Discussion Document - National Health and Social Care Workforce Plan

Are you responding as an individual or organisation?
Organisation

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British Dental Association

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Publish response with name
Yes, BDA Scotland are content for Scottish Government to contact us in relation to this consultation exercise

BDA Scotland response to the Questions:

1. Are these roles the right ones, or do you have an alternative mode? What steps will be needed to ensure these proposals are fully effective?

In the Ministerial foreword, the Cabinet Secretary for Health & Sport states:

“I want all health and social care staff to feel engaged and supported to continuously improve the care and treatment they provide. The health and social care services we need can only be delivered with the full engagement and contribution of a valued and skilled workforce.”

It is the view of BDA Scotland that the dental profession does not feel engaged or supported by Scottish Government and undervalued. Dentists are skilled professionals working hard to provide quality dentistry despite poor funding. It should be noted that in the NHS Digital Survey on morale and motivation dated December 2016, half of Scottish General Dental Practitioners (GDPs) were recorded as stating ‘I often think of leaving general dentistry’.

BDA Scotland considers that the document is similar in style to the recently Scottish Government Consultation Exercise – ‘The Future of Oral Health’, in that it is a wish list without being clear how the proposals will be implemented.

BDA Scotland suggests that the document is difficult to read, interpret and therefore, is difficult to answer.

BDA Scotland also notes that the ‘local and regional planning sections’ on the response pages do not apply to GDPs.
With reference to the Public Dental Service (PDS), BDA Scotland highlights that there is currently a problem with planning across Scotland, in that it is operated on a 12 month financial window. Each NHS Board has no indication of their budget for the following year. At present previous experience shows funding will most likely be a cut between 3- 6%. This will be achieved largely through ‘natural wastage’, which is very reactive, and not a sensible way to plan clinical services. When BDA Scotland has previously asked for Scottish Government’s views on the vision for PDS going forward, Scottish Government’s response is that the responsibility lies with the NHS Boards.

BDA Scotland notes that the consultation offers acknowledgement that both funding stability and more direction from Scottish Government is required, and that this is of the utmost importance. For example, sustainable funding of the primary care system of General Dental Services (GDS) is needed in tandem with a transparent system of remuneration which is ‘fit for purpose’. It should also be noted that independent GDPs have been faced with a decline in dental incomes dropping by 30% over the last five years which means that Scottish practices now have a much higher expenses to earnings ratio at 70.2%. BDA Scotland suggests that there should be transference of funding from secondary care for procedures which could be carried out within primary care GDS. It is suggested that secondary care is an expensive model for some procedures and existing funding could provide for better delivery of dental care.

This needs to be properly addressed if the profession are to build a comprehensive and sustainable NHS dental service.

2. How can organisational and individual collaborative working be improved, and barriers removed, so that workforce planning can be effectively co-ordinated to ensure people get the care they need where and when they need it.

Nationally?

BDA Scotland would highlight that the future population demographics of an ageing population will stretch resources considerably. It is inevitable there will be a larger care home population with more elderly people suffering from dementia. BDA Scotland questions how we could better care for this section of the population? The skill mix/manpower and proper funding needs to be considered. This can be provided by either the PDS or independent GDPs, preferably both to allow flexibility according to local needs.

BDA Scotland suggests extending the use of hygienists and/or dental therapists to visit care homes regularly to provide training to staff and supervise care although it is noted this is already carried out in a number of NHS Boards. Scotland no longer offers hygienist only training and BDA Scotland questions how well utilised dental therapists are. BDA Scotland notes that it takes 3 years to train dental therapists whereas hygienist training lasts 1 year after obtaining a dental nurse qualification. BDA Scotland questions whether the skill mix is correct and whether hygienist only training should be undertaken again in Scotland. BDA Scotland also questions whether all the dental therapists are fully employed in Scotland and are they undertaking the full range of therapy treatment or some being used as hygienists?

BDA Scotland also suggests that with regard to Primary care/Secondary care roles, some of the work currently undertaken in Secondary care could be carried out in Primary care i.e. some minor oral surgery and orthodontics. However, BDA Scotland would caution that careful consideration be given to the minimum staffing levels in secondary care to make a viable department. This would mean in some areas there may be small departments carrying out some procedures that could be done in primary care, but to remove these could make a department non-viable. Consideration also need to be given to training pathways to train staff for future services i.e. in Minor Oral Surgery.

BDA Scotland would highlight that dentistry is not funded in the same way as medicine and the lack of proper funding had led to the demise of some areas of dentistry within general dental
practice. For example, treatment of periodontal disease, provision of Chrome Cobalt partial dentures and endodontic treatment.

BDA Scotland suggests more complicated oncology cases will require Maxillofacial Surgeons and restorative specialists for functional rehabilitation. These would be best based in supra regional units with enough cases annually to support the correct number of specialist staff. BDA Scotland suggest Scotland would require 3 such units; West, East and North.

With reference to page 17, paragraphs 2 and 3 of the document which state:

‘Each NHS Board is currently required to produce an annual workforce plan, and IJBs are required to ensure they have developed one. These plans often acknowledge the changes required to deliver national strategies, but are either unable to articulate this fully, or choose not to address this – for example, in the absence of financial certainty. This works against effective long-term workforce planning (more than five years) and workforce plans tend only to outline fairly superficial responses to problems with recruitment and retention or succession planning.”

and

This is not an issue for NHS Boards alone; it also involves Scottish Government. One way Scottish Government might address this is by setting out requirements within a clearer context for NHS Boards, using a more structured framework. In developing new guidance and setting out a framework for NHS Boards, the SG could take the opportunity to develop guidance which would be of wider use to IJBs and local authorities as well. This might offer more explicit guidance about the need to address particular constraints.

Regionally? No comment
Locally? No comment

3. How should workforce data be best collated and used to undertake workforce planning in an integrated context based on current approaches of a nationally-led NHS system and a locally-led care system?

BDA Scotland considers the document to be an ‘ambitious and wide-ranging’ plan to streamline all workforce planning across the whole of health and social care sector in Scotland. However, it is important that it is more than ‘words and management speak’ and something that can be realised. BDA Scotland reiterates that dentistry must be properly funded across GDS, PDS and Hospital Dental Services so that the professions can have appropriately remunerated dentists with the right number providing quality dental care across Scotland.

NHS Education for Scotland publishes comprehensive work force planning data every two years which includes dentistry and BDA Scotland questions does it need to be improved upon.

BDA Scotland is concerned that there was no mention of non-EU clinicians. The Cabinet Secretary in her introduction, and the body of the document seek to praise and reassure our colleagues from the EU, but there is no mention of clinicians from further afield. BDA Scotland questions whether this is deliberate or an omission?

4a. How might employers and other relevant interests in the Health and Social Care sector work, jointly and individually, to identify and tackle recruitment and retention issues, ensuring priority gaps are identified and addressed:

Nationally?

BDA Scotland suggests that less regulation and reduced bureaucracy is required to retain and encourage younger and experienced practitioners to remain in general dental practice.
BDA Scotland would highlight that numbers of graduates are decided nationally therefore it is very difficult to workforce plan and it is in the realm of requiring ‘a crystal ball’. Given these difficulties in workforce planning for dentistry, cooperation and sharing of expertise with other branches of healthcare to achieve better planning and forecasting of needs would be a sensible approach.

BDA Scotland refers to Page 7, ‘Why is the national workforce Plan needed?’ Section 18, bullet point 8:

‘Gaps in some parts of the workforce and increasing demand, in conjunction with requirements to meet performance targets, also create additional pressures on the service that workforce plans will need to consider’.

BDA Scotland notes that Scottish Government acknowledges the pressure which performance targets put on workforces, and thereby workforce planning. BDA Scotland questions whether it is time to look again at more flexible, realistic and area, specialty specific targets. This will have a profound effect on staff retention and morale and a knock-on effect on planning. It is a contention that by easing some pressure quality & quality improvement can be maintained.

BDA Scotland notes that in general medical practice, many of their tasks are being delegated to ancillary professionals such as pharmacists, practice nurses and physiotherapists. Given the level of dentists in the workforce at present, the role for our ancillary workers such as dental therapists is limited and training more will be counterproductive.

BDA Scotland has already highlighted that Scotland is not training hygienists at the present time. Refer to answer 2, paragraph 2.

BDA Scotland questions:

- Who will train the new high street dental specialists and accredit that training?
- How much funding will be set aside for dentistry and will funding be increased?
- Will patient charges be increased?
- Is the current model for independent dental contractors within the NHS still viable?
- The funding for dentistry has contracted rapidly in the last decade, therefore, the previous assumption that a dentist would be paid a fair wage for doing a fair job is no longer applicable.
- Careful consideration is needed in how to allocate money within the dental profession

BDA Scotland suggest that in terms of workforce planning for recruitment and retention, it is increasingly important that Scottish Government must address the high levels of stress and low morale evident within primary care dentistry.

Regionally? No comment

Locally? No comment

4b. Are there any process or structural changes that would support collaborative working on recruitment?

No comment.

5. Would it be helpful at national level to have an overarching process (or principles, or framework) for workforce planning across the Health and Social Care sectors?

No comment.
6a. How can a more coordinated and collaborative approach be taken to assessing student intake requirements across all relevant professions, and what other issues should be addressed to remove barriers to successful workforce planning?

BDA Scotland notes that the document states there are bodies in place to advise on the student intake for dentistry and these bodies should ensure there is employment for the graduates. BDA Scotland would highlight that this may be an issue for dentists in the near future.

BDA Scotland notes that there is concern amongst the profession that it will shortly be hard to encourage students into the profession, to shoulder five years of student debt, to work long stressful days for little reward. Workforce planning in this environment becomes impossible and must be addressed now.

6b. What other issues should be addressed to remove barriers to successful workforce planning in both health and social care?

BDA Scotland is unsure that Scottish Government has accurate data of the numbers of “whole time equivalent” dentists and healthcare professionals working in the General Dental Service. This does not allow for accurate workforce planning. As an example 5 dentists could be working full time or 5 dentists each working part time hours which provides the WTE of 1 dentist.

BDA Scotland would suggest that proper workforce planning is rather like ‘building a house’ where it is essential to have good foundations to build upon. In respect to workforce it is important to have an accurate and detailed analysis of the workforce in place at the moment, and headcount is not enough.