and other bodies that may influence the plan, and when these decisions need to be made. A large element of the plan will involve visioning possible scenarios based on an analysis of current trends.

- *Scope: What does the plan cover?*

The scope defines the structure of the plan, the timescale, client group, geographic area, services and staff which will all need to be included in the planning process to ensure development of innovative solutions. However, although it is important that the plan is not too narrow to avoid missing essential factors, caution also has to be taken to prevent it being too wide and hence becoming unmanageable.



Step one: What you need to know

Who initiated the plan?

What resources are available for implementation of the plan?

Who will be affected by the plan?

Who needs to be involved in producing the plan?

Is everyone signed up to achieving the goals of the plan?

What outcome is the plan intended to achieve?

What decisions will need to be made by the organisations that are developing the plan?

What decisions, made by others, need to be influenced if the plan is to be successful?

When do decisions need to be made?

What is the timescale for the plan?

What are the characteristics of the population?

What geographic area does it cover?

Step two: Visioning the future

- *Goals: What are the outcomes that the plan is trying to achieve?*

The central part of the plan is the outcomes: the plan's goals. If the plan is to be successful it will need to have clear and concise goals that all the stakeholders can work towards. Defining the goals will also enable the desired changes to be described in a way that can be clearly identified, monitored and recorded. Identified goals will enable differentiation between intended and other possible outcomes.

- *Visioning the future: What will the service be like when the desired outcomes have been achieved?*

Visioning the future involves looking at future events, both within and outside of your control, and considering how these events may affect the service to be delivered. If these events are understood at the outset, there will be an opportunity to plan for them by preventing, changing, modifying or supporting the event so that the plan's objectives can be achieved. Developing a vision of what the dental service/workforce will look like once the desired outcomes have been achieved is generally an excellent way of ensuring engagement from all the stakeholders in the planning process. Gaining stakeholder buy-in to the vision will help in getting everybody working together as a team to help achieve the goals.

- *Scenario planning: What are the possible future changes?*

Once the goals have been identified and a vision of the future created, these can be used to create a range of scenarios or 'what if?' pictures of the future. It is best to keep these scenarios relatively simple at this stage, adding complexity will involve lengthy debate but not improve the overall plan.



Step two: What you need to know

What will the dental service and/or workforce be like once the desired outcomes have been achieved?

What will be improved by the plan?

How will improvement be measured?

What are the priorities for the desired outcomes?

What are the main events that will impact on the service?

How effectively can these events be controlled?

How are these events likely to work?

Has a range of scenarios been developed that captures all the possible future changes?

Scenarios will need to include the impact of disease prevention and management, supporting self care, improving community based services and better integration of allied health care services.

Step three: Assessing demand

Workforce demand means the numbers and types of people needed to deliver the planned service and the skills and competences they need to possess.

As discussed at the start of section two, planning workforce demand cannot be carried out in isolation. It needs to be an integral part of the wider service and financial planning process. Workforce demand will be driven by the planned delivery of services but, as with the funds available for commissioning dental care, the workforce is also a limited resource, which may constrain the services that can be delivered.

Demand numbers cannot be identified by looking forward from the current structures; this will restrict the demand to today's model of working. Demand will need to be worked up from the visioning of scenarios identified in step two and would bring together information on:

- Population oral health needs
- How this translates into demand for services
- The planned provision of services to meet these needs which will be informed by national and local policy on the quality of provision and resource assumptions
- The service models that are planned to deliver these services
- Ways of working including current staffing models, new roles, skill mix and productivity changes



- What are the characteristics of the population and the environment in which they live?

Community mapping data will be needed to enable identification of the characteristics of the population and a description of the environment in which they live. This process will also establish whether any up to date data currently exists concerning the expressed oral health needs of this population. The data should include:

- Demographic statistics such as population, ethnicity, deprivation and unemployment data
- Morbidity information such as dental decay, periodontal disease and oral cancers, as well as more general information such as rates of smoking and alcohol consumption
- Information regarding the use and capacity of services from service providers, service users and their carers
- A community map highlighting all relevant services in the locality as well as local knowledge relating to the accessibility and use of these services.



- What is the treatment need the service is expecting?

Once a picture has been formed in relation to the characteristics of the population and the services they can easily access, it will be possible to identify the treatment need the service is expecting.

The service will be faced with a heterogeneous mix of people both in terms of numbers and needs. It will therefore be necessary to understand the requirements of delivering treatment to this mix of people. It can be helpful to mind map the configuration of services around this mix of people before developing service pathways. Once service pathways have been established for the population, an opportunity is given to see if the pathways can be improved or shortened. In other words, an opportunity is provided to look at redesigning the service to more appropriately meet the needs of the population.



- *How can more be done with the same workforce?*

Productivity improvement is about achieving more service activity for a given level of workforce input. Increasing productivity is commonly misunderstood as trying to make people work harder. While improved motivation will, no doubt, produce some productivity improvements, the significant gains come through using a scarce workforce resource more effectively.

- *Will changing the skill mix and/or developing new types of workers improve patient care?*

An alternative to increasing the productivity of a specific staff group is to use the skills of that group more effectively by transferring tasks to other groups of workers. Staff at any level typically spend a large part of their time undertaking tasks that do not require their level of training or skill. These tasks can often be successfully transferred to other workers. Where these are existing staff, this is often referred to as changing the skill mix; in other cases the transfer may require the development of new roles. This provides the opportunity to envisage the service being delivered by new types of workers especially within the allied health professional group.

- *How many and what kind of staff are needed to meet this treatment need?*

The number of staff required in each function within the service and the skill mix of the staff necessary to fulfil the activities can now be planned. To assist in this planning, detailed prepared material can be referenced from *The First Five Years – A Framework for Undergraduate Dental Education* and *Developing the Dental Team – Curricula Frameworks for Registrable Qualifications for Professionals Complementary to Dentistry (PCDs)* www.gdc-uk.org, *Knowledge and Skills Framework for Oral Health Promotion* on request from www.nohpg.org and the *Skills for Health* website www.skillsforhealth.org.uk. However, it is vital that only the skills, knowledge and competence required by the service are identified at this stage by developing a profile of what is needed for the service pathways. However, the focus



should remain on the needs of the patient and all attempts to identify the necessary skills, knowledge and competence through the eyes of a patient will be beneficial. Only when this has been achieved should the number and type of dental professionals needed to deliver the service be identified based on the profile information. This should also identify the training needs of the whole dental team and ensure that all members can continue developing their skills, knowledge and competence.

Step three: What you need to know

What services will be needed to meet the patients' needs and how are they likely to change?

What is the treatment need these services will be expecting?

Can ways of working be adapted, including current staffing models, new roles, skill mix and productivity changes to meet these needs?

What are the financial implications?

Step four: Assessing supply

Many people with different working times and patterns and a diverse range of skills could be involved in delivering a dental service. These people make up the staffing profile. To achieve workforce planning effectively, you need to understand the composition of the current workforce and be able to forecast future requirements.

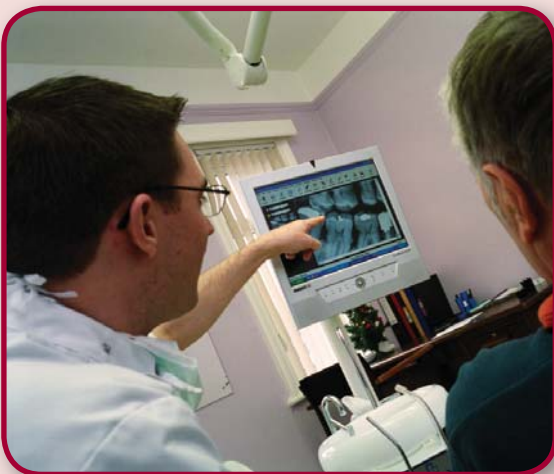
Some of the future demand for dental services may be adequately met by current staff, some may not. Estimates can be made for the future demands of a dental workforce to deliver the service by considering a number of key questions:

- *What are the characteristics of the staff currently in post?*

The starting point for assessing supply is the workforce that is in post now. This not only informs how current demands are being met but will also form the core of the future workforce. Developing the skills of this workforce is as important to the supply strategy as recruitment and training of new staff.

- *What is the rate of leavers and joiners from and to the service?*

An important characteristic of workforce supply is the flow of workers into and out of the organisation. An understanding of this



flow is needed in order to control workforce supply and forecast the future workforce. The number of workers at any point in time will be a balance between the leavers and the joiners.

- *How can staff be used more effectively?*

In step three, new ways of working to modify demand was explored. New ways of working can also be used to enhance supply. However, this considers more radical solutions such as total restructure of the workforce when more simple and straightforward options will not bring about sufficient change. For example, more dental therapists are being trained and introduced into primary care to enable the development of team working by delegation of many straight forward restorative procedures from dental practitioners to therapists.

Step four: What you need to know

Have options been analysed and costed for increasing the workforce supply?

Have the options for working differently been analysed and costed?

Has data relating to current workforce numbers/competence/career aspirations been collated and analysed?

Has the potential of the current workforce been maximised?

Can intrinsic rewards of posts be improved?

Have all possible sources of dental workforce supply been considered?

Are there untapped new pools of potential recruits to dental services such as the voluntary/independent sector?

Step five: Developing an action plan

Steps three and four gave a picture of how the demands for the workforce, and the supply available, are likely to change over time. If the two forecasts are compared, a picture will be established of the difference between them, the gaps, which are likely to occur over the period of the plan. Gaps can occur in the overall availability of people to deliver a service and also in the skill mixes that a group of people have. Remember, workforce planning is about **getting the right people with the right skills and competences available at the right time.**



- *How big is the impact on service of each gap likely to be?*

Once the supply and demand assessments have been put together, it is likely that a number of gaps will have been identified. On development of the action plan, actions will need to be prioritised so that the gaps that present the highest risk receive the greatest focus. One way to think about this is in terms of hot spots and cold spots. Hot spots are gaps that are likely to have a major impact on service delivery whilst, in contrast, cold spots are areas where there is under utilisation of skills or scope for flexibility.

It is possible to turn hot spots into cold spots. For example, if an important clinical skill is only possessed by a single professional group, it may be possible to train a wider group of people to safely carry out the activity.

- *What options exist for increasing supply or reducing demand?*

If a gap has been identified between supply and demand, it will need to be reduced by increasing supply, reducing demand or a combination of both. The options available will depend heavily upon the service area. The following are some things that should be considered:

- Increasing the number of people in education and training
- Reducing demand by reviewing the traditional staffing patterns and challenging the way care is delivered
- Increasing productivity.

- *How big is the likely impact of each option and how much will it cost?*

Once a list of options for increasing supply or reducing demand has been established, it will be necessary to assess these for the likely impact each could have on the outcome of the plan. It will also be necessary to consider the cost for the proposed solutions. It may be that some solutions incur additional costs, but it is possible that some may avoid further investment by maximising on the investments previously made in the workforce.



Once completed, a highly flexible robust plan should be established that will allow adjustments to be made in response to the influencing factors that will inevitably be present.

To test the plan a number of scenarios should be used. If the scenarios are chosen well, they can be very useful testing tools for the plan or strategy to see if it will stand up to different circumstances. Scenarios cannot test for every eventuality; they will however show which strategies appear more able to cope with different challenges.

Step five: What you need to know

How well does the plan stand up to different scenarios?

Have the workforce demand and supply figures for each scenario been compared?

Has a gap analysis for each scenario been undertaken?

What are the gaps between staff supply and demand and what can be done to close these gaps?

Have the hot spots/cold spots been identified?

Have the options been costed?

What are the best options to put into the action plan?

Are there any other tools available that can have an impact on workforce supply or demand?

What steps need to be taken now as part of the action plan?

Step six: Implementation and review

Strong plans are flexible plans that can be changed and adapted as new circumstances arise. This flexibility will allow adaptation and change to meet the challenges encountered during the implementation process.

- *Is progress being made towards the goals?*

At the beginning of the planning process, the plan's goals were defined. At that stage, goals should have been picked that had measurable outcomes. Now that the plan has been implemented, it is necessary to ensure that the progress towards the goals is actually measured. This will ensure that if the plan deviates from the desired goals something can be done about it.

- *What actions are needed to bring the plan back on course?*

It can be assumed that, realistically, no plan is likely to be perfect given the number of uncertainties that are being dealt with. If the monitoring processes are effective,

however, they will provide early warnings of when the plan strays from the intended course of achieving the goals. When these warnings are received it is important to review these carefully and reference the warning to the action list within the workforce plan.

If the problem has been spotted early enough, it may still be possible to adjust the action within the workforce plan to put things back on course. Corrective action can be taken or some of the other actions on the action list adjusted. In more complex areas, such as the introduction of new ways of working, an underestimation may have been made concerning the level of resistance to change in the organisation and additional organisational development activities may need to be invested in to win acceptance for the change. Corrective action can only be taken so far. If the scale of the problem is such that adjustments cannot be made to bring the plan back on course, the only option is for a radical review.



What happens when:

- A plan has been developed
- The plan has been implemented with a set of measures to monitor progress
- Reviews and course corrections have been carried out

- but the goals of the plan are still not going to be achieved? At this point a more radical revision of the plan may be required. If the workforce plan has been built following the guidance in this toolkit, a clear systematic approach to the development of the document will have been undertaken. This therefore makes it relatively easy to review each step to find out which part of the planning process was flawed or insufficiently robust.



The review process is not simply about producing an updated plan (the plan may need no changes) but is also a learning exercise. By undertaking a methodical approach in the review of the plan, a better understanding will be achieved concerning what worked well and what did not. This learning can be transferred when developing a modified plan or the knowledge used in the next planning exercise.

Step six: What you need to know

How often will progress be measured?

Who will review progress?

How will progress be measured?

What will progress reports look like and how will they be produced?

Have all the actions within the plan been implemented?

Is the plan still valid? If not, what needs to change?

Full details of the six step guide to workforce planning together with an e-learning programme based on these six steps can be found at www.healthcareworkforce.nhs.uk. This portal offers practical tools and resources, shares best practice, acts as a networking forum and provides up to the minute information that can support health and social care managers deliver smart workforce solutions to changing healthcare needs. Some useful workforce planning tools that can be found on the portal include:

- Six Steps E-learning Resource
- NHS Benchmarking Database
- Long Term Planning Guide and Audio CD
- UK Wide Workforce Planning Competence Framework
- Labour Market Information and Intelligence Guide for NHS planners
- Productivity Briefing Paper
- Workforce Development Resource Pack for long term conditions, 18 week patient pathway and public health
- Children's Workforce Briefing Paper
- Education Workforce Briefing Paper
- Working Time Directive projects.

Visit www.healthcareworkforce.nhs.uk to access free copies of the above resources.



Workforce planning checklist

The following checklists are for guidance only. Some of the questions may not be relevant to your level of workforce planning.

Workforce state of readiness checklist for dental services

| | YES | NO | ACTION REQUIRED |
|--|-----|----|-----------------|
| Strategy | | | |
| Does the SHA/PCT have a dental services strategy? If so: | | | |
| <ul style="list-style-type: none"> Has it been endorsed by appropriate boards/local authorities? | | | |
| <ul style="list-style-type: none"> Does the strategy take account of service provider/corporate/voluntary sector involvement in provision of services? | | | |
| <ul style="list-style-type: none"> Does the strategy embrace the implications of new approaches to the management of dental disease? | | | |
| <ul style="list-style-type: none"> If it does not is there an alternative strategic plan such as an oral health strategy that addresses improvement in oral health/reduction in dental disease? | | | |
| <ul style="list-style-type: none"> Does the strategy address workforce issues throughout? | | | |
| Leadership | | | |
| Does the SHA/PCT have a dental workforce development board or steering group? If so: | | | |
| <ul style="list-style-type: none"> Does the board/group include local authority representation? | | | |
| <ul style="list-style-type: none"> Does the board/group include representation from the deanery/service provider/voluntary/corporate sector? | | | |
| <ul style="list-style-type: none"> Does the board/group include representation from the finance department? | | | |
| <ul style="list-style-type: none"> Does the board/group include workforce lead or have other direct links to SHA? | | | |
| Operational policies | | | |
| Have the specifics concerning type of activity, location and volume been addressed in the following: | | | |
| <ul style="list-style-type: none"> In the dental service which is to be reshaped? | | | |
| <ul style="list-style-type: none"> For the proposed dental service which is now planned? | | | |
| <ul style="list-style-type: none"> Does the planned service include new types of workers? | | | |
| <ul style="list-style-type: none"> Has the capacity of existing providers to deliver services been assessed? | | | |

| | YES | NO | ACTION REQUIRED |
|--|-----|----|-----------------|
| Controls | | | |
| • Does the strategy align with financial plans/assumptions in the local delivery plan (LDP)? | | | |
| • Does the strategy align with financial plans/assumptions in multiprofessional education and training (MPET)? | | | |
| • Is the implementation of the dental services strategy subject to local performance management mechanisms? | | | |
| Commissioning education and training | | | |
| Have local stakeholders proposed changes to commissioning patterns for 2007/2008 to accommodate a new dental service strategy? | | | |
| Have the deanery/service provider/corporate/voluntary sectors been involved in making decisions about commissioning of education for the dental workforce? | | | |
| Have the deanery /service provider/corporate/voluntary sectors approached local education providers about training the future dental workforce? | | | |

Workforce training and development checklist

| | YES | NO | ACTION REQUIRED |
|---|-----|----|-----------------|
| Does the strategic workforce plan include staff development and training? | | | |
| Has any training and development been commissioned around the area of dental workforce development? | | | |
| Are you aware of any training commissioned by local authorities or PCTs in your area to support dental workforce development? | | | |
| Are service users involved in the development and/or delivery of training to support dental workforce development? | | | |
| If no training is currently being delivered, are there plans for this area? | | | |
| Is support available to make the commissioning process easier? | | | |

Section Three:

Frequently asked questions

Q What is a realistic time frame for the workforce development plan?

A A dental workforce development plan should encompass at least the next five years and be regularly reviewed and updated to take account of changing workforce needs in line with the oral health services strategy. Within this, particular local issues (for example, specific service reconfiguration or development) that need intense workforce planning may require two or three year timescales.

Q Who needs to be on the dental workforce development board or steering group?

A The board/group should consist of members who support a patient led approach to workforce planning and must include representation from the PCT, SHA and service providers such as:

- Commissioners responsible for dental services
- Clinical directors for dental services
- Finance specialists
- Consultants in dental public health
- Deans for dental workforce development
- Dental practice advisors
- Local dental committee representatives
- Training and development leads
- Consultants in public health
- Clinical governance leads.

Q Where can information regarding population characteristics be retrieved?

A Useful sources of information may include:

- PCTs
- Healthcare professionals
- Local authority departments
- Social services
- Patients.

As population groups and localities can be extremely diverse, it may also be necessary to look at other sources of information that can help build a bigger, better picture of the population:

- National Statistics
www.neighbourhood.statistics.gov.uk
www.nomisweb.co.uk
- Index of multiple deprivation 2004
www.odpm.gov.uk/stellent/groups/odpm_urbanpolicy/documents/page/odpm_urbpol_028470.hcsp
- Adult Dental Health Survey
www.statistics.gov.uk/ssd/surveys/adult_dental_health_survey.asp
- Child Dental Health Survey
www.statistics.gov.uk/ssk/surveys/cdhs.asp
- British Association for the Study of Community Dentistry (BASCD)
www.bascd.org
- Dental Observatory
www.dental-observatory.nhs.uk
- NHS Benchmarking Database
www.healthcareworkforce.nhs.uk/benchmarking

Q What is a skills, knowledge and competence profile?

A A skills, knowledge and competence profile identifies all the skills, knowledge and competences needed for the current and/or future dental service. This takes time and will need some clinical input from the dental team. However, the focus should remain on the needs of the patient and all attempts to identify the necessary skills, knowledge and competences through the eyes of a patient will be beneficial.

Once all the skills, knowledge and competences have been listed they need to be divided into three levels; basic, intermediate and specialist. This creates a lot of discussion and sometimes resistance with some professionals. It is, therefore, vital that these skills are allocated to the **service** and not an identified profession. In all job roles there will be a mixture of skills but the percentages of each will be determined by current/future ability through identified training.

An example structure is:

Basic = requiring experience and/or qualifications up to and including NVQ level 3

Intermediate = requiring a dental care professional qualification

Specialist = requiring a dental and/or specialist qualification

Q Will members of the dental team not get 'burnt out' if they are employing additional/specialist skills, knowledge and competence intensively?

A Identification needs to be reached of the balance between the different skills and how these will be translated within the dental team. Skill mix is not about saving money but removing inappropriate tasks from a workload whilst retaining job satisfaction within the dental team. As a guide, therefore, a member of the dental team with additional skills should have their time divided so that they are applying 80 percent of the time to additional skills, knowledge and competence and 20 percent

to more intermediate or basic skills to reduce the risk of 'burn out'. Likewise, other members of the dental team should be encouraged to apply 20 percent - 50 percent of their time to developing and applying additional skills to enable continued professional development and improve retention rates.

Q I can't recruit a dentist. How can this resource pack help me?

A By showing how an alternative solution might be found in developing skill mix/team working. Currently, the dentist is mainly recognised as having the expert skills needed to treat oral disease and improve oral health. This results in time and resources being spent on care that can be delivered by other members of the dental team such as therapists and dental nurses, and/or health professionals and community workers such as health visitors, smoking cessation advisors, teachers and ethnic support group leaders.

By following the steps within this resource pack, a definition of what the current and future dental workforce needs to look like to deliver your service will be reached. This in turn will identify the training needed to develop the necessary skills, knowledge and competence within the workforce in order to bridge gaps in service provision.

Q What should I do when my patients say they only want to see a dentist?

A Explain that members of the dental team work under the direction of a dentist. This resource pack was developed to encompass a patient led approach to commissioning a dental service and thus will enable efficient development of a contemporary dental workforce that is no longer tied to traditional roles but is able to access the skills and competence needed to deliver a dental service based on the needs rather than the demands of the population.

Section Four:

Innovative approaches to working differently

Since the introduction of *Modernising NHS Dentistry: Implementing the NHS Plan* and *NHS Dentistry: Options for Change* many recommendations have been made to explore new ways of working within dentistry. However, as the present dental workforce is currently going through immense change due to the advent of the new dental services contract and restructuring of PCTs, time capacity to explore new ways of working has been limited. The following, however, are a selection of examples that, whilst not necessarily of evidence based practice, illustrate how innovative ideas around working differently can be put into practice.

There is no doubt that there will be many more examples nationally and information concerning these would be welcomed to enable the sharing of evidence based practice via the NHS National Workforce Projects portal. www.healthcareworkforce.nhs.uk

Patient Centred Approach to Commissioning the Future Dental Workforce Toolkit

This toolkit resulted from a dental workforce development project funded by the North Western Deanery, Greater Manchester SHA and Cumbria & Lancashire SHA. It was in response to the recognition that overall knowledge concerning the current dental workforce is limited and that competence based planning will be used to deliver a dental workforce following modern service redesign.

Based on *A Patient Centred Approach to Workforce Planning* (Brooks and Bosma, 2003 © Manchester University), it provides PCTs with a functional model that will enable efficient development of a contemporary dental workforce, from a service provision perspective, according to the oral health needs of the local population. It emphasises a bottom-up approach of “starting where the population are” and is written in accessible language, using a structure that can be shared

with other agencies at all professional levels.

For further information:

Nick Ward, dean of postgraduate dental education, North Western Deanery, Barlow House, Minshull Street, Manchester M1 3DZ

Triage dental nurses

David Evans, SHA dental lead for Northumberland, Tyne & Wear, successfully ran an out of hours (OOH) pilot scheme in Newcastle & Tyneside and South East Northumberland based on the needs of the community. Set up in 2001 to support all practices across the PCT areas during weekday evenings, weekends and bank holidays, the service dealt with about 160 patients a month. Initially patients were put in touch with the service via NHS Direct. From here they were assessed and prioritised (known as ‘triaging’), and if they needed further advice or treatment from a dentist their details were passed via a GP cooperative to one of the dentists on call. The dentist on call also provided urgent advice, where appropriate, to the triage nurses. If necessary, patients were seen at a designated primary care OOH centre. More recently dental nurses have been recruited and trained by NHS Direct and integrated into the triage system – not only to help to fine tune the assessment process, but also to provide informed self-care support and advice to callers when required. The move has been well received by patients who, according to a satisfaction survey, welcome the option of telephone guidance and reassurance in addition to access to urgent dental appointments out of hours.

For further information:

David Evans, consultant in dental public health, North Tyneside Primary Care Trust, Benfield Road, Walkergate, Newcastle-Upon-Tyne NE6 4PF

Stop Smoking service in the dental practice

A pilot scheme to support the *Stop Smoking* service in Kent, and as a result, encourage more smokers to quit was carried out by Medway PCT. This involved dental care professionals undertaking *Stop Smoking* intermediate advisor training to enable them to deliver one to one in-practice support to smoking patients. The perceived benefits of this pilot scheme would be improved general health of smoking patients, improved oral health, support for national and local *Stop Smoking* targets and continued professional development within the dental team.

For further information:

Christopher Allen, consultant in dental public health, Department of Dental Public Health, New Court, 1 New Road, Rochester, Kent ME1 1BD

Infant preventive dental scheme

This scheme has been set up by the Department of Community Special Care Dentistry of King's College London Dental Institute for the referral for oral disease prevention of children under five years of age with medical, physical or intellectual impairments. Working in partnership with the consultant community paediatrician, parents are asked if they wish to be referred onto the scheme during a developmental assessment. If parents agree, a referral is made to the head/consultant of community special care dentistry who arranges a domiciliary visit by the oral health promotion team. Following the home visit, arrangements are made for the child to access a full oral health assessment as well as any necessary treatment. This scheme therefore ensures that access to oral health is available to children who are at greater risk of dental disease.

For further information:

Liana Zoitopoulos, consultant/hon senior lecturer, head of community special care dentistry, King's College London Dental Institute, Caldecot Road, London SE5 9RW

Child friendly general dental practices

In response to publication of the *Children, Young People and Maternity National Service Framework* and in partnership work with Sure Start, this local scheme to improve oral health in local children aged 0 - 5 years, was developed in a deprived area of Haringey with an historically low uptake of dental care. The scheme was called the Tiny Teeth programme and sought to improve access to dental treatment and prevention through child friendly general dental practices in a children's centre network area.

Through (i) recruitment of child friendly dentists, (ii) capital investment in preventive facilities at the practices and external signage, and (iii) training of practice staff in prevention, the scheme saw an increase of 29 percent uptake of dental care by under fives in its first year, compared to an 8 percent increase in dental practices not in the scheme.

As part of the initiative, 10 practice nurses, four health visitors and one school nurse also completed the Royal Society of Health Oral Health promotion course.

This scheme demonstrated that a coordinated network of preventively-oriented, child friendly dental practices can be set up and that local utilisation of these services increases.

For further information:

Steve Simmons, specialist in dental public health, First Floor, G Block, St. Ann's Hospital, St. Ann's Road, Tottenham, London N15 3TH



Trial of triage protocol software

The Birmingham Personal Dental Service (PDS) proposed to develop a computerised triage protocol for patients contacting the sixteen PDS daytime clinics, which would allow all members of the dental team to prioritise patients, booking appointments according to the patient's dental need in a standardised way across the service. This would include a standardised system of assessing patients' most suitable dental care provider (eg GDS, PDS or hospital).

Paper based Q&A flowcharts were designed and piloted across three of the daytime clinics. Various modifications were made following evaluation of feedback and a revised paper based system was trialled. The tested flowcharts were then incorporated into service software, which was then piloted at the same three clinics. Further modifications were made before introducing the software to all clinic sites for a three month trial.

The trial of the triage protocol software was overall very successful. Despite expressing initial reservations, the majority of both support staff and dentists, when surveyed at the end of the three month trial, commented favourably. They found it had helped to clarify registration of new patients, standardise procedures across all clinic sites as well as prioritise appointments.

Most of the support staff welcomed the guidance of a clinically approved triage system when having to make decisions. They felt that it helped them to identify patients' clinical/dental needs and prioritise appropriately, without having to consult a dentist. They found it quick to use once they were familiar with the software and felt that it helped with the management of appointments.

This view was supported by the majority of dentists, who said that the introduction of triage had empowered the support staff to make decisions which eliminated inappropriate booking and prioritised genuine emergency patients. Dentists who remembered to use it also found the triage history a source of useful information.

The views expressed by patients surveyed showed a high level of satisfaction with the outcomes reached by the triage protocol, even

though they were not necessarily offered an appointment on the same day. On the day of their appointment virtually all patients were seen within 30 minutes of their appointment time and found this wait acceptable. Waiting times would inevitably have been longer and therefore less acceptable if patients had not been triaged and prioritised on initial contact.

It would appear therefore that it is possible to involve all members of the dental team in using a triage protocol provided it is a sound, robust, evidence based and clinically approved system. The overall impact of introducing such a triage protocol has been shown to be beneficial to both patients, staff and service delivery, which, in turn, hopefully has a positive impact on clinical outcomes.

For further information:

Janet Clarke, clinical director, Medical Records Block, West Heath Hospital, Rednall Road, Birmingham B38 8HR

Increasing opportunities for self care

Having always felt that more harm than good was being done to patients by just repairing damaged tissue, Orkney Dental Clinic believed that giving enough information to patients about the disease process can enable them to take more responsibility for their own health. This more preventive rationale for treatment starts with an in depth oral health assessment that includes:

- Risk assessment for caries, based on seven measurements including strep mutans levels, saliva buffering, dietary and oral health factors. Followed by targeted advice to reduce risk factors and treat underlying conditions, and minimally invasive repair
- Risk assessment for periodontal disease followed by a comprehensive preventative programme based on education and disease control.

The project has been running for two years and, although initially aimed at the elderly, is now being expanded to include young people and expecting mothers.

The benefits already produced from the project are a reduced level of disease in the patient group under treatment and a better

use of resources, especially time, that can now be better utilised for patients in need rather than blanket covering a whole population group with generic preventive messages and treatment. A longer recall period for those identified as low risk has also increased time benefits. The perceived benefits also include less risk to both oral and general health in future.

The project not only demonstrates that increasing patients understanding and involving them in treatment increases their motivation and acceptance of treatment but it also increases job satisfaction within the dental team.

For further information:

John Shapter, Dental Clinic, 10 King Street, Kirkwall, Orkney KW15 1JF

Priority communities and special needs oral health promotion programmes

The Northumbria Healthcare NHS Foundation Trust's oral health promotion (OHP) team has developed oral health promotion programmes that cover 1) priority communities and 2) special needs groups. This was led by the results of British Association for the Study of Community Dentistry (BASCD) surveys which identified significant dental health inequalities across Northumberland and North Tyneside, and also an appreciation that certain health and behaviour challenges (eg autistic spectrum disorders) can bring people enormous personal problems if they suffer oral diseases.

These programmes involve the OHP team working with district strategic planners and managers (eg health visitor, children's centre and social services managers), service providers (eg health visitors, teaching staff, nursing and care staff, pharmacists, general dental practitioners) and key members of the public (eg parents and carers) to consult widely, and produce outlines of services that could reasonably be available both district wide and more specifically within the priority communities and then to help develop and facilitate these services.

The benefits that have resulted from this initiative are:

- Policies, supportive environments and routine practices that promote oral health have been introduced by a wide range of settings and professionals
- Oral health improvements, which whilst it is obviously difficult to say with 100 percent certainty that these were caused directly by this work data from the 2004 census survey showed improvements in oral health compared to other communities
- In partnership with a local children's centre and its community, this approach won the 2006 Partners in Excellence Award, in the promoting children's wellbeing category
- Money raised to develop and distribute resources. This comes from successful bids to a range of agencies and sales of resources
- The team is well known and valued across the area
- Oral health promotion and planning is an integral part of agencies' training programmes
- Oral health has a high profile on the agendas of many non dental professionals.

The benefits have been measured through:

- Ongoing audit through OHP team action plans
- BASCD dental health surveys
- Budget statement
- Programmes' feedback processes.

The lessons that were learned were:

- People, their visions and their needs are so important
- Involvement and partnership working must start at the beginning and be ongoing
- We can all help each other
- Many organisations' targets can be met in ways that also promote oral health
- Oral health promotion needs to be integrated within life as much as people want.

For further information:

*Peter R. Wilson, senior dental officer,
Northumbria Healthcare NHS Foundation Trust,
Health Centre, Gas House Lane, Morpeth,
Northumberland NE61 1SR*

Dental nurse cadet scheme

The scheme is a high quality work based training apprenticeship programme that provides local based training in the Oldham PCT area for local school leavers, particularly representing minority ethnic groups where an identified shortfall exists in the local dental workforce.

The quality training develops continuing professional development and the concept of the skills escalator for dental nurses and enables competent and efficient patient care delivery in:

- Patients rights and professional responsibility
- Communication skills
- Health and safety
- Delivery of first aid as an appointed person
- Dental nursing skills (NVQ level 2 in year one and level 3 in year two).

Regular progress checks are supported in work based training at the dental practice. Cadets steadily progress through the learning framework at college and feel proud to achieve the goals set out.

Staff involved with the scheme including PCT staff, college, and dental practice teams are able to fulfil new roles. These new roles have involved developing new skills within project management, mentoring, reviewing, training, report writing and integrated working and have brought about personal development which has resulted in greater job satisfaction for many.

Dentists are happy that recruitment and retention issues in the dental workforce are being addressed. They have also identified that they have benefited through improved communication between themselves and their diverse communities they serve.

For further information on the scheme:

*Colette Bridgman, consultant in dental public health,
Oldham NHS Primary Care Trust, Ellen House,
Waddington Street, Oldham, OL9 6EE*



Section Five:

Useful contacts/ resources

A Guide to using Labour Market Information and Intelligence for NHS Workforce Planners – February 2006

This guide aims to help planners in the NHS understand where labour market information and intelligence can help them in workforce planning.

It is not an academic guide to creating labour market information and intelligence, but is meant to be a practical guide, focused on the need of workforce planners in the NHS. Therefore it doesn't cover all aspects of LMI analysis but focuses instead on providing some shortcuts to information and intelligence that will be immediately useful for both short and long term planning.

www.healthcareworkforce.nhs.uk/lmi

Christmas trees

Christmas trees provide a visual representation of the NHS workforce, based on the NHS career framework. This approach can be used for competence based and service reconfiguration planning, and also workforce redesign.

It provides a useful tool for local planners in SHAs and trusts.

www.healthcareworkforce.nhs.uk/wrtmodelsandtools - click on 'Christmas trees'

CSIP

The Care Services Improvement Partnership (CSIP) was launched in April 2005. Its main goal is to support positive changes in services.

www.csip.org.uk

Department of Health

The dental services team at the Department of Health works to support the NHS, the dental care professions and other stakeholders to maximise oral health, improve NHS dental services and promote high quality dentistry. The team also has responsibilities in relation to the dental workforce, education and information technology (IT). The team includes the chief dental officer and other professional dental staff. These pages provide up to date information about the team's work in these areas.

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Dental/fs/en

Faculty of General Dental Practice (UK)

The Faculty of General Dental Practice (UK) (FGDP(UK)) has a section on its website, providing information on dentists with special interests (DwSIs). The DwSI scheme allows PCTs to contract general dental practitioners to carry out services which might otherwise have been carried out in a hospital environment.

In order to ensure quality and safety of care for patients, national guidelines and competence for the scope of treatment that can be undertaken by DwSIs have been jointly developed by the Department of Health and FGDP(UK). The first of these competence frameworks were published in April 2006 and are in the fields of minor oral surgery, orthodontics, periodontics and endodontics. The DwSI section of the FGDP(UK) website aims to answer many of the frequently asked questions about DwSIs, and includes dedicated guidance for dentists, PCTs and patients.

www.fgdp.org.uk

Integrated Service Improvement Programme

The Integrated Service Improvement Programme (ISIP) was initiated by directors of service improvement at service level in April 2005 and formally launched and endorsed by the Department of Health in November 2005.

www.isip.nhs.uk

Large Scale Workforce Change (LSWC) Programme

The LSWC team's work focuses on developing an adaptable and flexible workforce, reducing unnecessary boundaries, and enabling the effective use of staff skills to deliver benefits that are measurably better for staff and, as a result, better for patients.

www.nhsemployers.org

NHS Institute for Innovation and Improvement

The NHS Institute for Innovation and Improvement provides a focus for new ideas, technologies and practices to improve services to patients, users and the public.

www.insitute.nhs.uk

NHS National Workforce Projects (NWP)

The NWP team supports NHS organisations to achieve their workforce objectives through the development and implementation of a range of workforce skills, change management, information and planning tools.

www.healthcareworkforce.nhs.uk

NHS Networks

This website contains news and networking opportunities across a range of projects and initiatives currently taking place across the NHS.

www.networks.nhs.uk

National Framework to Support Local Workforce Strategy development: A guide for HR directors in the NHS and social care

This document provides a framework that can be used by HR directors and managers within health and social care to develop their local strategies.

www.dh.gov.uk/en/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/DH_4124746

National Oral Health Promotion Group (NOHPG)

The National Oral Health Promotion Group is a forum for all professionals interested in the promotion of oral health and was established in 1981. The aim of the group is to encourage the continued development of oral health promotion. The group provides support to those with a remit for oral health education and promotion.

www.nohpg.org

Primary Care Contracting

The NHS Primary Care Contracting website brings together information and resources to help understanding and implementation of the new primary care contracting arrangements and has a specific section on dentistry.

www.primarycarecontracting.nhs.uk

Skills for Health

Skills for Health works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services. Currently, there are competence frameworks for dental technology and dental nursing. These frameworks, together with information on frameworks under development can be found on the Skills for Health website.

www.skillsforhealth.org.uk

Social Action for Health

Working with communities to address issues that affect their health and wellbeing.

www.safh.org.uk

Standards for Dental Practice Professionals

Available from the General Dental Council website, this booklet sets out the principles that should be followed as a dental professional. The principles should influence all areas and stages of professional education and practice. The principles should be applied to any work involvement as a dental professional, whether or not patients are routinely treated.

www.gdc-uk.org

What DCP registration means

Available from the General Dental Council website, this information refers to the changes currently affecting dental care professionals (DCP) through the requisite to professionally register with the General Dental Council.

www.gdc-uk.org

Workforce Review Team (WRT)

The Workforce Review Team works at national level on behalf of the NHS in England. It coordinates and synthesises intelligence from local and national bodies on the supply and demand for appropriately skilled staff to deliver care. Its analysis of the evidence informs decisions about investment in training to secure a workforce with the right skills, in the right places and in the right numbers to meet future staffing requirements.

www.healthcareworkforce.nhs.uk/wrt



Appendix 1: Additional information relating to the key service and workforce policies

Our Health, Our Care, Our Say: A New Direction for Community Services

The white paper *Our Health, Our Care, Our Say: A New Direction for Community Services* published in January 2006 focuses on:

- Better prevention and earlier intervention for improved health and well being
- More choice, control and a louder voice for service users
- Improved access to community services
- Tackling inequalities.

The key strands of workforce development activity resulting from it are:

- Changing the culture of the workforce to improve well being, prevention and support for self care
- Increasing overall capacity in primary and community care
- Delivering greater personalisation of care by taking a more person centred approach to assessing need and stimulating choice
- Giving people a greater say about the way that the resources available to them are used and tackling inequality
- Working in different locations and across boundaries between agencies and organisations
- Integrating the planning and delivery of a range of services in the local community through joint strategic needs assessment, joint planning, joint appointments and new roles.

www.dh.gov.uk - search for '0101673728'

Choosing Better Oral Health – An Oral Health Plan for England

Choosing Better Oral Health – An Oral Health Plan for England was published in November 2005. It was developed as an important part of the Government's delivery plan for public health in England to help PCTs to prepare for commissioning NHS primary care dental services. It demonstrates a shift away from the traditional approach, with its emphasis on treating people when they've already developed oral health problems to a preventive approach involving fewer interventions, and is a major step towards providing better dental care in the 21st century.

It recognises that good oral health is central to healthy living and identifies the information and services that will enable people to take control of their oral health. Reducing sugar consumption and giving up smoking, as advocated in the white paper *Choosing Health: Making Healthier Choices*, will bring direct benefits to oral health. Additionally, the advice and support that dentists and other members of the dental team give their patients regarding risks such as these can contribute to the Government's prime objectives on healthier living. In particular, the regular access that the dental team has to people, who may have no other contact with health professionals, offers new opportunities for building partnerships.

The plan draws on current evidence of the main causes and consequences of poor oral health and the measures by which improvements can be made within an integrated PCT led health promotion programme. At the core of the plan is the need to integrate oral health into the wider public health agenda. Oral health should be considered part of general health, addressed through evidence based interventions focusing on the underlying factors that put people at risk of disease.

www.dh.gov.uk - search for '271025' - select first in list.

Commissioning a Patient Led NHS

Commissioning a Patient Led NHS was published by the Department of Health in July 2005 and outlined significant changes to the structure of the NHS affecting PCTs, SHAs and ambulance trusts. The document focused on the way healthcare services would be delivered and outlined developments in commissioning and how primary care will be configured.

As part of this restructuring there were new roles for these organisations:

- SHAs – performance management of trusts and PCTs, strategic planning and taking trusts to foundation status
- Foundation trusts – to deliver the service agreements with PCTs
- PCTs – to develop practice based commissioning; develop patient access and choice, prioritisation of services and value for money and develop closer links between health, social care and emergency services.

The paper also highlighted the need to integrate the new approach to performance management, commissioning and providing health care services with the other NHS developments such as Integrated Service Improvement Programme (ISIP), payment by results, balanced scorecard, connecting for health, new ways of working and the growth of the independent sector.

The changes to the structure of the NHS in this document resulted in the re organisation of the 28 SHAs into 10, matching the boundaries of most of the English regional governments. In addition the number of PCTs in England was reduced from 303 to 152 and the number of ambulance trusts decreased to create a total of 12.

One immediate effect has been to strengthen the commissioning function within healthcare as a result of the co-terminosity of SHA boundaries with Government Offices. Joint working between health and local government agencies has been improved leading to improved services for patients.

www.dh.gov.uk - search for 'Commissioning a patient led NHS' - select first in list

National Service Framework for Children, Young People and Maternity Services

The *National Service Framework for Children, Young People and Maternity Services* was published in September 2004 and is a 10-year programme intended to stimulate long term and sustained improvement in children's health. Setting standards for health and social services for children, young people and pregnant women, the NSF aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood.

At the heart of the Children's NSF is a fundamental change in thinking about health and social care services. It is intended to lead to a cultural shift, resulting in services being designed and delivered around the needs of children and families. The Children's NSF is aimed at everyone who comes into contact with, or delivers services to children, young people or pregnant women.

www.healthcareworkforce.nhs.uk/dohnationalserviceframeworkdocuments

Report of the Primary Care Dental Workforce Review

Report of the Primary Care Dental Workforce Review was published in February 2004 and estimated the future demands for, supply of, and training needs for the dental workforce. The review predicted an undersupply in clinical time in the range of 16 percent to 21 percent by 2011. However, the impacts of the new contractual arrangements for the provision of primary care NHS dentistry and the push towards a service that is focused on prevention have yet to be taken fully into consideration. The review made recommendations for the development of the dental workforce concentrating mainly on dental attendance and dental treatment provided by dentists, dental therapists and dental hygienists.

www.dh.gov.uk/assetRoot/04/08/60/76/04086076.pdf

The Health and Social Care (Community Health and Standards) Act 2003

The Health and Social Care (Community Health and Standards) Act 2003 legislated for far reaching reform of NHS dental services to deliver the *Options for Change* objectives. To meet their new responsibilities for dental services under the Act, PCTs will assess local oral health needs in order to tackle long standing oral health inequalities.

www.opsi.gov.uk - search for 'Health and Social Care (Community Health and Standards) Act 2003'

NHS Dentistry: Options for Change

NHS Dentistry: Options for Change was published in August 2002 and proposed a new NHS dental service for England. 54 years after the foundation of the NHS, this report contained recommendations to begin radical changes, designed to provide a first class NHS dental service, responsive to local needs.

It demonstrated how the quality of NHS dental services could be improved through:

- A better experience for patients
- A well educated and trained workforce
- Clinical pathways underpinned by clinical governance
- Installation of information and communication technology (ICT) in practices and clinics.

www.dh.gov.uk/assetRoot/04/08/22/78/04082278.pdf

Modernising NHS Dentistry: Implementing the NHS Plan

Modernising NHS Dentistry: Implementing the NHS Plan was published in September 2000 and provides a firm foundation for NHS dentistry for the next 50 years. It details the programme of investment that is needed to modernise NHS dentistry in the 21st century. It outlines the Government's commitment to improving NHS dental services, as set out in the *NHS Plan*. The *NHS Plan* offered the most far reaching programme of reform in the history of the NHS. It set out intentions to redesign the NHS around patients and deliver fast, accessible care. *Modernising NHS Dentistry: Implementing the NHS Plan* shared this vision and ensured that the development of dental services in England would be consistent with, and a core part of, the *NHS Plan*.

www.dh.gov.uk/assetRoot/04/01/93/04/04019304.pdf

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This document draws on material from *Patient Centred Approach to Commissioning the Future Dental Workforce Toolkit* (North Western Deanery, 2006) and *Six Steps – An e-learning programme to plan your future workforce needs* (NHS National Workforce Projects).





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