OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 15 June 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 15 June 2023

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COVID-19 RECOVERY COMMITTEE
13th Meeting 2023, Session 6

CONVENER

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*John Mason (Glasgow Shettleston) (SNP)
Stuart McMillan (Greenock and Inverclyde) (SNP)
Alex Rowley (Mid Scotland and Fife) (Lab)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab) (Committee Substitute)
Professor David Conway (Public Health Scotland)
Dr Manal Eshelli (West of Scotland Regional Equality Council)
Dr Declan Gilmore (NHS Tayside)
Adelle McElrath (NHS Borders)
Margaret McKeith (Health and Social Care Alliance Scotland)
Ash Regan (Edinburgh Eastern) (SNP) (Committee Substitute)
Antony M Visocchi (NHS Shetland)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 15 June 2023

[The Convener opened the meeting at 09:10]

Recovery of NHS Dental Services

The Convener (Jim Fairlie): Good morning, and welcome to the 13th meeting in 2023 of the COVID-19 Recovery Committee. We have apologies from Alex Rowley, who is replaced by Jackie Baillie, and from Stuart McMillan, who is replaced by Ash Regan.

This morning, we begin our inquiry into the recovery of national health service dental services. With our first panel, we will consider public perceptions and experiences of the recovery of NHS dental services. I welcome to the meeting Margaret McKeith, who is assistant director at the Health and Social Care Alliance Scotland; Professor David Conway, who is professor of dental public health at the University of Glasgow and honorary consultant in dental public health at Public Health Scotland; and Dr Manal Eshelli, who is project co-ordinator at the West of Scotland Regional Equality Council. Thank you very much for giving us your time this morning and for your written submissions.

We estimate that this session will run until 10:15. That gives each member approximately eight minutes to ask questions. I am keen to ensure that everyone gets an opportunity to speak, so I apologise in advance if time runs on too much. In that case, I might have to interrupt members or witnesses in the interests of brevity.

I invite the witnesses to briefly introduce themselves, starting with David Conway.

Professor David Conway (Public Health Scotland): I am professor of dental public health at the University of Glasgow dental school and honorary consultant in dental public health with Public Health Scotland.

Margaret McKeith (Health and Social Care Alliance Scotland): Good morning. I am an assistant director with the Health and Social Care Alliance Scotland.

Dr Manal Eshelli (West of Scotland Regional Equality Council): Good morning. I am project co-ordinator for several projects at the West of Scotland Regional Equality Council.

The Convener: There is no need for the witnesses to touch their buttons, as broadcasting will operate the microphones.

We move to questions, the first of which will be asked by Murdo Fraser.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning, and thank you for coming along. I want to consider the question of the impact that the pandemic has had on access to dental services. I will start with Margaret McKeith, because I know that the ALLIANCE has done quite a lot of work in that area.

I will provide a bit of context. We all recognise that there has always been a section of the population who are reluctant to go to the dentist anyway, but to what extent have there been more access problems since the pandemic? All MSPs will have been contacted by constituents who have raised concerns about the time that it has taken them to get an appointment. That seems to apply especially to NHS patients. Private patients have perhaps found it easier to access services, but NHS patients are struggling to do so. Indeed, in some parts of Scotland, NHS dentistry has disappeared entirely or seems to be disappearing. There does seem to be an issue with access.

What is your experience of the impact that the pandemic restrictions have had on attitudes to accessing a dentist? What needs to be done about that?

Margaret McKeith: Before I answer the question, I will provide some context, because it is relevant to know how we came to do the piece of work that we have done in the area. It was part of a 12-month primary care lived experience programme that the ALLIANCE was funded by the Scottish Government to undertake. Part of that involved looking at the experiences that people were having in accessing primary care services. Our first piece of work was on accessing general practice services. Around that time, the people who led on dentistry in the Scottish Government were hearing anecdotally that people had concerns about accessing dentistry. That is why we were asked to do a short, sharp piece of work.

Because that work was time limited, there were limitations around it. We looked specifically at what people's experiences had been in accessing dental services, and we asked them to make reference to their most recent appointment. That would span the Covid period. Out of the people who responded, 50 per cent were making reference to their experience in the previous six months—October 2021 to March 2022. In total, 75 per cent were making reference to the period between April 2021 and March 2022, which is when restrictions were in place and when they were being lifted.

09:15

That was a short, sharp piece of work, so it was really only key themes that we were able to identify rather than specific details. We found that people had challenges in accessing dental services. We cannot compare that with the situation pre-Covid; we just know what people's experiences were at the time. People experienced significant challenges in accessing dental services, particularly NHS services, because, as we heard across our survey and our interviews, the understanding was that many practices were not accepting new NHS patients.

There were reports from two people who said that they had been registered as an NHS patient but had been deregistered during that time. Obviously, that is based on what people told us. We heard that people who were able to pay privately were not disadvantaged—let me put it that way. There was a significant problem, but our research did not extend pre-Covid, so I cannot compare the two periods.

There also seemed to be a huge lack of understanding of what services were available on the NHS, and we picked up some inconsistencies. I am not sure whether those were actual or perceived, but there certainly seemed to be a lot of confusion around questions such as, "Is my dentist open?", "Can I go?", "Why can I get this treatment?" and "Why can I not get that treatment?" Therefore, there was a level of confusion as well as difficulty getting registered.

Murdo Fraser: One of the questions that I was going to ask you was on the level of public information that was provided about what dental services were available during the pandemic. Your response suggests that people just did not know what was available.

Margaret McKeith: Some people did know, and some clearly did not. That raised an issue that I am sure that Manal Eshelli will go on to talk about: the accessibility of information, particularly for those with a sensory loss or impairment or those for whom English is not their first language. We heard that there was a lack of information and, on top of that, a lack of accessible information.

Dr Eshelli: Minority ethnic people struggled to access dental services, especially those who had come to the United Kingdom just prior to or during the pandemic, and those who were seeking asylum, who were not able to get registered at all. They were put on waiting lists. Unfortunately, even young children were put on waiting lists. That was the case even for people who had been registered but then moved to a different location.

I know of a Syrian family that was relocated to the Isle of Bute. The family struggled there, and they decided to move to Motherwell because there were people from their community there, so they could receive support. The mother does not speak English at all, and her child is only 12 years old. There is no bilingual support in Motherwell, so they got in touch with us to help them to register with a dentist. We tried all the dentists in Motherwell, and we were not successful.

Because that was an emergency case, we called NHS 24 on 111 and asked whether we could register it as an emergency case. We were told that that person was registered with a dentist so that could not be done. Yes, she was registered with a dentist, but on the Isle of Bute, not in Motherwell. Technically, it was very difficult for the mother to go back, and there is no support. I was told that I did not have permission to speak on her behalf—that I did not have consent. I said that I had the consent and asked how I could send it to them.

Making the arrangement was very difficult. Unfortunately, we got the child, who was 12 years old, to be the interpreter for the mother. They had been in the country for only less than a year, so it was a real struggle.

Our organisation deals with such stories every single day. With dental and, indeed, all NHS services, a huge amount of information is contained on websites. For those of us who speak English, navigating to what we want is not a problem, although it can sometimes take time, but for those who do not have the language or whose English is at a very low level, it is a bit of a struggle and they cannot reach the information that they need.

Another issue that I want to highlight relates to those whom we manage to book in. People had to wait on a waiting list. Those who were lucky had to fill in a Covid questionnaire—anyone who wants to visit a dentist has to do so—but, because of its length, it was not possible for the patients to respond. The form asks for a lot of medical information, and they were not able to answer those questions, so our organisation had to intervene as a third party to fill the gap and put the information in on their behalf. That was made a bit difficult, because we were all working remotely or from home, so we had to put arrangements in place for that.

I have a lot of similar cases facing the same challenges and barriers. For example, there are some who do not have the information technology skills to deal with these things, and there are elderly people who do not know how to use phones to respond to calls or to get information.

I am quite happy to answer any other questions, if you want me to.

Murdo Fraser: I am sure that my colleagues will want to ask you questions as the session goes on.

Professor Conway, do you have any observations on public attitudes to access to dentistry as a consequence of the pandemic?

Professor Conway: I probably do not have any information on the public's attitudes or behaviours per se. The data that I shared in the submission are largely the routine administrative data that we hold in Scotland for managing the dental service, and they are based mainly on the claims that dentists make to NHS National Services Scotland and which are used to pay them. We have a secondary purpose, which is to look at dentists' contacts and treatment activities. I can give you a flavour of that over the pre and post-pandemic period, if you like.

Murdo Fraser: If you can do so briefly, that would be helpful.

Professor Conway: With regard to the headline figures, we were, before the pandemic, in a relatively reasonably good place, with about 95 per cent of the population registered. That masked the fact that only three quarters were attending regularly, although, in the scheme of things, that was a high level of activity. Moreover, before the pandemic, there were up to about 5.5 million treatment claims per annum but, in 2020-21, that figure dropped to 1.5 million, and it has since got up to only 3.8 million. By treatment claims, I mean courses of treatment. That is a drop of about 1.5 million.

Murdo Fraser: What is that in percentage terms?

Professor Conway: It is about two thirds to 70 per cent of the previous activity.

Murdo Fraser: So it is a drop-off of about 30 per cent.

Professor Conway: Yes. However, when you look at actual treatments, you will see that each of the claims contains more treatments. The figures for some treatments, such as fillings, go higher, to about 80 per cent of pre-pandemic levels.

Murdo Fraser: Thank you.

The Convener: Thank you very much. I call Jackie Baillie.

Jackie Baillie (Dumbarton) (Lab): Can you tell us how the childsmile programme was impacted at the community and clinical levels? Professor Conway, I think that that is a question for you.

Professor Conway: I should first of all declare that we in the University of Glasgow are heavily involved in monitoring and evaluating that programme, which has been highly successful since its inception in 2005-06 and after 15 years of development, evolution and improvement. Over that period, it has improved child oral health in Scotland dramatically, with real reductions being made.

For clarity, childsmile is several things. A lot of activity takes place in nursery and early primary schools, there is a lot of activity with health visitors and support workers who act like link workers in the community, and a lot of work takes place to deliver the programme in general practices, too. Our evaluation was that the two supervised toothbrushing programmes, in which 90-plus per cent of nursery schools had participated, had been a significant contributor to the improvement in the oral health of children.

All that activity stopped across the areas that childsmile heavily impacts—particularly, nursery and schools—at the end of the school year when lockdown came in and for the entirety of the next school year. There were many reasons why that activity stopped, such as the restrictions around access to nurseries and schools and the redeployment of 75-plus per cent of childsmile staff into a number of front-line Covid activities, such as vaccination. During the past school year, we got back to probably about 70 per cent of activity in nursery settings, which is where we currently are.

General dental services in the primary care setting and children's access to dentistry have been impacted in the way that I have described. That is worthy of a comment: people stay registered once they are registered, but the new registers for the zero to twos are not coming through following the pandemic. It was always difficult to get children registered—about half of zero to twos were registered pre-pandemic and to improve that rate was a big goal of childsmile—but registration has now dropped to 25 per cent.

Jackie Baillie: Although I would always note that registrations are not activity, I absolutely agree with your concerns that, if people are not registered in the first place, it is very difficult to make an impact.

Can I take you back to before the pandemic? I do not know whether it was you or one of the other witnesses who, in their evidence to the committee, suggested that

"Prior to the pandemic, persistent inequalities in child oral health were recognised as an ongoing challenge for the programme."

Why was that the case, given the effective community infrastructure that you have described? Was childsmile in need of reform? Did the pandemic expose its weaknesses?

Professor Conway: We recognised before the pandemic, and we still recognise, that there are inequalities and differences around children's oral health and dental decay levels by area of the Scottish index of multiple deprivation. An on-going

aim of childsmile was to improve and address that situation. We had made some inroads, in that we had improved the decay levels across all SIMD areas, but we had just not levelled that gradient. We were tuning in to what elements of the programme would better target that gradient and improve the situation, particularly for those children in the more deprived areas.

Childsmile is a range of universal things: it covers not only nursery education but targeted initiatives, such as the support workers who are linked to health visitors in deprived communities. We call it a proportionate universal and targeted programme. That is what it was trying to do.

Jackie Baillie: Has it got back to the level at which it was prior to the pandemic?

Professor Conway: No. I think that we are at about 70 per cent of that activity in nurseries. When we look at the oral health outcomes, the worrying statistic is that the improvement that we had seen for 15 years has stalled. We collected the current data differently, but the improvement has not continued on the trajectory that we were observing before the pandemic.

Jackie Baillie: You talked about community workers and health visitors as well as high street dental practices. How do you monitor what they deliver in the childsmile programme?

Professor Conway: A detailed monitoring programme is in place. High street dentists are monitored in the same way as others through the NHS NSS claims system. The University of Dundee health informatics centre developed a bespoke database that monitors a lot of the activity in nursery and schools and around support workers.

We and the University of Glasgow analysed that data. We looked at the impacts of delivering and receiving the interventions and the outcomes in oral health, which is where we have been able to see that linkage between elements of the childsmile programme and improvements in oral health.

It was a real flagship programme. Following the work in Scotland, it has, in fact, been adopted across the world. We have been part of sharing that message.

09:30

Jackie Baillie: I am very proud of the childsmile programme. It was put in place by the previous Labour Government and has subsequently been continued by the SNP Government. It has transcended political parties as an excellent programme.

If we are not operating at the same level that we were before, what does the recovery programme for childsmile specifically look like?

Professor Conway: We have a management group. We have brought a lot of that health improvement into Public Health Scotland—which, the committee will remember, was not there prior to the pandemic. Public Health Scotland's role in all of that has been ironed out and developed.

We are conscious of monitoring and of improving the uptake of the different elements of the programme. We particularly want to get back to the nursery supervised toothbrushing programme. There are still challenges in that sector in relation to fully getting brushing back in there. There is some hesitancy and nervousness about some elements of toothbrushing, as there were a lot of concerns about Covid spread, for example. We had to redevelop the guidance to ensure that those concerns were taken care of.

Jackie Baillie: I do not know whether any of the other members of the panel want to comment, but I will ask one final question of you, Professor Conway.

You mention

"slow recovery of training and support"

for the programmes. Why is that, and how urgent is it that programmes for adult oral health are reinvigorated?

Professor Conway: The same goes for adult programmes, which, ironically, are probably more in their infancy than the programmes for children. They are newer programmes, which we have had for five years or so. They are more focused on training different staff, such as care workers in care homes, to improve oral health. They are not as multifaceted. As I said, we are reviewing them collectively and considering what they can learn from childsmile. There are different processes. The fact that childsmile includes general dental services and high street dentists is a really important element.

Jackie Baillie: I do not know whether anybody has anything to add.

Margaret McKeith: Some of our survey respondents made comments to the effect that they were going to the dentist when there was a dental emergency. One of the questions that we asked was about what good dental services would look like, and more focus on prevention came across clearly in the responses to that. That could perhaps be an adult version of the childsmile programme. The responses spoke very much about a focus on prevention and public awareness raising of the need to go to the dentist.

The issue is about why people should go to the dentist and maintain good dental and oral health, but it is also about what not to do, such as not smoking tobacco. There was an identified gap in public health information as well as in information on what dental services were available and how to access them, and a lack of information about the charging structure. An awareness-raising campaign would be very helpful.

Dr Eshelli: We had a very good experience of working closely with the childsmile team during the pandemic. Part of the project was about raising awareness of health services among minority ethnic people. We worked well with them, because we invited them along and, although they were online, through Zoom, the team provided lots of educational services. The childsmile team also advised us, when we were struggling, about where we could register those families. It provided a list of all the dentists around Glasgow, which was very helpful.

The other question from us to the childsmile team was about whether we could find any minority ethnic dentists in those lists. Following that advice, we managed to reach a few people. I think that the team is doing well. There are some gaps between minority ethnic communities and the childsmile team, but we are trying to help it to reach those unreachable communities.

Jackie Baillie: That sounds very positive.

The Convener: Professor Conway, I have a quick question for you. You said that the childsmile uptake is running at 70 per cent of what it was previously and that there is a bit of hesitancy in nursery education about the supervised brushing programme. Is that hesitancy from the staff or from the families?

Professor Conway: To be honest, we are probably at the stage of trying to identify where the barriers and facilitators lie—whether they are at staff level, headteacher of the unit level, or even the educational directorate level. We are trying to explore ways of improving and how we can build that improvement into daily activity. Can we use some of the examples of where something is working to spread the word to those places where the figures are not back up? There were always some nurseries and early-years establishments that did not engage with the programme and that was a gap that we wanted to address before the pandemic. It is an on-going challenge to optimise uptake of the programme.

The Convener: Are you confident that you can get the levels back up to where they were before the pandemic?

Professor Conway: I would like to be optimistic that we could. That is the key improvement. We want to communicate to the relevant group that the programme has made a big difference to the health of children in nurseries. We are also doing a bit of work on the impact on school attendance of the relationship between dental decay, the need for general anaesthetics for extractions and time off school. There are actually wider social benefits to improving children's dental health, and they have been part of our effort.

Brian Whittle (South Scotland) (Con): I want to follow up on some of Jackie Baillie's questions about inequalities. There was always inequality; Professor Conway says in his submission that it was increasing before the pandemic, but the pandemic exacerbated it considerably. The figures back that up, showing that the gap grew from 7 per cent to 12 per cent between 2010 and 2020, and that between 2020 and 2022 it went up to 20 per cent. That is an obvious direct correlation with the impact of Covid.

On the pressures that have been put on dentistry, from reading through the evidence it is clear that longer times between seeing a dentist mean that more treatment is required, so the time that is required per patient has gone up significantly. It is almost a perfect storm. When we speak to people in private dentistry, we hear that they, too, are incredibly busy, so it is difficult to get an appointment with a private dentist. The system is obviously under extreme pressure. Given that we are the COVID-19 Recovery Committee, what is the pathway back from that?

Professor Conway: It is a big challenge. We have been here before, in the early 2000s—back then there was a workforce crisis in dentistry. It was challenging to get access to dentistry. For example, in Stonehaven, when a dentistry practice opened there were queues around the block. A concerted effort was made in improving oral health services, workforce planning, modelling and recruitment, and in increasing the number of dentists in the system.

The workforce is part of the challenge: it does not look, in the greater scheme of things, as though there has been a big drop, but there was a drop directly because of Covid, during which the dental schools had no output of students; every year in which dental school was deferred, we had no student output. The number of new joiners to the workforce has dropped, so the number of dentists who are active in the workforce is down from pre-Covid numbers. That is a big part of the problem, so it is probably important to start working on a solution to that.

On inequalities, we had them before Covid, and we were always keen to address them in order to meet the unmet need. However, inequalities are exacerbated because there are fewer appointments available, so the gap between affluent and deprived people has been stretched a

bit because deprived people are less able to access the system.

Brian Whittle: As most of my colleagues know, I am always interested in the prevention angle in relation to healthcare in general. It seems to me that, in dentistry, we need to look at it as a long-term solution. However, we have a short-term crisis, so how will we work our way out of it for the short term and for the long term? I am happy to hear from any of the witnesses on that.

Margaret McKeith: I can pick up on your comment about health inequalities. Covid exacerbated an issue that was already significant for many people. Across our work—not just on dental services but in the ALLIANCE's wider work—we see the impacts that health inequalities are having on many people. We saw that half of respondents were not aware of the NHS low-income scheme, for instance, so part of a solution might be that more people access support to pay for dental services. Again, we need to raise awareness of what is available, including to support people accessing services.

What came across—it was not surprising, but it was not particularly happy reading—was that people were saying, "Dental care is now a luxury for us." One person commented that a scale and polish on the NHS is £38, which would put some people off, because that amount could be a weekly food bill for a family. We were hearing things like that, and 38 per cent of respondents—almost 50 per cent—said that dental treatment should be free of charge, as other healthcare is free of charge. Again, people were saying that dental treatment should be a right, not a luxury; however, many people see it as a luxury right now. That was not happy reading.

Brian Whittle: I want to dig a bit deeper. The reality is that, for many people, dental treatment would be free of charge. What you are saying is that there are people who do not realise that dental treatment would be free of charge, so there is a marketing issue.

Margaret McKeith: Yes, absolutely. As part of the work that we did around accessing general practitioner services, there was quite a large public messaging campaign to let people know that their general practice is still open, although it might look different, and so on, which was reasonably successful. Therefore, perhaps a longer-term campaign is needed on accessing dental services and support for treatment, saying what options are available, what support there is for paying for them and what makes a person eligible for free dental care. Lack of understanding and knowledge is, potentially, putting some people off.

Brian Whittle: Dr Eshelli, I imagine that that messaging is even more difficult for the communities with which you work.

Dr Eshelli: Yes. When we did that project, it was three years of changing behaviour. We tried to raise awareness of the services that are available and to change behaviour, because we are dealing with people who have different cultures. We tried to understand their cultures and how they impact on their oral health. We then had to design our delivery to make people understand how their daily practices impact their oral health.

09:45

We have found that there is a lack of understanding of the system. For example, people do not know that a baby has the right to be registered from the age of zero. When we engage people, we give them a questionnaire to find out the level of their knowledge. For the vast majority of people whom we work with—they are from various backgrounds—their knowledge is 20 to 50 per cent. Most people think that the dentist will cost money if they go. Just yesterday, one lady said, "We do not know whether it is free of charge if we go every six months." There is a lack of information and lack of awareness, as well as difficulty in navigating what is available in the system. The vast majority of people whom we deal with are living in the private rented sector and struggle financially.

Even I was previously not aware of the childsmile team, which does fluoride varnishing. People do not know that children can have that done four times a year—twice at school and twice at the dentist. When many people go to the dentist for a routine check-up the dentist does not offer that fluoride treatment.

A lot of information was provided while we were delivering the project. The situation is difficult for people because of the language barrier, because of misunderstanding of the system, and because they are digitally excluded. Most of them do not use computers—they do not have the capacity to buy one or do not have the skills to use one.

To be honest, we have a complex situation.

Brian Whittle: Convener, do I have time for another small question?

The Convener: Possibly—I will come back to you.

Brian Whittle: Thank you.

John Mason (Glasgow Shettleston) (SNP): I should start with a confession: I go to the dentist when they send me a reminder, and my dentist has stopped sending reminders, so I have not been to the dentist since before Covid. I am

interested in whether that is a common experience.

I will move on to my main point. Professor Conway talked about treatment claims being at 70 per cent and fillings being at 80 per cent of pre-Covid levels. Is there a measure of people's dental health? Does somebody get 100 people in a room, look at their mouths and see whether their dental health has deteriorated over the past three years? I understand that there is a measure of decay in children.

Professor Conway: There is a programme in primary schools—the national dental inspection programme in primary 1 and primary 7—so we have good data in that regard, but the situation with adults is not so good. It is limited to some questions in the Scottish health survey, which is done on a self-reporting basis. The measure that we have pulled out of that is on whether people have no teeth: the denture really is the end game of poor oral health.

There is very little adult oral health information. There is an opportunity to collect it routinely in primary care, but we have, thus far, not taken the opportunity to capture diagnostic information, as would be done in any other health context. We could get simple oral health information from that contact but, at the moment, we are just left with information on treatment, as you said—we are left with information on activity rather than on dental health. There is a gap.

John Mason: That takes me on to what we can do about that. Actually, before I ask about that, I have another question. Can we therefore assume that, in quite a lot of the population, including me, dental health is deteriorating, and will perhaps continue to deteriorate over the next few years until that 70 per cent figure goes up again?

Professor Conway: We do not definitely know that, but over time dental health generally deteriorates without intervention and prevention, which was asked about earlier. It is a cornerstone of what dentistry is and should be about.

John Mason: Where should we go from here? The Government has said in its response that it plans to continue the blended system of payment and it lists all the different things that that comprises, including

"fee per item, capitation, allowance and direct reimbursement payment".

Should we move to something that is more like a GP system, in which dentists are paid a much larger amount?

Professor Conway: Costs and payment of dentists are a bit beyond my expertise, to be honest. I am more interested in prevention. I totally agree that we should prioritise that.

Childsmile is an excellent example of trying to do prevention right. We did some modelling on it; it does not come free. The brushing programme costs approximately £2 million per annum, but within five years we realised £5 million per annum in savings through reduced treatment costs, so it is a case study in preventive spend. If you invest, you can realise such savings.

Dentistry has an untapped potential in relation to prevention. There are lots of risks that are common between what we do in dentistry and other areas. The main risk factor for gum disease is smoking, so there is an important role for dentists in delivering smoking cessation programmes. We should do that properly and it should be reimbursed. On reimbursement, I would invest in prevention work rather than always investing in treatment.

John Mason: I take your point that the financial side is not your primary area of expertise, but it obviously has an impact. From some of the information that we have been given, it sounds as though NHS dentistry is dying and private dentistry is growing. If we ended up with only private dentistry, would there be any preventative work?

Professor Conway: There is, in the data, a big gap on the level of private activity. We do not know whether it is filling the gap or not completely doing that. Margaret McKeith might have survey information on that.

Margaret McKeith: Yes—although our survey was very small and had only 91 respondents. Of those, 79 per cent were registered for NHS dental services, four had a private dental plan, one respondent was unable to register due to unavailability of NHS services and two were unregistered because their practice was no longer seeing NHS patients. However, we have no way of knowing whether that reflects national statistics.

John Mason: Has that survey been published yet?

Margaret McKeith: No, it has not been published. We are still in discussions with the primary care team in the Scottish Government. It was work that was commissioned by it as part of grant funding. There was to-ing and fro-ing with the survey and we are still waiting for the formal sign-off, which is why I was not able to share it ahead of the committee meeting. However, we are very keen to publish it.

John Mason: Okay. I understand that. Looking forward, do you have views on whether we should tidy up the present system or do something more major than that?

Margaret McKeith: My view, based on my experience and what we heard while doing that short piece of work, is that a radical overhaul is

required. Generally, people who respond to our surveys have a strong feeling either way: they are either very happy or very unhappy. In free-text answers there was concern from, I think, three people, that there has been "desecration"—I think that that is the word that one of the respondents used—of NHS services, and the creation of a two-tier system. They fear a move to a completely private system. We did not specifically ask about that; people volunteered the information.

John Mason: Do you have views on the financial arrangements, or is that not within your scope?

Margaret McKeith: That is not our area of expertise. We were interested in asking people about their understanding of the charging structure, not for views on it. I do not understand it fully.

John Mason: Dr Eshelli talked about needing more information about the current system. Do we need to do that or should we change the system?

Dr Eshelli: I think that we should change the system, to be honest. I will mention two cases that happened during the pandemic. In the first case, a patient who did not have a dentist contacted a dentist and sought to register with them. It was an emergency; her filling was falling out. The dentist said that they were sorry—that because she was an NHS patient they could not take her. She said that she was suffering and needed emergency treatment, but they said,

"We can't book you under the NHS"—

I know that these are the exact words that they said, because I was in the middle of the conversation—

"because it's on hold at the moment."

They offered to book her a private appointment the following day. That was a bit disappointing to me.

In the second case, which was similar, the cost of the treatment was high. The dentist said that the treatment was not covered by the NHS, but that they could give an appointment and price for the private treatment and take the person immediately. Again, that was a bit disappointing. How come dentists will refuse to take patients under the NHS? What is the policy?

John Mason: How should we change the system? Should it become more like general practice? There is virtually no private GP work—it is all in the NHS.

Dr Eshelli: To be honest, I also have a comment about GPs, because—

John Mason: Okay. We will not go there. [*Laughter.*]

Dr Eshelli: I am sorry. I do not want to go over that.

As a patient, I need to know my rights and I need a policy that protects them. I need the dentist to know that I have a right to treatment under the NHS and they need to offer me that. I do not know how we can put that into practice. It is difficult.

John Mason: Okay—thanks very much.

I will ask a final question. A new thing that has come up is vaping. Professor Conway, is there any evidence that vaping is causing harm to, especially, young people's mouths?

Professor Conway: There is no evidence that I am aware of. We are involved in a trial that is being led by Newcastle University, which is doing smoking cessation work in dental settings. There are three arms to the trial—prescribing of vape starter kits, e-cigarette nicotine replacement therapy, and brief interventions. We will look at which is the most effective for smoking cessation. As part of that work, we will also look at the gum health that is associated with the various interventions. Obviously, smoking is very bad for the gums and oral health, so we will look at vaping, as part of that study.

The Convener: Brian Whittle has a short supplementary question.

Brian Whittle: We are trying to look forward from the decisions that were made during the pandemic and the impact on dental services. Hindsight is 20:20, of course, so we can see what we would now do in a similar situation. Were the interventions and restrictions correct and appropriate, given where we are now, in relation to impacts and slow recovery? Looking back, were the decisions that were made the right ones?

Professor Conway: At the time when the decisions were made, dentistry was one of the top-risk occupations for Covid. We work in people's oral cavities and the pharynx and we do aerosol-generating procedures. There was real uncertainty about how that would go and how much we could do to mitigate the risk.

The infection prevention and control measures were set at a very high bar, as was use of personal protective equipment, and there were many restrictions. I think that that was right. We did not have huge numbers of infections. We could not necessarily identify infections from patients to dentists, but that is not to say that dentists did not get Covid: we could not necessarily identify that link. The strict measures were right.

However, there are lots of sector-specific lessons to be learned with regard to preparing for or preventing future pandemics. To be honest, we probably took our eye off the ball on aspects such as ventilation of dental clinics. Irrespective of

pandemics, ventilation is an issue in dental settings, so a lot of lessons could be learned from the situation.

10:00

Dentists stepped up in a number of areas, including surveillance, vaccination and other actions that they took part in. There was a balance to be struck between direct involvement in Covid support activities, including redeployment, and keeping dental services on the road. To establish 70 urgent dental care centres across the country to provide emergency care while surgeries had stopped opening was an amazing effort. That was done at a time when no one was leaving their house. Some of the work that was done in the heat of that decision making was impressive. However, the difficulty has been in coming out of that situation—it has taken us an awful long time, and other issues have come with that.

The Convener: I have a question on coming out of the pandemic. I fully accept your answer on whether what was done was proportionate at the time. For me, it absolutely was—it was the only way things could have been done. Dentists are spraying in people's mouths and stuff will go everywhere, so I understand that the approach was essential.

However, I am more interested in recovery. Did you lose dentists as a result of the stress that the Covid pandemic put on them? I went to my dentist during the pandemic, and the staff were completely covered in PPE, wearing masks and going about with huge gloves on. I was in there for half an hour and felt awful, but they were dressed in full hazmat gear all day. How many dentists dropped out of the profession as a result of stress?

Professor Conway: I do not know the detail, but people have left, as can be seen from there being 190 fewer dentists. There is a lack of new joiners in the system, but there will also have been early leavers. NHS National Services Scotland continues to monitor those aspects of the workforce.

The Convener: On getting people back in, you mentioned dental school output and said that you are not getting enough new dentists coming through the system. How do we sort that? Is there a way to increase the numbers of people on courses whose status could be finalised so that they can be brought through, or do people just not want to go into dentistry in the first place?

Professor Conway: No—there is no issue with filling the number of dental school places. My main point was that we had one year in which we did not have an output—students did not graduate, so they did not subsequently go into the NHS because they could not get the experience element of their training. That happened to every dental student in Scotland. After the first time, we increased the number of places in order to meet demand, and other activity was done on recruiting dentists from overseas, including from the European Union. That work was done proactively. Similar measures might now be required to increase the workforce.

The Convener: Where is the workforce just now, compared with what it was before the pandemic?

Professor Conway: As far as we can tell—it is not an exact head count—190 fewer dentists are claiming activity.

The Convener: Are those posts that you are actively trying to fill, or is that caused by people going into the private sector and not claiming any more?

Professor Conway: Some could be opting out of the NHS completely, but we do not know that.

The Convener: Okay.

Murdo Fraser: On training, you have said that there is no difficulty with filling places, but do we currently have enough university places for dentists?

Professor Conway: I could not answer that, but modelling could be done to work it out. We should bear it in mind that that lever is quite slow: once the process was turned on, it would be five, six or even seven years before that decision would come through, so other measures would be needed in the interim.

The Convener: No one has more questions, so that brings us to the end of our session, which has given us a lot to think about.

I thank our witnesses for their time. The committee's clerks will keep in touch with you in case you would like to raise anything further with us or give us more information.

10:04

Meeting suspended.

10:07

On resuming—

The Convener: I welcome our second panel to the meeting: Adelle McElrath, interim director of dentistry and dental practice adviser at NHS Borders; Antony Visocchi, director of dentistry at NHS Shetland; and Dr Declan Gilmore, director of dentistry at NHS Tayside. Thank you for giving us your time this morning on Zoom.

We estimate that the evidence session will run until around 11.20 am. Each member will have approximately eight minutes to speak to the panel and ask their questions. If you would like to respond to an issue being discussed, please type R in the chat box and we will bring you in.

I am keen to ensure that everyone gets an opportunity to speak, so I apologise in advance if I have to interrupt members or witnesses in the interests of brevity.

Ash Regan (Edinburgh Eastern) (SNP): Good morning. I want to ask about funding that was allocated in 2021-2022 to support the recovery of services. Some £5 million pounds was made available for ventilation improvements, and in 2021, £7.5 million was made available for the purchase of electric red band handpieces and motors. Did the funding improve the ability of practices to see more patients, and did it build long-term resilience into the system?

The Convener: Do you want to ask somebody in particular?

Ash Regan: Antony Visocchi is indicating that he would like to come in.

Antony M Visocchi (NHS Shetland): Good morning. The funding was primarily targeted at improving the ventilation to a required level in order to improve access or the amount of fallow time, which was the time that had to be left between patients after generating aerosols. That improved access and it will have a long-term legacy from the point of view of having surgeries in practices, because practices can now do the air change that is required for those procedures.

The electric motors were certainly a help to begin with, and many practitioners used them to improve patient access, by which I mean seeing more patients per day than they were able to before the funding was available. Having said that, because the restrictions are now reduced or removed altogether, the electric motors are not providing any additional access than they would have done prior to Covid.

Ash Regan: If no one else wants to come in on those points, I will move on.

Should funding have been provided for other measures? Antony Visocchi, you were saying that the electric motors were not as helpful as they might have been. Were there other measures that might have improved the rate of recovery of services? Looking to the future, on funding for support for reform, are there other types of funding available or are there other issues that need to be funded in order to move things forward?

Dr Declan Gilmore (NHS Tayside): Hello; it is nice to see you. I will respond to your comment that the red band handpieces were not as useful as we might have hoped. I would say that that was a reaction to our knowledge at the time, and it was probably very welcome and useful at that stage, so I would not want it to seem that that money was not well used or well purposed. Going forward, those handpieces will still be utilised in practices for treating patients—not in the way that was initially intended in terms of reducing the amount of time between patients and increasing access, but in day-to-day dentistry. They will continue to serve the provision of NHS dentistry, so I would not like to think that that money has been wasted in any shape or form.

On future funding, you will be aware that there is a new statement of dental remuneration—the new SDR—for dentists, so there is a new pathway for remunerating the dental profession and general dental services. We do not have full insight into that at the minute. The Scottish Government and the British Dental Association are in negotiations and talks, and we are waiting to see the outcome of those. We hope that those talks will help to retain and recruit more NHS general dental services in Scottish dentistry.

Ash Regan: That is helpful.

Adelle McElrath (NHS Borders): Good morning. On your question about funding, under our blended payment model, which is comprised of payments per item of service, as already discussed, and the fees and allowances, there was a 30 per cent uplift on one of those specific allowances, the general dental practice allowance, which supported many practices within NHS Borders, for which I can speak.

10:15

The current climate within dentistry has significantly changed and that is really in relation to dental inflation. Primary care dentistry is very expensive at the point of delivery. Lab fees, for example, have risen astronomically—in many cases, they have risen to an untenable level. Practices, practitioners and practice owners are really struggling in relation to those fees as well as the cost of dental materials and staffing increases—arguably, your biggest expenditure on a monthly basis if you are a practice owner is on wages. Therefore, the new payment reform is indeed incredibly welcome and will be received very positively.

The issue of dental inflation, however, is still something that could cause a concern for the future, so I am not quite sure what additional funding could be available in relation to that.

Ash Regan: Okay, thank you. Antony wanted to come back in as well.

Antony Visocchi: It was simply to further qualify my comments regarding the electric motors and to echo what Declan Gilmore said. At the time that they were made available, they increased the ability for access and they increased the amount of patient treatments that could be done. In the long term, they are certainly not going to sit gathering dust—they will continue to be used within NHS dentistry.

My point was more to do with the specific relation of those motors to on-going access in the future. However, it was very welcome at the time and it was certainly done, from my understanding, with the best of intentions in order to help dentists access patients.

Ash Regan: Okay. What are your views on whether other measures should have been funded to improve that rate of recovery and on other funding for the future?

Antony Visocchi: At the time, other measures would have been very difficult because there were so many restrictions on what we could do and how many patients could be seen within a dental practice or within any setting at the time. In general terms, the sector was certainly working at its optimum level, given all the restrictions at that point.

Touching on what Adelle McElrath said, there has been a recognition that the current system needs to be looked at. That is a historical issue that perhaps was highlighted during Covid, which gave us an opportunity to review and to take stock. The system is being looked at with a view to a new payment system in the relatively near future. I understand that it is under negotiation at the moment.

Murdo Fraser: Good morning. I would like to explore the support that NHS boards give to dentistry services more generally. We are in quite a strange situation, where dentists are independent contractors and yet, as NHS boards, you have got the responsibility to ensure the general health of the population, which is delivered through this network of what are, in effect, independent businesses.

I will direct this question first to Declan Gilmore. To put it in context, a constituent came to me last week about a practice in NHS Tayside. This constituent is registered with an NHS practice in Perthshire and has just been told that she will not get the six-month check-up that she has been used to, because the practice is moving to a 12-month check-up. As we have already heard this morning, she is perhaps one of the more fortunate ones because some people do not get any check-ups at all from their NHS dentists. However, I am interested in exploring what the role of the health board is here. What do you do to make sure that there is good access to NHS dentistry in the areas that you have responsibility for?

Dr Gilmore: Hi there. As you might be aware, the situation is different to that for our doctor colleagues or general medical practitioners in that the health board is not required to ensure dental provision in the same way. However, there is a wide blanket of public dental services that have their own remit, from delivering childsmile, delivering dental care in our nursing homes and care homes—in Tayside, anyway—and delivering special needs care with children's community services through to overseeing our independent contractors.

On ensuring safe care for the population in Tayside and across Scotland, health boards are responsible for ensuring that practices provide a safe working environment and work to certain standards within a framework called the combined practice inspection, which is a large part of our governance within practice. That relates to practices that are providing NHS dental care. Any practices that are purely private have to go through Healthcare Improvement Scotland to ensure that they tick all the correct boxes for delivering safe care.

In Tayside, we are aware that there is an access issue. You mentioned a patient who is going to 12-month check-ups. That is potentially quite acceptable. If the dentist has done an assessment on that patient's oral health and has deemed that the 12-month recalls are satisfactory to ensure that they maintain oral health, we would not have any argument with the dentist in that situation.

Beyond that, like all health boards in Scotland, we are aware that there is an issue with access to NHS dentistry our area. To that end, we have set up a task force that combines people from the health board executive, me, primary care, the Scottish Government and our finance department to see whether there are ways that we can facilitate access.

One of the big problems that we have, which has already been alluded to in your discussions with Professor Conway, is recruitment. At present, we have empty surgeries in Tayside. That is the same across other health board areas; we are not unique in that respect. We do not have enough dental staff to fill all the available surgeries. As was discussed earlier, people have perhaps taken early retirement after the pandemic or made lifestyle choices that they want to work fewer hours.

Those are the sorts of challenges that we face within the health board at the minute. We are trying to address them and are discussing across the board any innovative ways that we might be

able to help. However, without more dentists to fill the surgeries, we will find access challenging.

Murdo Fraser: Thank you. Does either of the other witnesses want to add anything to that?

Adelle McElrath: Health boards have absolutely no role in, have no oversight of and do not even have a say in what dental practices register which patients and how many NHS patients they register. The only role that health boards have nationally is to offer emergency and unscheduled care to people who cannot access GDS. The core remit of the public dental service—PDS—is slightly different and targets slightly different patients.

However, it has been highlighted very clearly within NHS Borders, and in feedback from regular area dental committee meetings, which are very well attended by all GDS practices in NHS Borders, that the barriers that many practices face are myriad in function. There are workforce issues in all aspects of the team around the ability to recruit. There is also a change in demographics within that. Many people have reduced their sessions or reduced their commitment to work.

Business running costs and the costs of being able to deliver NHS dentistry within the rigid NHS fee structure have been identified as a barrier. There have certainly been no practices in NHS Borders that have identified that they wish to reduce their NHS commitment or do not want to offer NHS care, but—this has been reported within our area dental committee—they have simply had to look at augmenting income streams to be able to continue to deliver that NHS care.

To that end, when I was appointed in July 2022 as the director of dentistry on an interim basis, I completed a survey with the 16 NHS GDS practices that we then had to further understand what was happening with the workforce. Again, those are independent third-party contractors. The health board has absolutely no oversight of who is employed where and how many people are employed.

I received 12 responses to the survey that I sent out, which was quite a good response rate, and each of those 12 practices reported significant and protracted recruitment and retention issues at all levels of staff. They also reported that more than 67 per cent of practices had reduced their NHS availability to deliver NHS care. That may well have been because they had to augment their income streams, or because of work-life balance issues that became apparent after the pandemic, or potentially because of both those things. More alarming than that, more than half of practices intended to further reduce their NHS time commitment—not their NHS commitment but the time available to deliver NHS dental care.

Murdo Fraser: I do not know whether Antony Visocchi from NHS Shetland wants to come in, but I want to ask a follow-up question, which I am interested to hear your perspective on, Adelle. You talked about the role of health boards in providing emergency care. Has there been a substantial knock-on impact on the hospital dental service because of the problem of access? Could you talk about your experience, please?

Adelle McElrath: In NHS Borders, our public dental service has had to remobilise its services and to devote significant time and manpower to supporting access to unscheduled and emergency care. The remobilisation of NHS Borders public dental service for its core remit—that is, treatment of patients with special and additional needs or complex medical conditions—has stagnated much more.

We also have, as a legacy of the last access crisis, a much higher percentage of patients who could be registered in an NHS general dental services setting, but we cannot rebalance that, because we have nowhere to place those patients at the moment because access is very challenging and, quite frankly, precarious in NHS Borders. Increasing demands have been placed on the PDS to undertake domiciliary care.

On what the health board can do and what we have done, I note that we completed an oral health needs assessment pre-pandemic, which set out our challenges. It gives us focus and sets out where we are going, where we want to go and where we need to go. It devised 10 priorities, which we have reviewed and have decided are still completely and utterly relevant. The priorities range from raising the profile of oral health, to meeting the needs of our ageing population, to maintaining and improving access, to maintaining and improving recruitment and retention, to the structure and workforce of our public dental service, to engagement between the wider dental community of dentists and their teams with, most important of all, the patients and all the public whom we serve.

10:30

We will look at that and are working hard on it. Part of that work has helped us to target our childsmile programme return, to look at community mapping in our services and to support a very receptive chief dental officer, as I know from when I have approached him on two occasions to increase our Scottish dental access initiative application area to further support and widen access in our area.

Although I appreciate the actual oversight that we, as a board, would have over an independent GDS contractor, a lot of work is going on, and

there is a lot of communication: there are a lot of open discussions. NHS Borders covers a large geographical area and we now have only 19 practices, one of which is an orthodontic practice. Therefore, relationships with all practices are formed through people being very approachable and knowledgeable.

Murdo Fraser: Does anyone else want to say anything about the impact on hospital dental services or emergency care?

Antony Visocchi: Yes—I would like to draw a distinction between the hospital dental services, which are secondary care, and the public dental services, which are provided directly by health boards. I think that the latter is probably what we are talking about.

I echo what Adelle McElrath said about the fact that, initially, after the pandemic, dental services in their entirety had to be remobilised. They then moved on to providing what is commonly termed a safety net for unregistered patients who cannot access unscheduled or emergency care. Frankly, the public dental service is neither funded nor structurally set up to provide that kind of care. It is set up for what it does, which is to provide special care and to serve priority groups.

In my opinion, that has had two effects. First, it has taken the focus of the public dental service away from those priority groups. Secondly, the PDS has been unable to provide the volume of treatment that is expected in general dental practice, because it is dealing with a different demographic of patients. The public dental service has stepped up really well, but it has been asked to do work that it is not necessarily structured for.

If I may, Mr Fraser, I will comment on a couple of your earlier points. In more general terms, we are working in a uniquely funded model, the frailties of which sometimes come to the fore. That is where what we talked about earlier with regard to boards' oversight of independent practitioners, which can be quite limited, comes in. I do not wish to make my point too Shetland specific, but I submitted the evidence that I submitted in order that we could look at changing the balance in NHS Shetland to address that specific problem. That is not necessarily the answer for many health boards, but we certainly believe that it is the answer for our health board.

Finally, I want to touch on the annual examination that your constituent mentioned. We have been very wedded to the six-monthly exam. There is a lot of evidence that the frequency of recall examinations should be patient specific; that was certainly the clinical guidance from the National Institute for Health and Care Excellence a number of years ago. It is in our national psyche that we need to go for an exam every six months, but it is not necessarily to the detriment of a patient for them to be told that they should go in only annually.

The profession needs to do a bit of work not only to give that message to individual patients but to say generally that some patients need to be seen less or more frequently. That might be seen as being a small action in the context, but it would play a part in our ability to recover. Rather than starting our recovery by seeing every single patient every six months, which is a big request, it might be that divergence from the rigid pattern of six-monthly check-ups that people are used to would help with access.

The Convener: Declan Gilmore would like to come in.

Dr Gilmore: To be honest, Antony Visocchi has already covered everything that I was going to say. I just emphasise again the difference between hospital dental services and emergency dental care that is largely provided by a blended system consisting of public dental services and our general dental practitioners at weekends.

Jackie Baillie: I want to pursue the point about which aspects of oversight a board is responsible for, which Antony Visocchi touched on. Let me take the example of a scale and polish, which one would think is an aspect of front-line prevention work. Some 59 per cent of providers are operating at pre-pandemic level, so there is still a way to go to recover that service. Does your board have any oversight of such treatment? Is it happening in your areas? Can you take action, or does the problem belong to someone else? I put that first to our witness from Shetland.

Antony Visocchi: Specific items of treatment are decided on through clinical judgment, which involves the dentist's assessment of the patient's needs when they are seen, and a treatment plan is discussed and completed. The health board's oversight of that individual decision—what we might call micromanagement—is almost nil. The board ensures that anyone who applies to provide NHS services within the board's area passes the appropriate applications. The treatment that they provide is then randomly monitored. Declan Gilmore touched on the three-yearly combined practice inspection, which ensures that treatment is carried out in a safe and appropriate environment. The health board's oversight of such matters is therefore far more global than it is specific to the treatment needs of an individual patient.

Jackie Baillie: Let me clarify that I am talking not about the needs of individual patients but about preventative measures that we know have an impact on the population. Let me illustrate my question in a different way. We know that there is

growing inequality between the number of children and young people who are registered with dentists and the number who actually participate in treatment at their local dental surgery. Prior to the pandemic, in 2010, the figure for the gap between the least and most well-off areas was 7 per cent; it is now 20 per cent, which represents huge inequality in respect of attendance levels. Do you get involved in monitoring that or trying to adjust it?

I see that you are shaking your head.

Antony Visocchi: No—we do not, really. We look after registrations and ensure that the dentists with whom patients are registered are listed to provide NHS care to them, and that the dentists follow the guidance, but we would not have oversight of that gap. Within the guidance and the fee structure there exists the ability to provide preventative care. I give the example of the childsmile programme, and point out that additional fees have been added to the fee structure over the past couple of years to encourage a preventative approach, but that is the limit of our oversight.

Jackie Baillie: Okay. Can I just sense check that with the witnesses from the two other boards? I take it that you are in agreement with what the witness from Shetland has said? Yes—I am seeing nods. Thank you.

I have a final question. The Scottish Government has committed to abolishing all dental charges. Given the challenges that you have outlined—such as dentists leaving the NHS, there not being enough staff and people making lifestyle changes—and given that the service is not operating at the level that it was previously, how feasible is that approach? How much extra resource would be required? I put that first to our witness from Tayside.

Dr Gilmore: That is a deep and difficult question to answer.

On resources, I would like to think that Adelle McElrath and Antony Visocchi agree that we are looking first and foremost for more dentists. Adelle McElrath eloquently touched on—or rather, spoke in detail about—how the new statement of dental remuneration needs to attract dentists into the system and retain them. One of my great concerns is that, if the new statement of dental remuneration is not attractive to our independent GDS colleagues, there will be a further transition away from NHS dental provision towards private dentistry and the resulting consequences.

My greatest concern at the minute is that the new SDR keeps NHS dentistry within provision of GDS. If we do not focus on that, it will not matter how much we tinker around the edges in terms of providing access via general dental services or hospital dental services, which are more available in Dundee, Edinburgh, Aberdeen and Glasgow. They can cope with only so much of the fallout. Thereafter, there is the problem that they are not able to meet the obligations of their core remits—the things that they have to deal with in secondary and tertiary care. Therefore, I would push hard to ask the powers that be to ensure that the new SDR is as attractive as possible so that dentists are retained within NHS services.

Adelle McElrath mentioned dental inflation. I know that it was not terribly accurate, but there was a report from one of the dentists that talked about denture fees. I am pretty sure that they were referring to denture repair fees. They are already out of date because inflation has taken them further away from the numbers that were mentioned. In our practice, we get £21.10 for a dental repair and our lab charges us £32, including collection and delivery fees, so we are losing money on every denture repair that we do for patients.

Those are the sorts of things that are barriers to dentists continuing to work and provide services within NHS GDS.

Jackie Baillie: That strikes me as a rather long answer to say that, until we resolve the existing problems, any question of abolishing charges is probably for the birds.

I see that Adelle McElrath is nodding. Would you like to add anything to that?

Adelle McElrath: Yes. I am hugely supportive of what Declan Gilmore said. To abolish NHS patient charges would be a very positive move. To remove a significant barrier to so many people accessing care can only be positive.

The real issue with primary care dentistry in GDS at the moment is deeper than that. It is myriad in function, as I tried to explain. Dentists being paid 100 per cent by the Government or 80 per cent by the patient would not make a dentist leave or stay within the NHS.

I can speak for the NHS Borders practitioners with whom I speak often. There is a reluctance to have to augment income streams in order to maintain the level of NHS provision. Nobody wants, on that basis, deliberately to go private, to my knowledge. It is about patients and patient care, which is what dentists generally want to deliver at a high level.

10:45

Jackie Baillie: Absolutely. Thank you all very much.

The Convener: I will move on to John Mason now and come back to Brian Whittle, because John's theme follows on from the previous one.

John Mason: There has been a lot of doom and gloom, rightly, around the pandemic and all that has happened. Has anything good come out of the pandemic by way of lessons that we can learn for the future?

Dr Gilmore: I suppose if something similar were to happen again, we are probably better placed to respond. However, whether the measures that we had in place this time were still suitable for any future pandemic would depend on the type of virus that arose and its form of transmission. That is doom and gloom again—let us hope that that does not happen.

In Tayside, we find that the relationships between our fellow general dental practitioners and our public dental services and hospital dental services are very positive. We have a much better understanding of how each different sector works, which has probably arisen from working in the dental hubs when they were created, for want of a better word, to deliver emergency care at the start of the pandemic.

Personally speaking again, I am very new to the role of DOD and dental practice adviser, but our relationships with Scottish Government and the policy makers in the sector have improved, and there was greater communication during that time. I do not know whether my colleagues feel the same way, but I think that that has been a positive over the past months.

John Mason: That is positive. Ms McElrath, would you like to come in?

Adelle McElrath: Absolutely. I was going to type R to speak about the team environment and the communication between GDS and PDS, which has greatly improved. The way for that shared partnership, which is part of our oral health needs assessment was paved during the pandemic, and I hope to develop that shared care pathway in the future. I completely agree with Dr Gilmore that the communication with the CDO's office and the deputy CDOs has been absolutely fantastic, as have the relationships that boards have been able to make with the CDO's office.

One very good news story for NHS Borders is the CDO being so receptive to the issues and precarious concerns that I had about access in NHS Borders and could evidence. We had a very successful Scottish dental access initiative grant allocation scheme. Two new practices have opened in the past year as part of that scheme, and we have had a third application, which has been approved. The acquisition of an existing practice will safeguard the NHS dental care provision that is offered at that practice. A further extension of our SDAI area means that it now encompasses the entire board area, and I am aware that I have another two applications imminent; one is to move to an existing surgery and expand, and another one is to expand a current surgery.

There are still issues and concerns with recruitment, and it is worth noting that of those two new SDAI practices that have opened, one has had more than 7,000 patients apply to be on its waiting list before it was open, with no advertisements, so it can no longer register any more patients until it recruits. The other one, which has two dentists, is really struggling to recruit and, with the fees structure and rising dental inflation, it is having to consider augmenting its income stream while maintaining the NHS commitment, as per the terms and conditions of that grant.

There are good news stories but the challenges still exist.

John Mason: Can I clarify a couple of points, based on that answer? Are the two new practices taking NHS patients? Are they mixed practices that will do some NHS work and some private?

On the recruitment point, who sets the wages and salaries for dental staff? Is it each practice or is there any uniformity?

Adelle McElrath: No, it is each practice. Independent GDS providers are third-party businesses. The owners will pay their staff what they decide to pay them. They will also organise a specific percentage with their associate dentists, which is unique to them. The health board has absolutely no oversight over anything to do with that. It is not part of the agenda for change arrangements that we might have in the public dental service.

One of the two new practices is taking on new patients. The other one cannot until the dentist gets some more people to come and work for him because he has 7,000 people who want to register with him and that number is possibly growing as well.

On the private-NHS split, almost every high-street NHS GDS practice is a mixed-economy practice. If you did one white filling, you would be a mixed-economy practice, in essence. The public dental service can offer only what is available within the remit of the SDR. General dental practices can offer that and other treatments, should the patient wish and should they be suitable for them.

John Mason: Thanks. I might come back to you on that point afterwards.

Mr Visocchi, Shetland is a bit smaller, so I guess that you are all friends with each other. Did you gain anything positive from the pandemic?

Antony Visocchi: Yes, we are all very friendly up here. Because of the size of the area, there was always a more informal relationship than there would be in bigger boards. For that reason, it was a possibility. However, I do some work with Forth Valley NHS Board as well and know that one of the biggest positives out of the pandemic has been the increased collegiate working environment that we all have within health boards, between health boards and between health boards and the chief dental officer's office. There has been an awful lot more communication and an awful lot more contact with each other to try to work our way through the challenges that we all face.

John Mason: Should we change the whole system? To judge from your submission, there is quite a desire to change it in Shetland, partly because you have only one private practice, if I understand correctly. To start with NHS Shetland, would you bring the whole service into the public sector and get rid of the private sector?

Antony Visocchi: I would not get rid of the private sector because there is a role for it. We have a unique funding model in that 80 per cent of dental services nationally are provided by independent contractors. Those independent contractors have their fees set by a third party.

You asked about what role the health board has and how practices pay their staff. They all have different overheads. The overheads in the Borders are different from those in central Glasgow, and there are different overheads in Inverness and Shetland, but practices that provide NHS services work to the same fee structure. As an independent business, that can be quite restrictive. That is where the mixed-economy practice is a must to ensure that such practices are viable.

To go back to the evidence that I submitted regarding Shetland, the structure of the majority of dental services being provided by general dental services—that is, the high-street dentist, for want of a better phrase—in the majority of other health boards relies on there being a significant, robust framework of high-street dentists. For instance, in NHS Greater Glasgow and Clyde, there are in excess of 200 dental practices, so if there is a fall-off in one or two, the body of the GDS can still take on the majority of the work. The problem that we have had in Shetland specifically is that, over the years, there has been an attempt to replicate that but we are working from a standing start, so there is not the structure there to take on the lion's share of the work.

Therefore, rather than going down that road, my proposal—and I am still in what are very positive discussions with the Scottish Government and with the CDO on this—is that we become a little bit more in control of our own destiny in an island situation and we take dental services more under the umbrella of directly delivered services from the health board rather than relying on independent practices, given the challenges that they face.

The other reason for doing that is that it is simply not feasible for somebody in Shetland who cannot get to a GDS practice to drive to another health board to be seen, whereas people may be able to do that with a mainland health board. There is a specific and quite unique situation there.

John Mason: That is great—I appreciate that the situation is quite unique in Shetland. Dr Gilmore, should we be thinking of radically changing the dental system to something more like the GP system—where the GPs work for the public sector almost 100 per cent—and drop the private side?

Dr Gilmore: That would require a really radical change to how we provide things just now. Presently, there is a restriction on what can be provided in terms of dental care via the statement of dental remuneration. It would have to be funded in such a way that it would make it attractive for dentists to continue to provide general dental services within the NHS, which would require a significant monetary input from the Scottish Government.

We have just got sight of a new statement of dental remuneration. The main issue will be whether it will be properly funded and remunerated to continue making it attractive to GDPs. At present, I feel that the best way forward may be evolution rather than revolution. I know that some would definitely argue for a complete dismantling of the system just now, but it would have to be done in such a way that it kept dentists within the NHS. You would then have to make decisions such as whether to include dental implants within such a service and I think that it would be very hard to bring it all within a new structure as well. As I say, my feeling on it at the moment would be that we need evolution rather than revolution.

John Mason: Okay—can I ask Ms McElrath that question as well?

The Convener: Very quickly.

John Mason: Can I ask you for a quick response, Ms McElrath—would you agree with Dr Gilmore?

Adelle McElrath: I completely agree with Dr Gilmore.

John Mason: That is great.

The Convener: Before moving to Brian Whittle, there is one thing that I am looking for clarification on from Adelle McElrath. Are the grants that you

were talking about the £100,000 Scottish Government grants that allow you to set up a new practice?

Adelle McElrath: Yes—I was talking about the Scottish dental access initiative, which enables you to either open a new practice, buy an existing practice or extend your current practice to widen the access to NHS dental care. It also brings with it the recruitment and retention eligibility within that area for new dentists.

The Convener: If I have time at the end, I might come back to you about that. Brian, I will go to you now.

11:00

Brian Whittle: Good morning, panel. I would like to dig a little bit into the issue of inequalities. As we heard in the last session, inequalities were already increasing, but the pandemic has exacerbated them quite dramatically.

I suggest that we really need to look both at how we reduce inequalities and at the whole prevention agenda. As someone eloquently put it earlier, dentistry has been, to a great degree, untapped in terms of the prevention agenda. With prevention and inequalities in mind, what role can health boards play in reducing inequalities in dental care and oral hygiene?

Adelle McElrath: Health boards can play a great role in overseeing that. We are in a fortunate position, as we are currently reviewing our oral health needs assessment, and I feel that we have been able to do the absolute maximum that we can. When the national dental inspection programme—or NDIP—was re-established, we inspected not just the primary 1s but the P2s, because they would have been missed. We set those children as a priority. One innovative test of change that we put in place was to deliver fluoride varnish at that point of contact.

We have extended our childsmile programme; we have recruited another oral health support worker; and we have extended our education programme and the sites where we can deliver it, as well as the number of places that we can infiltrate to deliver our packs, which are now being delivered to—and signposted at—food banks and early learning establishments. In the Borders, we have had a 97 per cent positive response rate from early learning establishments to childsmile.

The Government extended the child exam for GDS, which increased the fee for child examinations. We never used to get a fee for those, but now it has been increased. The Government also extended the age of a child for whom a dentist could get paid to deliver fluoride application. Pre-pandemic, the age was six, and it has been extended to 12. In addition, we can submit a childsmile annual claim until patients are 18.

I feel that that has not quite answered your question. I have perhaps digressed a little, and, if so, I am sorry. I do that, although I promised myself that I would not do it today.

Brian Whittle: You might have a role in politics, in that case.

I am trying to find the solution here. We know that big issues have arisen, that inequalities are increasing and that there is a problem with, for example, the length of time between treatments, which increased so much during the pandemic. In the earlier evidence session, we heard again about an increase in the treatment required by patients. There is a perfect storm with regard to the squeeze on NHS dentists' time, and we need to look at a long-term strategy for bringing the inequality level back down again—or, at least, preventing it from rising any further before we do so.

I want to widen the discussion out. I am happy to take comments from any member of the panel, but I will give Ms McElrath another chance to come back on to the path.

Adelle McElrath: You are absolutely correct. This is not about focusing on only one preventative programme but about looking at all our preventative programmes. After all, we have the open wide programme, the caring for smiles programme and the mouth matters resource. It is all about maximising those programmes to improve education and raise the profile of oral health, and it is about scratching the surface and seeing who is underneath—that is, who has been left behind or left out of those programmes—and having the intelligence behind that.

NHS Borders health board has a strong oral health improvement team. We have been communicating part of the good news story with regard to Covid, which was the improved team working between GDS, PDS and all the domains of our health board. We have maximised, to the very best of our ability, all our preventative programmes—and continue to do so—and we have community engagement. I have to be honest, though, and say that a lot more benefit could be gained if there were a nationwide approach. It might therefore be best if you went back to Professor Conway for an answer to that question, Brian.

Brian Whittle: I will go to NHS Tayside to see if I get a similar response, but I will also broaden the question out slightly.

One thing that came up in the previous evidence session was the lack of understanding of what

NHS services are available, especially in the lower SIMD areas. It is almost a marketing issue. Perhaps I can expand my question into that area, Dr Gilmore, and ask you what NHS services and boards can do to alleviate that particular issue. It seems like something that we should be able to tackle.

Dr Gilmore: With all due respect, I do not know whether the question almost puts the cart before the horse, but I completely agree that we need to be very transparent about what is available and make sure that the wider public in all sectors of the community are aware of what is available. I probably come back to the fact that even if you are aware of what is available, gaining access to those services continues to be problematic. We need to address both sides of the coin.

As for advertising and making folks aware of what is available to them, I would say, much as Adelle McElrath has just said, that we have a tremendous group of people and a superb team in PDS delivering childsmile and maximising awareness of that remit. We are also working with other healthcare providers in Tayside to deliver the information that patients require to fully understand what is available to them. Beyond that, we use our comms teams to advertise via social media platforms, communicate what is available and share oral health improvement messages.

Brian Whittle: Perhaps broadening the question out as far as I can, I would say that this is about understanding where the issues are and, as we have just discussed, ensuring that everybody is aware of what services are available to them. Indeed, Dr Gilmore, you touched on the fact that the service is making people aware of not just what they are entitled to, but its availability.

I go, then, to Mr Visocchi for my key question. Do we have the resource to tackle increasing post-pandemic inequalities?

Antony Visocchi: In a word, no. This goes back to a lot of the comments that have been made, but the fact is that the workforce is just not there. You mentioned the perfect storm earlier. We have increased need, because people have not been seen; we have a backlog; and we have a reduced workforce. At the same time, independent practitioners, as Dr Gilmore has pointed out, are saying that it is costing them money to provide NHS services. All of that together means that the simple answer to your question is no, we do not have the resource to recover services.

Brian Whittle: Finally, given that we are sitting in the COVID-19 Recovery Committee and are trying to map our way out of the current problem, I am looking for the positive steps that we can take in this building or in this environment that can help alleviate those issues. How do we plan our way out of the situation?

Antony Visocchi: It is a challenge. We really need to focus on preventative measures, because they were a huge success, especially childsmile.

In addition to Professor Conway's evidence, it was specifically commented on in Shetland that the childsmile team was a vital point of contact for health boards during the pandemic and the restrictions. Shetland has the second lowest decay rate in Scotland and we are trying to maintain that, so it is all about maintaining what is being done well already.

More generally, on what can be delivered, my opinion is that we perhaps need to clarify what is involved in providing NHS dental services. Is it about maintaining the health of the population or is it about providing all dental services? There is a difference and I think that that is something to consider when thinking about how the service can be appropriately funded to provide what it needs to provide.

Brian Whittle: Do the other witnesses want to comment?

Dr Gilmore: The answer to your question is so complicated that there is no way that the three of us could even begin to respond in any great detail or depth. It is a question that needs to be put to the directors, to the CDO, to the clinical leads, to PDS and to the clinical directors of our hospital services.

If you are looking for a pathway, you will need to bring together all the different factors in and facets of the provision of dentistry in Scotland, with the needs, wants and problems of the individual areas discussed as a whole and then brought together, too. There is also a web of connections between the different services. We all rely upon each other to provide dental services and a structured pathway towards recovery will require all of us to come together. However, it is not a pathway that I or Antony Visocchi or Adelle McElrath can provide for you just now.

Brian Whittle: I will just give Ms McElrath the opportunity to respond. Do you have anything that you would like to add?

Adelle McElrath: Honestly, I have to say that both Antony Visocchi and Declan Gilmore have really hit it on the head. Your question is too complicated for a simple answer, because there are so many issues with so many facets.

I firmly believe that prevention, education and signposting for all and a maximisation of our oral health improvement programmes—as well as our payment reform, which we are desperate to see whether it will support the profession—are a very good place to start. With our blended payment

model—our item of service—we saw during the pandemic that we were very well supported and there were Covid emergency top-up payments. However, activity dropped—and did so for many reasons. Because of infection prevention and control, staff were working in different bubbles; there was also the issue of fallow time and so on and so forth.

However, the fact is that activity dropped, and the taxpayer deserves a well-balanced, economical service that is the best possible. The item of service in dentistry has always worked on that basis in terms of activity. What is stretching the profession is trying to get the other factors correct. Within an independent GDS setting, it is all about the workforce, the changing demographics and some governance with regard to the nuances between different practices and who has what oversight over what is, by and large, dental inflation and the running costs.

Brian Whittle: Thank you.

The Convener: Adelle, I just want to pick up a couple of points with you. You have talked a number of times about dental inflation, but what do you mean by that? Is that the general inflation that we are all experiencing just now or is there some other factor that we are not picking up on?

Adelle McElrath: It is about the high cost of utility bills, which we are all experiencing, but there is also the cost of lab fees, which are rising exponentially, as Declan Gilmore touched on. In the past three months, the fees have kept hiking and hiking, to the point that, in many instances, they are more expensive than what dentists are being paid. It is also about the cost of purchasing dental materials.

11:15

The Convener: Is it the lab fees that are driving your inflation, plus the cost of materials?

Adelle McElrath: I am not an economist, so I cannot give you a great answer to that. When I referred to dental inflation, I meant the increasing costs of running a practice.

The Convener: On staffing, is it just dentists that you are missing, or is it nurses and hygienists, too? Is it across the board?

Adelle McElrath: Yes, it is across the board.

The Convener: Are health boards competing with private services for the same staff?

Adelle McElrath: Absolutely. PDS dentists are struggling to recruit and there are many vacancies, not just for dentists. We are struggling to recruit hygiene therapists. At the moment, hygiene therapists are being used largely as private hygienists, and they can get whatever they can in private practice. That is what we are trying to compete against.

We are also struggling to get nurses—dental care professionals—to stay. There are also training issues. The Mentor Training Centre, a large online nurse training provider, has raised an issue about grants for people who are over the age of 25. Those grants are going, so it will be even harder for practices to get more experienced people to train as dental nurses. It is about the whole sector.

The Convener: Does anybody want to add anything to that, or are you all content?

Antony M Visocchi: Just to add to what Adelle McElrath said, I would also say that the issue is right across the board. We lost a lot of staff—and not only dentists—during the pandemic. What was asked of dental staff during the pandemic was described very well earlier; they had to wear PPE and there were risks. Indeed, we were at the highest risk, and a lot of dental nurses and people working in the sector left the profession as a result. Frankly, it is very difficult for independent practices to compete with the private sector on wages. The combination of those things has meant that we have lost a lot of staff, and attracting them back will be very difficult.

The Convener: Declan, do you want to add anything, or are you content?

Dr Gilmore: I am content. Adelle McElrath and Antony Visocchi have put it very succinctly, so I have nothing to add.

The Convener: I think that we will be looking at the model for how dentistry works next week, so we will be able to expand on that.

Thank you all very much for giving us your time this morning. If there are any other issues that you want to raise with us, the clerks will be happy to liaise with you.

I see that Declan Gilmore wants to come in again.

Dr Gilmore: Apologies—I should have taken the opportunity a moment ago to say this. I know that there is a discussion taking place about reform and what have you, but I think that it would be a missed opportunity if I did not comment on the issue that was touched on earlier about the dangers and difficulties that our colleagues faced at the height of the pandemic. Antony Visocchi mentioned that they were the most at-risk profession, or were perceived to be so. Many of our colleagues put themselves on the front line in difficult times. Their perceived danger seemed particularly high, as there was a lot of news coverage about how many people were dying from Covid infection. Therefore, at this point, it would be nice to mention how our colleagues stepped up at

a difficult time and continued to provide services at their own personal risk. It would be good if that was acknowledged.

The Convener: Absolutely. Everybody on this committee would absolutely concur with that. As I said earlier, when I was at my dentist, they were completely hazmat-suited up. It must have been horrendous, and your point is duly noted.

That concludes the public part of the meeting. We intend to continue the inquiry at next week's evidence session, and we will hear from the Scottish Government on 29 June.

11:20

Meeting continued in private until 11:37.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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