Response to the Health Select Committee
Education, Training and Workforce Planning

Introduction

1. The British Dental Association (BDA) is the representative organisation for dentists in the UK, with 19,000 dentist and 4,000 student members. Members work in all spheres of dentistry, including NHS, private and mixed NHS-private practice, as well as in salaried services, hospitals, universities and the armed forces.

2. We are pleased to see that the Select Committee has undertaken to review the proposed arrangements for education, training and the workforce but are concerned that the Government has not yet published a response to its Developing the Healthcare Workforce consultation. Much of the evidence provided here draws on our response to the consultation and references issues raised in the consultation document.

   The right numbers of appropriately qualified and trained healthcare staff (as well as clinical academics and researchers) at national, regional and local levels

3. We were disappointed to note that Developing the Healthcare Workforce did not include dentists or dental care professionals (DCPs) in its workforce calculations\(^1\). Dentists’ contribution to the health service must not be overlooked, and we seek reassurance that numbers in training will be preserved to ensure that access to dental services remain consistent. The Department of Health is in the process of piloting a new dental contract which, if implemented, will see a significant shift in the way that oral healthcare is delivered and the way in which patients access the service. We understand that there will be a full evaluation of the contract pilots, and we recommend that Health Education England (HEE) and the Centre for Workforce Intelligence (CfWI) use the data from this evaluation to ensure that any impact on access to dental services is countered by intelligent planning of future student numbers.

5. It is vital that planning is undertaken based on evidence of need and not calculated on the basis of existing numbers in post. The dental public health workforce, for example, is considerably under-resourced (there are currently 20 lost or frozen posts, which represents around one third of the total consultant and academic workforce) and requires investment. Although we appreciate the need for efficiency savings to be made across the NHS, such savings should not compromise the provision of core services. The BDA

\(^{1}\) Developing the Healthcare Workforce, DH, pg 20, para 3.2
has made representations to Public Health England’s transition team to ensure that workforce numbers are calculated based on pre-2011 statistics. We are of the view that present staffing levels provide an inappropriate baseline for future planning.

**That training curricula reflect the changing nature of healthcare delivery, including the medico-legal context**

6. The Department of Health is in the process of piloting a new dental contract which focuses on prevention. Within the pilots, all patients receive a full oral health assessment to inform a treatment plan, with patient education and interim appointments to ensure that patients are supported to improve their oral health. This way of working will be a significant shift for practitioners, and it is essential that, if the new contract is to be implemented, the care pathway approach to prevention and treatment is embedded in the undergraduate curriculum.

7. Smaller dental specialties must be safeguarded throughout the transition to meet the existing and future needs of the population. The so-called ‘heavy metal generation’ – individuals currently aged between 35-60, who have multiple amalgam fillings – will continue to have high restorative needs as they age. Significantly, of the 231 specialists in Restorative Dentistry, 135 are aged 50 and above, suggesting that urgent succession planning is required if we are to meet the needs of this patient cohort. Similarly, as life expectancy increases, periodontal disease\(^2\) will become more prevalent, and it is vital that we continue to train appropriate numbers of specialist practitioners. Alongside this, it is imperative that investment is made to ensure that academic careers remain a viable option for dental graduates.

**That all providers and commissioners of healthcare (both NHS and non-NHS) play an appropriate part in developing the future workforce**

8. As stated in our response to *Developing the Healthcare Workforce*, the BDA strongly opposes the introduction of a levy on providers to fund the future education and training of the workforce. The present top-slicing arrangements are a fair and equitable funding mechanism and there does not appear to be a compelling reason to change.

9. Dentists are subject to increasing practice expenses, significant regulatory burden and are the only healthcare specialty to have received a real-terms pay cut. When we add increased tuition fees and a potential duty on providers to fund continuing professional development, dentistry has the potential to become an unattractive career choice in future.

**Multi-professional and multidisciplinary leadership and accountability (encompassing the full range of healthcare professions, specialties and grades) at all levels**

10. We support the commitment to improve leadership training and believe that this should be embedded in the undergraduate curricula.

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\(^2\) Periodontal disease affects the gums, bone and other supporting tissues of the teeth.
That the existing workforce can be developed and reskilled for the future (through means including post registration training and continuing professional development)

11. We agree with the proposals for a flexible approach to the planning and development of the healthcare workforce. In the transition to the new system, it is essential that relevant and affordable courses currently provided by PCTs continue to be available to professionals.

Open and equitable access to all careers in healthcare for all sections of society by means including flexible career paths

12. The BDA welcomed the position of the Browne Review and subsequent statements in Parliament that dental courses would be safeguarded in the same way as medical, engineering and science degrees. Parliamentary statements have guaranteed that the government will continue to subsidise “part” of the cost of dental courses. We are concerned, however, that there is a lack of clarity about the proportion of subsidy that will be provided.

13. The increased levels of debt facing dental students on graduation as a result of the funding reforms and the unclear contribution of the NHS bursary beyond 2012-13 could hamper the government’s aims of widening access and participation in the dental profession for those from lower socio-economic groups. The BDA’s Student Debt Survey 2010 showed that the average dental student debt was £25,545. This is based on fees of £1,200, rather than the increased £3,375, the effects of which will not be known until next year. If fees increase to £9,000 for dental courses, debt will become even higher. While we understand that fees are to be increased to £9,000 only following an agreement with HEFCE and OFFA to increase access, we are concerned that increased debt will be a sufficient deterrent to students from lower socio-economic groups. Debt could potentially rise to around £60,000 for dental students. This is a huge figure and the BDA is concerned that students are being asked to take on this significant burden to study a course that is of direct public benefit.

The future of postgraduate deaneries

14. The BDA remains unconvinced of the need for any change to the way in which postgraduate education and training is delivered.

15. Dental and medical postgraduate deaneries are highly valued and the BDA is of the view that their function must be preserved through the transition and beyond. Dental Postgraduate Deans and their teams provide services that directly contribute to patient safety and ensure that all members of the dental team have access to the relevant education and training. There are good economies of scale surrounding the provision of training by Postgraduate Deaneries which would be lost if training was provided on a smaller geographic scale.
The proposed role, structure, governance and status of Health Education England (including how it will take on the roles of Medical Education England and the Professional Advisory Boards), and its relationship to professional regulators and to other parts of the new NHS system architecture

16. The BDA is largely in agreement with the role, structure, governance and status of HEE as outlined in the consultation document, Developing the Healthcare Workforce, and we are pleased to see that the Dental Programme Board (DPB) will be retained. The DPB has made significant progress on key issues affecting the dental workforce, and its considerable expertise will be an important resource for future planning.

17. Although there must be strong links between the Board and regulatory bodies, we do not agree that the Board should be responsible for setting standards for education and training in areas that are currently the responsibility of the profession-specific regulators.

18. One of the key challenges of the new NHS architecture will be to ensure that workforce planning is undertaken with the input of all relevant bodies, and the duty to consult must be embedded within HEE. Effective collaboration with Public Health England, the Department of Health and the NHS Commissioning Board will be the first step in ensuring that each aspect of the workforce is appropriately commissioned.

The proposed role, structure, governance, size and composition of local Provider Skills Networks/Local Education and Training Boards, including how plans for their authorisation by Health Education England will address issues relating to governance, accountability and potential or perceived conflicts of interest, and how the Boards will relate to Clinical Commissioning Groups and the Commissioning Board

20. Although we commend the government’s ambition to put practitioners at the heart of the system, it must be acknowledged that there is a limit to the time that practitioners can dedicate to providing services and developing infrastructure in the new system. It is clear that there are benefits to a clinician-led service, but this must be tempered with appropriate strategic oversight and guidance from HEE.

21. The proposals for the introduction of Provider Skills Networks as outlined in Developing the Healthcare Workforce are of some concern to the BDA. The list of suggested functions in this document appears to suggest a GP-led service, and we are of the view that this would be inappropriate for the other healthcare professions, including dentistry. The BDA would be supportive of the introduction of a small number of dental Skills Networks to ensure national consistency of training provision, but do not see great value in a multi-professional structure. There has been some progress made on the development of the wider NHS infrastructure, and a review of these proposals in light of the emerging structure of the National Commissioning Board would be pertinent.

22. We are concerned that the proposed Skills Networks would be unable to attract the appropriate expertise and indeed, that small providers would not be appropriately represented within these organisations. It is also unclear what funding would be made available for these Networks, and how this would be managed. Overall, we are not assured by these proposals and await further detail from the government.
The role of the Centre for Workforce Intelligence

24. The CfWI must have adequate resources to employ and engage appropriate experts. It must work closely with stakeholders to understand existing issues and plan for future challenges.

How funding will be protected and distributed in the new system

25. We support the continuance of the Multi-Professional Education and Training (MPET) but do not agree that money should only be used to fund the next generation of healthcare staff. The transition to a revised system must ensure that it accounts for those who are currently providing services and invests in those practitioners to ensure that they have the required skills.

26. In an environment where dentists’ expenses are rising year on year and income is static, we do not believe it is appropriate to shift the financial burden of education and training to practitioners. We appreciate the challenges of the current financial climate, but do not believe that practitioners should be responsible for absorbing the impact of government cuts. As already stated, we are entirely opposed to the imposition of a levy on providers to fund education and training.

How future healthcare workforce needs are being forecast

27. We believe that forecasting should be a cross-organisational exercise, utilising the existing expertise of the professional Boards of HEE and with the relevant representative organisations. We are concerned that the emergence of new organisations will result in a more complex structure than existed pre-2010, and it is vital that new organisations conduct their planning in conjunction with one another to avoid duplication.

The impact of people retiring from, or otherwise leaving, healthcare professions

28. The Dental Schools Council reports that 48 per cent of Clinical Teachers and Senior Clinical Teachers, and 62 per cent of Professors, Senior Lecturers and Lecturers are aged over 45. Succession planning must be a priority as 25-30 per cent of the academic workforce in dentistry is expected to retire in the next five to seven years.

29. The public health workforce faces similar challenges. There are 32.5 whole time equivalent (WTE) consultants in practice, 10.4 WTE academic consultants with 5.2 WTE pending retirement. Worryingly, there are 9.4 WTE frozen posts and 9.8 WTE lost posts. There is an urgent need to address staffing levels in public health, particularly to ensure a smooth transition to local authorities.

30. During the transition, public health staff will be transferred into local authority structures, and will become civil servants rather than NHS employees. Existing staff will be transferred by TUPE to local authorities, although future arrangements remain unclear. We understand that a TUPE transfer relates to the transfer of the staff member rather than the post, and therefore seek assurances that posts will be protected by local authorities.
The place of overseas educated healthcare staff within the workforce

31. Dentistry, like other areas of healthcare, has a diverse workforce and overseas educated practitioners play an important role in the delivery of care. The current system allows for non-UK qualified graduates to take up dental foundation training places, however, and we have concerns about the potential for the displacement of UK graduates.

32. We are aware that 21 graduates did not take up a foundation training place last year, although the reasons for this were not captured. It would seem sensible that this data is recorded by universities in future to ensure that any emerging problems with entry to the scheme are picked up at an early stage. The significant financial investment made by individual students in their education and by the tax payer for training suggest that there should be a commitment to achieving value for money through a guarantee that all UK graduates who wish to take up a dental foundation training place are able to do so.

How the public health workforce will be affected by the proposals

33. The public health workforce will face additional challenges to those identified above. The BDA is concerned that the decision to locate Consultants in Dental Public Health (CsDPH) in local authorities will mean that education, training and continuing professional development will be fragmented. There is a need to ensure that robust systems are in place to ensure that career development opportunities are safeguarded, and that public health remains an attractive career choice for young dentists.

34. Current proposals suggest that dentists will begin their career in the NHS and will move to the civil service when they complete their training. Public health is a core element of the NHS, and underpins the government’s proposals for the health service. To remove the public health workforce from the NHS means that CsDPH will no longer have access to core NHS data, and we believe that this presents an additional challenge for an already overstretched workforce. It is essential that all members of the public health workforce are able to work with their NHS colleagues to deliver against the Public Health Outcomes Framework, and we believe that this separation means that the workforce will be required to spend significant time working across organisations, networking and rebuilding an infrastructure that exists and functions well in the current system.