OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 10 December 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
35th Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Tom Ferris (Scottish Government)
Johanna Irvine (Scottish Government)
Tim McDonnell (Scottish Government)
Jenni Minto (Minister for Public Health and Women's Health)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 10 December 2024

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 35th meeting in 2024 of the Health, Social Care and Sport Committee. I have received apologies from Gillian Mackay, and we are joined remotely by Sandesh Gulhane and Carol Mochan.

The first item on our agenda is a decision on taking business in private. Do members agree to take agenda items 6, 7 and 8 in private?

Members *indicated agreement.*

Subordinate Legislation

Burial (Management) (Scotland) Regulations 2025 [Draft]

Burial and Cremation (Inspection) (Scotland) Regulations 2025 [Draft]

09:30

The Convener: The next item on our agenda is consideration of two affirmative instruments. The purpose of the burial management regulations is to make provision for the management and maintenance of burial grounds in Scotland applicable to all burial authorities, both local authority and non-local authority. The purpose of the burial and cremation inspection regulations is to provide for inspection and enforcement in the funeral sector and for any subsequent appeals in that regard.

The Delegated Powers and Law Reform Committee considered the instruments at its meeting on 26 November 2024 and made no recommendations. The committee will now take evidence on both instruments from the Minister for Public Health and Women's Health and her supporting officials. Once our questions have been answered, we will proceed to a formal debate on both motions.

I welcome to the committee Jenny Minto, Minister for Public Health and Women's Health; Johanna Irvine, solicitor; Katerina McNeill, team leader, burial and cremation; and Ruth Wilson, senior policy adviser. I invite the minister to make a brief opening statement.

The Minister for Public Health and Women's Health (Jenni Minto): Thank you, convener. I am delighted to join you today to discuss these regulations.

The death of a loved one can be one of the most painful experiences that many of us will ever face. To some degree, that pain is an unavoidable part of grief itself, and there is little that can lessen it in the immediate aftermath of a death. However, as many of us know only too well, there can be solace in coming together to share the pain of the loss and to say goodbye. Funerals are a profoundly important part of that process, and, by facilitating funeral services, funeral directors as well as burial or cremation authorities can also be a source of comfort when we are at our most vulnerable.

The funeral sector is entrusted to guide families through those difficult times. They care for the deceased, and they should be respectful and sensitive to the bereaved. Fortunately, the

overwhelming majority of those services are provided with care, compassion and kindness. However, on those occasions when standards are not met, an already distressing and profoundly difficult time can turn into a long-lasting source of distress and regret.

The regulations that the committee is considering today seek to prevent loved ones from having to face that additional distress and to protect the majority of responsible, compassionate businesses from the reputational damage that can arise when less scrupulous businesses fall short. The inspection regulations will give funeral inspectors powers in relation to inspecting relevant bodies, and both sets of regulations will put in place clear legal requirements that burial authorities will have to adhere to and be inspected against.

The funeral director code of practice already sets out requirements for funeral directors, and we propose that the code and the three sets of regulations—including the Burial and Cremation (Inspection) (Scotland) Regulations 2025—will all come into force on 1 March next year. Cremation regulations have been in force since 2019. Therefore, from 1 March, there will be a comprehensive package of legislation that will maintain and build confidence across the whole funeral sector.

We have developed the regulations in close collaboration with the funeral industry and other key stakeholders, drawing on their experience and expertise to ensure that the provisions are effective, proportionate and fit for purpose. That engagement included a full consultation in 2023 on all three sets of regulations. Respondents were generally supportive and their feedback has been instrumental in the drafting process.

I am proud that Scotland is leading the way on regulating the funeral sector in the UK.

I stress again that the majority of the sector is professional, compassionate and dedicated to providing the best service possible to both the deceased and the bereaved. We are regulating because we recognise the depth of distress that is caused in the rare instances when bad practice is allowed to go unchecked. The regulations build on the previous steps that we have taken to prevent such unscrupulous practices. In approving the regulations, committee members can help to ensure that the funeral sector meets the highest standards and offers greater peace of mind to the bereaved.

Although the regulations are an important step, there is more work to do and, in particular, we are focused on taking the necessary steps to introduce the licensing of funeral directors and regulate the use of alkaline hydrolysis.

I welcome the continued engagement and close collaboration with stakeholders as we move forward, and I will be happy to answer questions from committee members.

The Convener: Thank you very much, minister, for that opening statement. Committee members have some questions, and we will start with Elena Whitham.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): I bring members' attention to my entry in the register of members' interests as a former councillor in East Ayrshire Council.

The committee has received the report that says that the majority of people are in favour of the regulations as set out, but several local authorities raised questions and issues, so I will explore them with the minister.

One of the issues that East Lothian Council brought to the attention of the committee is the requirement to "make safe" versus "repair". Given that the ultimate responsibility for headstones lies with the lair holder, can we explore that a little? Local authorities say that they have a backlog with regard to bringing headstones up to the required level, as set out in the instruments.

Jenni Minto: Thank you. I recognise what you are talking about in your question. I used to manage a museum that was located in a former church surrounded by gravestones and I remember the distress caused for some people when local authorities went there to ensure that the gravestones and memorials were safe. That absolutely comes under not just the Health and Safety at Work etc Act 1974, but the Occupiers' Liability (Scotland) Act 1960, which ensure that employees of local authorities are given the correct protections when they are at work.

The guidelines in the regulations tie into the best practice that is already happening. I recognise that some local authorities might have concerns, but additional guidance was brought in in 2019 after the tragic loss of a young boy in Glasgow. Work was done across the board to bring in local authorities and ensure that they recognised the importance of that work. Local authorities should have an established memorial safety inspection programme, and making safe should be part of their regular work anyway.

I believe that what we are asking for is proportionate. I also believe that all the appropriate people and parties have been consulted and informed about the change.

Elena Whitham: I will briefly explore the requirement to "make safe" versus "repair". Some local authorities were questioning what that actually means. Will further guidance be offered to them in that respect? In my experience, making

safe is about staking and tying the headstone so that it will not further deteriorate. Some local authorities are worried that a “repair” requirement means that they will have to undertake actual repair work to the headstones. That would normally be the responsibility of a lair holder but, obviously, some headstones are very old, so there might be nobody who has that responsibility.

Jenni Minto: Absolutely. That reflects my experience with regard to the graveyard that was around the museum that I worked in.

It is clear that South Ayrshire Council did fantastic work in response to the recent flooding of graves. It has done proportionate work to support families who were severely impacted and distressed by the flooding incident that happened there.

It is very much the case that local authorities have to look at gravestones and do the appropriate, proportionate work to them—whether that means, as you described, staking them, or looking at ones that might be of cultural or historical significance and perhaps doing more. We do not expect the regulations to change the work that councils are currently doing with regard to graveyards and gravestones.

Emma Harper (South Scotland) (SNP): Good morning, minister. You mentioned alkaline hydrolysis. In preparation for today’s meeting, I had one of my team do some research on newer, more ecological and environmentally friendly methods of burial and cremation. I was surprised to learn about all the different methods that are available. Newer methods such as alkaline hydrolysis, which is also known as resomation, have a reduced carbon footprint, but funeral directors might require on-going training or knowledge and skills development in order to take up those newer, more ecological methods of burial and cremation. I would be interested to hear your thoughts on that.

Jenni Minto: Emma Harper raises an important question about methods of cremation and burial and the decisions that people are looking to take in that regard. Wicker caskets are being used and trees are being planted as an alternative to grave sites.

Training is an important topic, and officials have been discussing it. At this point in time, there is no specific UK-wide course. We are aware of the issue, but it is important that we get the inspection regime and the regulations right. That will enable us to ensure that training is provided for our very competent and compassionate funeral directors.

In relation to water cremation, which alkaline hydrolysis is also known as, we are speaking to the Scottish Environment Protection Agency to ensure that the right environmental standards are in place.

We are aware of the need for training. That issue is not specifically addressed in the regulations, but it is one that we are looking at.

Emma Harper: The funeral directors who were consulted as part of the development of the regulations will be well aware of what they are being asked for in relation to people’s end-of-life choices.

Jenni Minto: Yes. A key part of the work that the Scottish Government has been doing is that it has been working directly with funeral directors to ensure that they have been closely involved in the process and have been able to give advice to ensure that we get the best, most rounded regulations.

Paul Sweeney (Glasgow) (Lab): I thank the minister for her comments. I want to ask about the burial management plans that are proposed in the regulations.

Recently, there has been coverage of the distress that has been caused as a result of Glasgow City Council placing adhesive stickers on gravestones that are deemed to be unsafe in cases in which there is doubt about who the owner of the lair is and how to contact them. Similarly, after a tragic incident in 2015 in which a young boy was killed by an unstable headstone in a cemetery on the south side of Glasgow, the council has increasingly taken to toppling headstones, which has caused distress not only to those who own the plots or the lairs, but to people who attend the cemetery, because a bit of an eyesore has been created, with a huge number of headstones lying flat. Victorian-era memorials have been included in that process, and although the descendants have long passed away, those memorials are of cultural or historical significance to the city.

Has consideration been given to those behaviours in the drafting of the regulations? Could expertise in conservation masonry skills and so on be recommended to local authorities by Historic Environment Scotland, whose Engine Shed is a national centre for such skills? Could local authorities be encouraged to develop conservation management plans for cemeteries, especially the older cemeteries of a Victorian character, where there is less likelihood of there being living descendants of the deceased, but which represent a significant part of the nation’s heritage?

09:45

Jenni Minto: Paul Sweeney raises some really interesting points. I was completely shocked when I saw the pictures of the gravestones in Glasgow

with the stickers on them. I have referenced the museum that I worked in that was surrounded by a graveyard, and there are many other old graveyards across Argyll and Bute. In my role, having looked at the regulations, I have to admit that, when I visit graveyards in Argyll and Bute, I look at them with completely different eyes.

In order to ensure that we have very good burial regulations, we have worked closely with a wide range of stakeholders—that is one of the regulations' strengths. It is important that we recognise the cultural side, too, and inspectors are part of that. They ensure that burial authorities, which are likely to be local authorities in the main, are following the right procedures, and appropriate ones for what Paul Sweeney described as a key part of our culture in Scotland. The regulations and the inspection regime will ensure that we and the burial authorities have much better understanding and knowledge of what is appropriate.

Emma Harper: I have a wee supplementary question about historical graveyards. I have a colleague who has 15 family members in an old graveyard in Moniaive. She learned about the regulations coming down the line and she is worried about how communication will take place with her and other members of the public who have historical links to old gravestones, for example on Victorian sites. What is the best way for information to be communicated about and to those who are responsible, whether that is the local authority or members of the public?

Jenni Minto: We are clear in the regulations that, if a local authority is looking at a specific graveyard, it needs to publicise that as best it can, whether that is through social media or in newspapers, to ensure that people know that it is likely that it will be coming to inspect the graveyard. A lot of that should already be clear in the regulations.

The Convener: We move on to agenda item 3, which is the formal debate on the regulations on which we have just taken evidence. I remind the committee that officials may not speak in the debate. I invite the minister to move and speak to motions S6M-15517 and S6M-15516.

Jenni Minto: Thank you, convener. I will simply move the motions and propose that the committee recommends that the regulations be approved.

Motions moved,

That the Health, Social Care and Sport Committee recommends that the Burial (Management) (Scotland) Regulations 2025 [draft] be approved.

That the Health, Social Care and Sport Committee recommends that the Burial and Cremation (Inspection) (Scotland) Regulations 2025 [draft] be approved.—[*Jenni Minto*]

Motions agreed to.

Burial (Applications and Register) (Scotland) Regulations 2024 (SSI 2024/334)

09:49

The Convener: The next item on our agenda is consideration of two negative instruments. The first is the Burial (Applications and Register) (Scotland) Regulations 2024. The purpose of the regulations is to make provision for standardised burial application forms and information to be included in burial registers, and to set out record retention requirements.

The Delegated Powers and Law Reform Committee considered the regulations at its meeting on 3 December 2024 and agreed to bring them to the Parliament's attention on the general reporting ground in respect of the wording of regulation 3(2)(a)(v). In its report, that committee welcomed that the Scottish Government has undertaken to amend the regulations to improve the drafting of that provision at the next available opportunity. No motion to annul the regulations has been lodged.

As members have no comments on the regulations, I propose that the committee makes no recommendation in relation to them.

Members *indicated agreement.*

Sports Grounds and Sporting Events (Designation) (Scotland) Amendment Order 2024 (SSI 2024/352)

The Convener: The second instrument is the Sports Grounds and Sporting Events (Designation) (Scotland) Amendment Order 2024. The purpose of the amendment order is to amend the list of designated sports grounds in schedule 1 to the Sports Grounds and Sporting Events (Designation) (Scotland) Order 2014, which is SSI 2014/5, to reflect a promotion to and a relegation from the relevant levels of the Scottish football pyramid for the purpose of ensuring consistency of approach to the application of the alcohol and other controls and frameworks that are set out in the Criminal Law Consolidation (Scotland) Act 1995.

The Delegated Powers and Law Reform Committee considered the amendment order at its meeting on 3 December 2024 and made no recommendation on it. No motion to annul the instrument has been lodged.

As members have no comments, I propose that the committee makes no recommendation on the amendment order.

Members *indicated agreement.*

The Convener: I will suspend the meeting to allow a changeover of witnesses.

09:51

Meeting suspended.

10:22

On resuming—

National Health Service Dental Services

The Convener: The fifth item on our agenda is an evidence session on NHS dental services. I welcome Jenni Minto, the Minister for Public Health and Women's Health; Tom Ferris, the chief dental officer for Scotland; and Tim McDonnell, the director of primary care for the Scottish Government. I invite the minister to make a brief opening statement.

Jenni Minto: I apologise for the slight delay in my arrival, and I thank the committee for shifting your agenda to accommodate that.

Thank you for the opportunity to return to the committee to provide an update on NHS dental services. When we last met, the Scottish Government was preparing for the introduction of significant reforms to the NHS dental payment system. I am pleased to confirm that that reform was successfully delivered, as planned, on 1 November 2023, with the introduction of a realistic package of fees for NHS dentists to better reflect the market cost of providing NHS services. The draft budget, which was announced last week, reinforces our commitment to the sector, with a 15 per cent increase in funding for primary care dental services planned for 2025-26.

The reforms have also introduced a number of clinical benefits for dentists and patients alike. The system is now more focused on preventative care, reflecting modern dentistry, and offers more clinical discretion to practitioners in a less bureaucratic environment, although I recognise that we could make further progress on that.

The primary aim of reform was to incentivise dentists to provide more NHS care and, in turn, to support patient access. One year on, the latest official statistics show that almost 4 million courses of treatment were delivered to patients between the introduction of the reforms and the end of September 2024. That demonstrates that the sector has been sustained and that high volumes of patient access are being delivered in the new system. It also reflects the conversations that my officials and I have had with dental stakeholders, who have reported a largely positive response to reform. However, I am acutely aware that localised access issues remain, and I am clear that payment reform is only the first step in ensuring the sustainability of NHS dental services.

We continue to make a range of additional financial support available to the more challenging areas of Scotland, while actively considering the

long-term actions that are required to improve patient access, including those on workforce and governance. I stress that there are a number of complexities involved in addressing recruitment and access challenges. The issues that we face are not Scotland specific, and there is no short-term solution. However, I recently met the new Secretary of State for Health and Social Care and my counterpart in Wales to discuss the actions that are required to improve international recruitment pipelines, and I look forward to working with my colleagues across the UK to find solutions.

In line with our programme for government commitment, we will continue to work collaboratively with stakeholders across the sector to monitor the impact of reform over the remainder of this parliamentary session to ensure sustained and improved access to NHS dentistry for the people of Scotland.

The Convener: Thank you. We will move straight to questions.

Paul Sweeney: I thank the minister and her officials for attending today. I want to build on the point about access, particularly with regard to inequalities. Is an increase in payments for treatments a reliable measure of increased activity and engagement? What other measures does the Government use, given that evidence from boards suggests that people are finding it more difficult to access NHS dental care?

Jenni Minto: We have worked closely with Public Health Scotland to ensure that we have robust methods for knowing how many people are getting dental treatment. It is very important that we recognise the increase from the first figures that we have had—the 4 million courses of treatment. We are also gathering information on preventative care and improvements in that respect. For example, we know that there have been 1.7 million preventative care appointments in dentistry.

However, as I highlighted in my introductory remarks, we recognise that there are issues in certain areas of Scotland. Ninety-five per cent of the population are registered with dentists, but I recognise that, in areas such as Dumfries and Galloway, the figure is in the mid-60s, so there is work to do. That said, our work on payment reform has been important in stabilising the situation with dentistry and has allowed us to look at specific areas where we need to do more work, whether they be specific areas of Scotland or areas such as employment, workforce and governance.

Paul Sweeney: It is difficult to tell the full extent of the numbers of people who have felt forced to move to private dental care, but, from what we have heard anecdotally, it is not uncommon, and there is a risk of a two-tier system being created that exacerbates inequalities. In fact, that can even happen with the upselling that takes place in what are ostensibly NHS dental practices. Are you concerned that that is an issue, and what can be done to reduce the number of patients who feel that they have to go private to get timely treatment?

Jenni Minto: I thank Paul Sweeney for that question, as I recognise the picture that he is painting. We have to recognise, though, that dental practices are businesses, and dentists can make the decisions that they feel are appropriate in order to run them. However, my team and I are absolutely focused on ensuring that we put the right investment into the right places in NHS dentistry in Scotland to ensure that people do not have to make that very difficult choice.

Paul Sweeney: Do any of your officials have any comments to make at this stage?

Tom Ferris (Scottish Government): There are lots of reasons for access being reduced in certain areas. Usually, though, the issues are local, not systemic or national. Looking at the national picture, I am, in general, quite heartened by what we have seen following November 2023.

However, we are not complacent, and there are definitely particular areas where access has been reduced. That can quite often be attributed to workforce issues, and our major focus as we move forward is how we can maximise the workforce that is able to deliver NHS dentistry in Scotland. It is not just dentists who are needed; dentistry is a team sport, and we need to have the whole dental team delivering for patients.

We recognise that there are areas where access is difficult and that there are tough choices to be made by individual patients. However, when we can get the workforce in and NHS dentistry becomes more available, people will have the freedom to come back and seek the care that they want under the NHS.

10:30

Tim McDonnell (Scottish Government): When we started payment reform, the core objective was to preserve access. That is about enabling choice for patients, so the payment system was intended to incentivise dentists to remain in the NHS and offer NHS dental services. In that mixed model of private and public dental care, preserving access is key to allowing choice. We will work with Public Health Scotland to analyse registration and usage and to target the health inequalities that we know about. We will work with PHS at a national level and with boards, using the mitigations that we have in place, to allow access for those who cannot afford to pay for dental care.

Paul Sweeney: I want to touch on the point about payment reform and the idea of creating an incentive, which is certainly logical. NHS National Services Scotland payment remuneration data shows an increase on the pre-dental reform figure, which demonstrates an increase in NHS activity. However, the most recent Scottish health survey found that the proportion of adults reporting difficulties in accessing a dentist is at its highest since 2019, at 34 per cent. Might there be a lag between the data sets, and do you agree that we might need to look at a richer picture of data in order to understand fully what is going on?

Tim McDonnell: With regard to making balanced policy and recovering from the pandemic, we realise that, given those pre-2019 figures, dental sector recovery is a very significant ask of the Government and the NHS. Although I appreciate that we are not at pre-pandemic levels of activity, given the data that has emerged from the NSS, to which you referred, we have, in a sense, tried to change the basis on which treatment is offered. There is now time for an enhanced examination, which allows for oral health and prevention to be embedded in the payment system.

I accept that MSPs and health boards highlight instances of difficulties in access, to which we respond on the minister's behalf. However, payment reform is a major Government programme—we embarked on it in 2023, and it will take some time to test and adjust to get us to a position in which we fully meet the policy objectives of the reform.

Paul Sweeney: A total of 94.6 per cent of the Scottish population are registered with an NHS dentist, but people in the most deprived areas are less likely to have had contact with NHS primary dental care, with just 122,513 adults from the most deprived areas accessing care in comparison with 131,032 in the least deprived areas. Is the Scottish Government aware of that inequality, and what is it doing specifically to address it?

Jenni Minto: Yes, of course the Scottish Government is aware of that. The comments from Tom Ferris and Tim McDonnell underline the breadth of the work that we are doing in primary care dentistry in Scotland. There are some very good examples of areas of inequality being served by health boards.

Health boards know their areas very closely. For example, the Tayside dental bus specifically goes into areas of deprivation, and I am pleased that that service was recognised at the NHS Scotland awards last month. We also have a public dentistry service in Edinburgh that holds certain clinics in more deprived areas, in recognition that not everyone can go to Chalmers Street. That is important.

I underline the work that we are doing on prevention. We continue to invest in childsmile to support children. If we teach children, that goes to parents, too. Specific funding has also been directed to people in care homes, people with drug addiction and members of ethnic minorities, which supports them on the preventative side of healthcare. That is very important, and it is a key investment in Scotland's dental services that ensures that we work towards everybody in Scotland having better oral health.

Paul Sweeney: One of the main difficulties that has been reported in accessing a dentist has been getting an appointment. The Scottish dental access initiative funding was intended to address that concern, but it has been made clear that only nine dental practices have received that funding over the past four years. Will you provide some context as to why so few practices have benefited from that funding? What could be done to develop that further?

Jenni Minto: I will give an overview, and I will then pass to Tom Ferris.

As I indicated earlier, each health board is responsible for looking at dental support within its footprint. Each health board has a director of dentistry, and we rely on them to have conversations with the Scottish Government regarding areas that they believe need SDAI funding. We have been working very closely with directors of dentistry, and we have listened to a lot of comments from your colleagues at the two dental round-table meetings that we held earlier this year. We are considering how we can focus more on where the SDAI grants are available.

Tom Ferris: The funding that we have available for SDAI grants is driven by practices and dentists themselves; it is not the boards that have control of it. If a dentist identifies a site or a community where they would like to open a practice, they can apply for the funding. That sits alongside other funding that they may seek through banks. A practice that could expand in its area will come to the health board and make its case that it would like some of the funding. That is driven not by us but by demand from the sector. Not a huge amount of demand is coming from the sector, which is probably why only nine practices are involved.

We might need to rethink how the access initiative money is spent. Given that there are areas where access is quite difficult, perhaps we should be targeting more. We are considering what we do with the money. If it is open to everyone but take-up is relatively low, perhaps we should be targeting it at communities where there has been a definite reduction in access. That might result in better value for the resource.

Paul Sweeney: Do you know when the reformatting work will be concluded?

Tom Ferris: It is tied up with our recruitment and retention funding. There are active policy discussions, and we will probably go to the minister in the early spring with our views on how to take things forward.

You are right—as we have only nine successful processes in train, we definitely need to consider a better targeting approach.

Paul Sweeney: I appreciate that response. Thank you.

Brian Whittle (South Scotland) (Con): Good morning, minister and colleagues. My questions follow on from those asked by my colleague, Mr Sweeney. The fact that 95 per cent of people are registered with a dentist does not mean that 95 per cent of people are getting access to a dentist. We should recognise that.

What we have heard anecdotally about waiting lists and the amount of time that it now takes to get an appointment with a private dentist is another indicator that we still have a wee bit to go.

On inequalities, we read that there is a 23.5 per cent difference between the most deprived and the least deprived in the rate of obvious decay. Before the pandemic, there was a significant rise in the number of children with extractions, which is really worrying. You will be aware of my fascination with preventative medicine. On top of that, we have had Covid, exacerbating a significant problem. How are we monitoring that? Are we measuring the impact that childsmile, which is a significant intervention, is having on inequality?

Jenni Minto: You are right to pick up on the statistic about the difference between the least deprived and most deprived areas. In fact, this year we had the lowest gap between the least deprived and most deprived areas, so improvement is taking place. It is nothing to shout about, however, and we absolutely recognise that we have much more work to do.

You are right that childsmile is one of the key areas where we can make a difference. I am pleased that dental practices, communities and schools have re-embraced childsmile after a pretty awful time for oral health during the Covid pandemic. Registrations from nought to two-year-olds, which had fallen to 25 per cent, are up at 40 per cent this year. Again, we are seeing improvement.

Brian Whittle: That is very welcome, but on the ground in my area, third sector organisations in particular are finding that there are issues with getting access to a toothbrush, let alone dental treatment. It worries me that, potentially, we are not collecting the data that we need in order to understand the direction of travel. I go back to the issue of how we are measuring this. How are we gathering the data? Any information in the particular area of prevention is helpful.

Jenni Minto: Public Health Scotland gathers the data for the Scottish Government, as you well know. When I was at its annual review, alongside Paul Kelly from the Convention of Scottish Local Authorities—we co-chair the annual review with COSLA—we were shown a tool that is pulling in data from an education perspective and from a health perspective. It has been piloted in a few schools over the past year or so. One school recognised that there was an issue with oral health; as a result of the pilot, it was able to focus on that. That is the kind of information that we are getting.

However, the information is only as good as the decisions that come out of it. That pilot is a good example of where data is being gathered from two different sources—education and health boards—and acted on to improve people's health. We need to focus on that.

Brian Whittle: I think that we would agree that investment in prevention is probably the greatest investment we can make. Is there potentially a way to expand oral health checks into secondary schools? Has any work been done on what the impact of that would be?

Jenni Minto: It is important to recognise that secondary school children have access to free dental health care. One of the conversations that I have quite regularly with Tom Ferris is about the number of adverts on telly for toothbrushes and toothpaste. There is an important point to be made about ensuring that people of all ages are aware of their oral health. I am happy to take that point away and have a conversation with my colleagues in education about how that fits in.

The database from Public Health Scotland that I have just described has the potential to result in improvements. The example that I gave was in a primary school, but I imagine that secondary school teachers would recognise the importance of bringing in education on oral health for older children. That is an important point.

10:45

Sandesh Gulhane (Glasgow) (Con): I remind members of my declaration of interests as a practising general practitioner in the NHS.

I will put this to you directly, minister. Do you accept that the fact that someone is registered with an NHS dentist does not mean that they can get timely access to that dentist?

Jenni Minto: It is important that people are registered with a dentist, because timely access is

important if they need to see a dentist. However, there is also emergency access to dentistry within hospitals, for people who need that.

It is important that we have the right workforce within our practices. We are now very much concentrating on ensuring that we have the right number of dentists. As Tom Ferris indicated, that means not only dentists but dentistry teams, so we are looking at the importance of dental therapists and ensuring that there is the right training and governance to allow patients to see the appropriate person in a dental practice and at the right time.

Sandesh Gulhane: Given that answer, do you feel that being registered means that people can get seen in a timely manner?

Jenni Minto: I would very much prefer it if people were able to see dentists sooner than they currently do. That is what we are focusing on in delivering the wide range of outputs and changes that we are working on now.

Sandesh Gulhane: Everyone on the committee would want people to be able to access all of the NHS in a timely manner when they need it. We are focusing today on dentistry and I keep coming back to this question because, every time you speak about this in the chamber, you quote statistics about the number of people who are registered but do not qualify it by saying whether they can actually access their NHS dentist in a timely manner. I put it to you for a third time: do you accept that being registered does not necessarily mean that someone can see their dentist in a timely manner?

Jenni Minto: In a perfect world, we would want everyone to be able to see their dentist at a time when they want to. We are working on that. It is important for you to remember that being registered with a dentist means that the dentist can get the capitation payment, which is important to their on-going business.

The work we are currently doing is trying to increase the availability of dentists and their teams to ensure that people can see their dentist in a timely manner.

Tim McDonnell has kindly just given me the latest statistics, which show that 60 per cent of those registered—which means 3.1 million people—have seen a dentist in the past two years. Do I think that we should be improving that? I do, which is why we are working hard on workforce planning, fees and governance.

Sandesh Gulhane: You are not answering my question, minister, but that is okay. We will move on.

Jenni Minto: I think I did answer your question, Dr Gulhane.

Sandesh Gulhane: The committee has heard about the difficulties that people have in accessing NHS GPs and the statistic that you just gave me says that 40 per cent of the population have not seen their GP in the past two years.

I have spoken to dentists who find it extremely difficult to deregister patients. They feel that if someone has not come to see them for a number of years, despite letters asking them to come in for an annual review, they should be allowed to deregister them. Do you agree with those dentists?

The Convener: Can I clarify that, Dr Gulhane? Are you talking about GPs or about dentists?

Sandesh Gulhane: Dentists.

The Convener: You mentioned GPs twice in your question.

Sandesh Gulhane: I apologise. I am talking about dentists.

Jenni Minto: Dentists can deregister patients. I am not quite clear about the timeframe, but Tom Ferris can explain.

Tom Ferris: There is no restriction on a dentist deregistering a patient. It is absolutely open to them to do that, but they must give the patient and the health board three months' notice that they are doing so. There is no restriction at all. I do not want dentists to deregister patients, but there is no restriction and there is nothing to stop them.

Sandesh Gulhane: I will put that to the dentists whom I have spoken to.

Tim McDonnell: Could I come in on that, please, Dr Gulhane? The statistic that the minister used was that 60 per cent of those who are registered have seen a dentist in the past two years. That is only slightly lower than pre-pandemic and follows a major programme of reform post-Covid. It will take time for that major reform to bed in. The 2.6 million enhanced examinations between the date that payment reform came in and September 2024 is a sign that what is intended by that reform is starting to bed in in the system. We need another few turns of the handle when it comes to data. We came informally to the committee to talk about that dataset. It would be fair to consider it in the spring, when publication is next made.

Sandesh Gulhane: I turn to domiciliary visits, which I brought up in the chamber. A practice in my region of Glasgow has stopped domiciliary visits because it found it to be simply uneconomical to continue them. Obviously, that involves the most vulnerable proportion of people who are seen. What is the Government doing to improve and increase domiciliary visits?

Jenni Minto: We recognise that we need to improve that. I pass over to Tom Ferris to give you the details.

Tom Ferris: I always go back to the point that we set the national picture, and the anecdote of a practice not making it work has to be set against the experience of others that are making it work—what about a particular practice's business model makes it feel as though it does not work, when others are still making it work?

I worry that, sometimes, we are driven to try to change policy because of anecdote. We need to understand the situation far better, and there needs to be much greater pressure than the example that you gave of one practice. There may be a legitimate reason for that, and it is right that that should be explored; however, in general, I am not hearing similar stories across Scotland.

Sandesh Gulhane: Minister, the UK Labour Government has increased employer national insurance contributions, which has put a lot of strain on to the NHS dentists to whom I have spoken. Can anything be done to help practices? Obviously, a greater cost will equate to their needing to recoup that money. In many cases, that means more private work rather than NHS work.

Jenni Minto: I recognise exactly that point. Dentists have written and spoken to me directly about the impact of the increase in employer national insurance contributions.

It is also important to recognise that, if dentists deliver more than 50 per cent of their activity for the NHS, they are not eligible for relief through employment allowance. That is concerning. The cabinet secretary has written to the Secretary of State for Health and Social Care, and we continue to highlight the issue and press for greater clarity as to what will happen.

The important thing to recognise is that the Scottish Government has increased dental funding to more than £0.5 billion in the next budget. That is very important and I do not think that anyone here would disagree that that money should be spent on improving dental care and oral health in Scotland and should not be going to the Treasury.

Over this parliamentary session, we have increased our spend on dentistry by 33 per cent, which shows the intention of the Government on oral health.

The Convener: Emma Harper has a brief supplementary question.

Emma Harper: There are challenges in rural areas. You mentioned Dumfries and Galloway. I know that Moffat accepted the Scottish dental access initiative and 2,000 people were registered; however, that is a small number in terms of the whole of Dumfries and Galloway.

There are challenges with recruitment, including rural recruitment, and challenges about accessing dentists who may have trained in Europe, to get them to come here. Is that also part of the challenge?

Jenni Minto: Yes, that is absolutely part of the challenge. Prior to Brexit, about 50 per cent of rural dentists came from Europe, but that has changed.

Indeed, one of the major items on the agenda of our four-nations meeting about two weeks ago was how to increase the pipeline of international dentists into Scotland and the UK. Sadly, some of that is reserved, but I know that the previous Conservative Government, along with the General Dental Council, which runs the exams, carried out a consultation to see whether there was some way of improving how and where the exams were delivered, to allow all four nations to increase the number of dentists available to look after people's health.

Emma Harper: So we have been able to make some progress with encouraging people who have trained elsewhere to come here, as well as encouraging our own young people to train, too, of course. Movement is happening.

Jenni Minto: Absolutely. Your point about training our own is really important, too; the dental courses that we have in Stornoway and Dumfries ensure that people from the local area can get training there, and you would hope that they would stay in that local area, too.

Tim is looking at me, because he wants to add something.

Tim McDonnell: As part of the budget, there was a set of workforce measures, one of which was about the intention to work with NHS Education for Scotland on allowing existing dental therapists in Scotland to articulate to full dentist status. I very much hope that, with Tom Ferris and the team, we can establish that programme in short order, which will help with that key workforce issue that you and the committee have rightly identified.

Tom Ferris: I am sorry, Tim, but just for absolute clarity, I should say that we are talking about international dentists who have registered with the General Dental Council to work as therapists in the UK. There is a logjam in respect of their being able to sit the examination to be registered as a dentist, but there was also a bit of a loophole that allowed them to register as dental therapists. In short, the people whom we are talking about are international dentists working in the UK as therapists; we would hope to bring them to Scotland to work in primary care, and we will work with NHS Education for Scotland on a development package that will sit alongside that,

to allow them to sit the exam and then work for us as dentists.

Emma Harper: Thanks.

Brian Whittle: First, I should say, as a slight aside, that I have a wee morality issue with our trying to draw people from other countries.

I want to follow up what Dr Gulhane was saying about 40 per cent of people not having access to dentists in the past two years—or, I should say, that 60 per cent have had access—and about that being an improvement. My concern would be, as Emma Harper has said, that 40 per cent would include a high percentage of people in rural areas as well as in Scottish index of multiple deprivation 1 and 2 areas. With regard to the point that Mr Ferris made, it is important that we make policy based not on hearsay but on strict data, so how are we measuring that? Given the importance of our being able to measure where that 40 per cent of people are, so that we can target them, how is that happening?

Jenni Minto: Public Health Scotland is doing a lot of work to ensure that we have that information. The changes that were brought in on 1 November last year included looking at the regularity of dental appointments. When I grew up, you went to see your dentist every six months but, under new determination 1, that will be a clinical decision, which means that appointments could be up to every two years for those with very good oral health. We are looking at that information and trying to understand whether that can be captured, too.

Joe FitzPatrick (Dundee City West) (SNP): We have talked about the figures of 60 per cent and 40 per cent in respect of access to dentistry. We know that a lot of the pressures that are experienced are shared across these islands. Tom Ferris, I know that you will discuss those matters with your colleagues across the UK, so perhaps you can say a little about how we are doing in comparison, given that the four nations all face the same post-Covid challenges.

11:00

Tom Ferris: Yes, absolutely—I will take the 40 per cent figure first. We need to be careful that we do not assume that all those people have been unable to access NHS dentistry. Undoubtedly, that will apply to a proportion, but some will have elected not to attend. We do not live in a society where 100 per cent of people go to the dentist—it is a choice. I am disappointed that some people make the choice not to go, but we need to be clear that not all those who make up the 40 per cent figure have been denied, or are unable to access, dentistry—some people elect not to access it.

We should not be complacent, however; the figure is quite high and—to respond to your comment—we need to deal with that.

If we are being honest, we should acknowledge that the British Dental Association in Northern Ireland would love to have our system. Its representatives have gone to the equivalent committee in Stormont to say, “Give us what Scotland has got,” so there is something about what we are doing that chimes with people.

England and Wales have very different systems, and they have much larger areas where there is definitely no access. We do not have many areas in Scotland where there is no access to NHS dentistry—there are areas in Scotland where there is restricted access, usually for workforce reasons. In NHS England, however, there are areas where there is no access at all. I do not think that we are at that point.

That goes back to what Tim McDonnell said earlier. Determination 1 for the new payment system in November 2023 was to stem the outflow from NHS dentistry to private dentistry. We have been relatively successful in that, and it is important that we hold on to that.

We can always do better, and we will be looking at trying to do better. The workforce is critical in helping us with that, but we need to be careful about how we describe what we see in the data.

Carol Mochan (South Scotland) (Lab): I want to go back to childsmile—I know that it has been mentioned, but I have a question for the minister. I have no doubt that she agrees that we should be doing something about the stark health inequalities in dental health, in particular among children. We know that 60.1 per cent of children who are living in the most deprived areas have no obvious dental decay, in comparison with 83.6 per cent in the least deprived areas. That is a marked difference.

The minister spoke of some good work that is going on. However, I have a frustration with many of the things that we talk about, and in this case with the preventative approach for young children in deprived areas in particular. If good work such as childsmile is going on, why are we unable to target that work and share it across different areas so that we can start to make a difference and ensure that the inequality figure gets smaller?

Jenni Minto: Carol Mochan and I have a lot of conversations about inequalities, and I agree strongly with her that we need to focus on ensuring that inequalities are reduced.

As I highlighted in response to an earlier question, although I do not want to see any gap at all, the inequality gap is the lowest in almost 15 years. In 2010, it was 32.2 per cent—it is now

down to 23.5 per cent. Can we go further? Yes, we have to go further, and we are investing in dental health support workers, who go specifically into deprived communities.

I highlighted the dental caravan in NHS Tayside—I had never before met two people who so enjoyed the work that they did, and they recognised the importance of that work. There are various elements of work that are doing well, but I take on the challenge that Carol Mochan has given me, which we discuss regularly. I will bring in Tom Ferris to speak further on that.

Tom Ferris: In general, if you bring in a population-level health improvement initiative, the people who live in the least economically deprived areas do best out of it, because they comply—they do everything that they need to do—and people in the most deprived communities tend to improve less. However, Sir Michael Marmot coined the phrase "proportionate universalism" to describe a situation in which everyone gets something to improve their health.

Childsmile is about oral health, but we do additional work in areas of relative deprivation so that they get an enhanced level of service. That is the ethos of childsmile. Everyone gets prevention if they go to a dental practice and everyone gets daily toothbrushing if they go to a nursery school. However, in our more deprived communities, we target fluoride varnish application, currently in nurseries and primaries 1 and 2. We also have dental health support workers who work alongside health visitors with families who are identified as being at risk of having poor oral health. They have a more targeted and tailored approach.

The inequality gap has reduced, although not by a lot, but there was a real risk that we would have exacerbated it had we not done the additional work in our most deprived communities. We continue to do that, and the childsmile team continues to look at the evidence behind what they do to ensure that they do the best that they can to deliver care.

As Ms Minto said, if we could do better, we would love to, but I am heartened that, in the most deprived communities, the level of oral health is much better than it used to be. It is not where we want it to be, but it is much better.

Jenni Minto: That is where my portfolio intersects with different areas. Family nurse practitioners are doing amazing work in deprived areas in supporting new mums and young mums with various elements of their healthcare, as well as income and various other things. Following on from what Tom Ferris said, the introduction of a toothbrush to the baby box, which people asked for previously, is an important recognition of the importance that the Scottish Government places on healthcare and ensuring that children, young people and their families are much more aware of the importance of cleaning their teeth.

Carol Mochan: I want to come back on something that Mr Ferris said. I am familiar with Marmot's work and with the issue of universalism and targeting. We should not just love to get oral health better but see it as our responsibility to get it better because, until we target the inequalities, there will be difficulties across Scotland. I appreciate how much work has gone into improvement, but we need to see ourselves—I refer to MSPs and the people who are in charge of the relevant section—as having a responsibility to take a targeted approach.

You touched on the cross-portfolio stuff, minister. That is really important if we are to get over the line in tackling health inequalities. Thank you very much for your time.

Joe FitzPatrick: I will ask about the oral health improvement plan. I had some supplementary questions, but we covered quite a bit of ground in the first couple of questions.

The oral health improvement plan has been around for a number of years. We have talked about the payment reforms that have been made but it does not feel that those fit with what the plan envisaged, which was to move closer to a GP-type model. Are we getting to the point where we need a new plan to reflect how reality has moved on and is a bit different from what was envisaged back in 2018, when the plan was first brought in?

Jenni Minto: I recognise that things have changed dramatically since 2017-18, when the oral health improvement plan was set in motion. The important thing to note is that that was very much an evidence-based piece of work to understand exactly what was needed. There were a number of recommendations, and many elements of them have been delivered through the payment reform.

As Tom Ferris has discussed, there has been a focus on preventative care. We also note the importance of continuing to provide the full range of treatment. In the payment reform, we have reduced the number of categories that people can claim against, but there is still the full range of treatments. I believe that the evidence that we have given so far is that payment reform is the foundation or underpinning of the other developments that we must make, both in reform and in investment.

There has been a range of governance proposals regarding NHS boards. In including the directors of dentistry, we have been cognisant of that. We have also been monitoring clinical quality, which is very important. We work with Healthcare Improvement Scotland on that.

We are still considering the use of the dental team and where it is right to fit that. The oral health improvement plan underpins the work that we continue to do on workforce, which we view as the key focus. There is also the matter of governance of dental practices.

You asked whether we should review the oral health improvement plan. I do not believe that now is the right time to do that. We have done a lot of work to stabilise dental services, and we need to keep the focus on that. I have been speaking to my officials about workforce, and that is where we need to focus our efforts to ensure that we get the right number of dentists, dental therapists and hygienists in Scotland and that we can give them the right training. That is where we should be focusing, rather than going back to the sector at this point.

Tim McDonnell: For me, the 2018 plan sets the core elements of reform, as the minister has said. We are now in the programme implementation phase so, in Government, we are treating the 2023 payment reform and the associated elements as a major programme, with major programme discipline and the wraparound support that is needed to monitor and assess.

We have spoken at the committee a number of times about data. Our work—my work and Tom Ferris's work on behalf of the minister with PHS and NSS—involves trying to equip the programme with the data sets that it needs to evaluate success. For me, there is a distinction between a plan, which has a very clear objective and a clear grounding, and the fact that we are now in a programme delivery phase. We are trying to ensure that the payment reform that is enshrined in legislation is delivered. We assess its component parts and, along with the British Dental Association and other stakeholders, we test and adjust what is needed by way of enablers such as the workforce to ensure that the plan and the programme are delivered appropriately.

Joe FitzPatrick: The Scottish dental practice owners group and NHS Orkney have raised concerns that we are not focusing enough on prevention, and that services are still too treatment based. I know from my time in the post of Minister for Public Health, Sport and Wellbeing that Tom Ferris feels passionately about prevention. Will you talk a bit about how the budget will support prevention as part of the evolution of NHS dentistry?

Jenni Minto: I will touch on payment reform, part of which has involved listening to what dentists have been saying about preventative work. As Tim McDonnell referred to, it is a matter of allowing dentists to spend more time with their patients to ensure that they get the prevention message. For example, my dentist on Islay attended the Islay show with a model of a tooth to explain that. That slightly left-field prevention message is coming across, and dentists are absolutely at the core of that. I pass to Tom Ferris.

11:15

Tom Ferris: In the payment reform in November 2023, a fee for preventive advice was introduced for the first time ever. Previously, there was an altruistic assumption that that just happened, but I am not convinced that it always did, whereas it is now built into the way in which dentists work. Having seen some of the early data, I can say that it is happening, which is good.

I have commissioned work to understand the patient perception of preventive advice. Do they recognise that they are being given such advice? What took place? What is their understanding of that and what did they get from it? I have commissioned a couple of the leadership fellows who are working with us to take an early survey of patients who are completing their courses of treatment, and who have had that preventative advice session, to understand exactly what is coming from it. It is right that we fund that, but it is equally right to understand what we get for that funding. That work is in train.

Tim McDonnell: In designing the payment schedule, we were very careful to ensure that the views of the chief dental officer's advisory group were taken into account, and the many bilaterals that we had with the profession, particularly with the British Dental Association, were focused on trying to create more time for the professional to take that longer-term view and not necessarily to rush. That balanced approach, incentivised by the payment system and now being measured in the way that Tom Ferris set out, allows for that preventative approach to be truly embedded.

Emma Harper: Most of my questions on dental reform have been covered already. Minister, I am interested in hearing about remuneration packages for dentists as a way of encouraging more graduates, for example, to choose dentistry. Would you consider reviewing remuneration packages again?

Jenni Minto: Dentists on the high street run their own businesses, and remuneration is determined by the owner of that practice. If you are talking specifically about those in the public dental sector, I ask Tom Ferris to answer.

Tom Ferris: We make available recruitment and retention payments. Traditionally, those have been for rural areas—that is, they have been made available in island and rural boards—because those have been the most difficult areas to recruit to, and they still are. However, during the pandemic, we probably extended the scope of

applicability of those allowances, so we have kind of minimised their impact. Why would someone go to an island board to work if they could get the same remuneration package from Tayside? We need to step back, almost, from where we currently are, to look at the policy intent, and, if the allowances are not meeting that intent, we need to look at how we refocus them.

There is an element of making it worth while for dentists to work in the NHS; however, if that only works in the central belt, we must have something else that benefits those who go to work in a more rural area, such as Dumfries and Galloway, or in NHS Highland or an island board. That is part of the approach. The package will help everyone and sustain them within NHS dentistry, which was the intention, but we need to look at the recruitment and retention allowances, too.

Emma Harper: I have heard about the increasing cost of the materials that are required for crowns, posts and implants, for example. For those dentists who choose to treat NHS patients, do the payments cover those increasing costs?

Tom Ferris: Will I take that?

Jenni Minto: Yes—you are on a roll.

Tom Ferris: That was the intention behind the reform. We needed a fee programme package that better reflected the costs of delivering modern NHS dentistry. That was part of the issue. Some lab-based items were almost being priced out. Dental labs have their own cost pressures and were putting up their prices, but we had dentists who had fixed fees for delivering NHS care and the gap between the two was disappearing. That is why we radically reviewed the fees that we pay for lab-based items of treatment so that they better reflected the cost of delivering modern dentistry.

Emma Harper: Everything that you are describing is really complicated. You mentioned international dentists coming to work as therapists, but there is also potential to have a role that is equivalent to an advanced nurse practitioner. I am a nurse, and we can see how nursing has evolved to become quite specialist. Is providing that kind of training being looked at?

Jenni Minto: That fits exactly with the work that we are doing with the other three nations. I have experienced going to a GP surgery and seeing an advanced nurse practitioner, which made everything much easier. When people go to a dentist, they cannot get any treatment until the dentist has seen them. This is about understanding how can we ensure that people who are working in the dental team are working to the top of their qualifications.

Emma Harper: My understanding is that dental nurses can take X-rays for somebody who is in pain, but it is the dentist who would interpret the X-ray and, for instance, prescribe an antibiotic. Processes can be carried out without having to go direct to a dentist.

Tom Ferris: The dentist would have to see the patient first, before the nurse can take the X-ray, which is part of the complexity of how the dental team works. We almost need to move away from a position in which dentistry is dentist-delivered to one in which, although the team is dentist-led, the whole team delivers the care. It needs to be more flexible. However, that is all regulated on a four-nations basis by the General Dental Council, which is the four-nations group that we are trying to influence.

David Torrance (Kirkcaldy) (SNP): How do you plan for the dental workforce when it is so easy for dentists and dental staff to go into the private sector?

Jenni Minto: That is a key question with regard to what we are doing. It also relates to the number of spaces on university courses. I think that you will remember that, during the pandemic, we lost about 180 people because they did not get their practical experience; we are playing catch-up in that regard. That all falls into health workforce planning. We have conversations about that. It is also recognised that there are a lot of women in dentistry, and they might have different work patterns. We have to pull in all that information.

Generally, staff planning for health does not fall under my remit, but I would be happy to come back with a specific response to your question. We talk about workforce planning regularly to ensure that we have the right profile in dental teams. That ties in closely to Emma Harper's questions about people working to the top of their qualification and how we can work across the UK to get more people into dentistry and working at the right levels.

David Torrance: Do the different ways in which NHS dental services work in Scotland make it a more or less attractive place to practice dentistry than other parts of the UK? What are you doing to remove any barriers to dentists moving to Scotland to work?

Jenni Minto: That ties in with our work with the other three nations on ensuring that we get that pipeline of dentists. My view is that I cannot imagine a better place to work than Scotland, and I know that certain practices have been very good at attracting dentists. I appreciate what Brian Whittle said about the number of international dentists coming to Scotland and the impact on their home countries, but I should say that I have had the privilege of meeting five dentists from India who chose to work in the Borders. They

wanted to come to Scotland, because they saw it as an opportunity.

We have to ensure that we provide the right opportunities, but it is also important that we give dentists who are either coming out of university in Scotland or coming from an international country the right support once they are qualified. That is part of the work that we have been talking about with regard to next year's budget and ensuring that, as Tom Ferris indicated, we have the right support in place for dentists and dental therapists in these areas so that they are able to enjoy living and working in Scotland, which I am sure they will.

David Torrance: Given the range of suggestions and solutions coming from the directors of dentistry, how are you engaging with them collectively and individually to improve recruitment and retention?

Jenni Minto: The directors of dentistry are a very important group of individuals who work closely with my officials. As you know, there is one in each health board, which is important, because they have oversight of what is happening in their areas and can feed that directly back to the Scottish Government dental team.

I have engaged directly with them as a group on two occasions, once in a Zoom—or Teams—meeting and once in person at one of their regular get-togethers. I think, Tom, that you meet them—

Tom Ferris: I meet them six-weekly.

Jenni Minto: That does not mean that the rest of us do not have regular meetings with the directors of dentistry in between. Indeed, when I was, as I mentioned earlier, in the Borders, I had two specific meetings with the director of dentistry and discussed how they are looking at this issue not only at high-street level but within the hospital. I have also engaged with Dumfries and Galloway, Highland and others. We have on-going, regular meetings with the directors of dentistry; indeed, I started by saying that they are key in giving us information from a local level.

Sandesh Gulhane: Minister, I want to ask a direct question on something that I have been told—and if it is wrong, I am quite happy to be corrected. Is it true that a fully qualified dentist who wants to come to Scotland from another UK country needs to do a year's work under supervision?

Jenni Minto: I will reflect on that, but Tom is shaking his head.

Tom Ferris: If they are UK qualified and are working in another country in the UK, they can come to work in Scotland directly; all they will have to do is take a one-day course to understand our system's complexities so that they do not fall foul of it. We brought that approach in a few years ago, because we were finding that dentists who were coming to work in practices were getting little support within the practice and were falling foul of the regulations. Instead of letting someone end up in that position, we ensure that they go through that course, which is delivered by NHS Education for Scotland, and that they understand our system. After all, the NHS dental system that we have is not the same as that in the other countries. An international dentist who has never worked in the UK before but who has sat the General Dental Council exam and then comes to Scotland will have to spend a year in supervised practice.

Sandesh Gulhane: What happens to overseas-qualified dentists working in England who want to come to Scotland?

11:30

Tom Ferris: That would be the former situation. They would have to take the one-day course, perhaps even just half a day. They will already be doing X-rays and will know about health and safety, which is common across the UK, but there will be some elements of regulation that sit alongside general dental services in NHS Scotland that they might risk falling foul of and we do not want that to happen.

Sandesh Gulhane: Overseas-qualified dentists who are coming to Scotland do extra work. Is that unique to Scotland or does it happen across the UK?

Tom Ferris: It is unique to Scotland.

I am sorry: before I answer further, are you asking about the process that the minister mentioned by which, following the budget, we hope to bring internationally qualified dentists in to work as therapists?

Sandesh Gulhane: No.

Tom Ferris: I misunderstood you.

Sandesh Gulhane: I am asking about an overseas-qualified dentist who wants to be a dentist in Scotland and has to be supervised for one year. Is that unique to Scotland or is that applicable across the UK?

Tom Ferris: There will be similar processes in all four countries. The processes might not be exactly the same and the period might not be a year. It might be targeted—I am not sure—but all four countries would have something that the dentist would have to comply with.

The Convener: Minister, the Scottish Government made a commitment to provide NHS dental care and treatment that would be free at the point of need for everyone in Scotland. Please give us an update on where the Scottish Government has got with that.

Jenni Minto: That is still our intention, but, given the current financial climate, we have been focusing on ensuring that we can stabilise dentistry in Scotland and that we have the right workforce. That commitment is still our intention.

The Convener: We already have free dental care and treatment for 18 to 25-year-olds, as one of your officials referred to today. How much has the Scottish Government invested in that? What has it cost the NHS? I do not mean that the cost is detrimental, but I want to know how much has been invested in dentistry.

Jenni Minto: As I highlighted, we have allocated £0.5 billion to dentistry in the 2025-26 budget, which is a 33 per cent increase during this session of Parliament. If the Scottish Government had simply allocated Barnett consequentials, the amount would have been about £300 million, which would have left a shortfall. That emphasises the importance that we put on investing in dental health in Scotland.

The Convener: I have a brief question, which you might not be able to answer now, about an issue that has been raised with me. Traditionally, there have been one or two-person dental practices on our high streets, but there now seems to be an expansion of corporate dental businesses across the country. Do you see that as being advantageous to Scotland, or are you concerned about the ability to provide traditional NHS dentistry for the population?

Jenni Minto: My answer is probably a mixed one. We need dentists on the high street, but a number of MSPs have raised concerns about the way in which high-street dentistry is being provided in their constituencies. We are very alert to that issue and are looking at it as part of our governance workstream.

Elena Whitham: Health boards tell us that public dental services are under pressure but that the service could support resilience when access is challenging. What more can you do to fund and support public dental services to ensure that there is resilience and better equity of access? Was anything in the recent budget statement designed to support that public service?

Jenni Minto: Public dental services are a very important part of our dental tapestry in Scotland and, as you highlighted, they provide emergency support. In areas where there has been an issue with high-street dentistry, we have worked closely with health boards by working directly with the public dental service. I can reference NHS Shetland and NHS Greater Glasgow and Clyde in that regard. We are considering how we can support them, whether it is providing funding for additional dentistry support or supporting them in other ways.

That is the work that we have been doing to date, and it will continue with the new budget. As part of the funding in the new budget, £100 million has been set aside to support entry into primary care, and we will look to spend it in dentistry to support access.

Elena Whitham: Do we understand why the PDS is struggling to attract dentists? Is there an issue with the limitations on what they can do in practice versus what other dentists can do in private settings?

Jenni Minto: I can speak only from my experience of having visited a couple of public dental services. They are being innovative in the work that they do, such as providing the anaesthesia to do operations or extractions in a non-theatre location. They are looking at what they can do. A number of questions have been asked in the chamber about how we retain university graduates in NHS dentistry services, and we are looking at how we can provide support to encourage people to join the PDS.

Elena Whitham: Previously, I was a peripatetic homelessness worker. At the time, I was occasionally supported by a health and homelessness nurse. We became aware of how much oral health was at risk in that population. I am very aware of the report “Smile4life: The oral health of homeless people across Scotland”, which was published back in 2011. That was about targeting support for populations who are at the hard edges, have experienced severe and multiple disadvantages and often live with health comorbidities. Will you give us a flavour of how the aims of that report work in practice across the country to improve access to oral health for those who are homeless?

Jenni Minto: That is a really important question. I referred to what I saw in Edinburgh and the fact that the PDS is not simply in Chalmers Street; it goes to other areas of Edinburgh to provide exactly the care and service that you have described.

It has been said to me on a number of occasions that the health of someone’s mouth is an indication of their full-body health. In answering Carol Mochan’s question, I talked about the cross-portfolio work. We are considering how we can pull everybody into the population health framework, especially those who are homeless.

I do not know whether Tom Ferris wants to add anything.

Tom Ferris: A better way to look at the matter is probably through the theme of inclusion oral health, because people who are homeless probably have other issues alongside oral health ones. They might not and it might just be an acute

experience for them, but they might have experience of the custodial system or drugs.

In probably the past month, we have come to the realisation that having a range of siloed programmes for a type of vulnerability does not help anyone and that we could deliver services more efficiently if we looked at inclusion oral health in its widest sense. We are doing that work with the leads of the various programmes. There is the “mouth matters” programme, which is for the custodial setting, and we are developing a new programme for people with experience of drugs and homelessness. We are trying to draw all those things together to determine the best way of managing the resource—the staffing resource as well as the financial resource—to deliver care for people in their communities by working alongside third sector, voluntary and even health service and social care partners that work with the same community.

We are having quite a rethink of how we look at that. We need to be seen to be delivering, not just talking about programmes.

Elena Whitham: Understanding the need to break down silos is important. If we are thinking about primary prevention, we want to prevent as far upstream as we can, so that people do not experience any of the situations that you described and so that, if they do, they have a pathway to access support for their oral health.

There are more than 10,000 children in temporary accommodation in Scotland, and I have a concern about their access to programmes such as childsmile. Having worked in a women’s refuge, I know that children often change schools repeatedly when they experience homelessness and can move from accommodation to accommodation. Therefore, I have a concern about certain groups of children missing some childsmile provision in a school setting and not getting fluoride sealants applied to their teeth. How can we work with the third sector and other organisations to drive good oral health for groups of children who are perhaps being missed?

Jenni Minto: That is a really important point, and I am happy to take it away and consider it. I agree that we have to work closely with third sector organisations that support health settings. I will take that point away, and we will add it to the work that we need to do on access, specifically for young children.

The Convener: I thank the minister and her officials for attending. We look forward to seeing you back again next week in relation to a legislative consent memorandum for the Tobacco and Vapes Bill.

Jenni Minto: Yes.

The Convener: Next week, the committee will also take evidence from the Cabinet Secretary for Health and Social Care on the 2025-26 budget.

That concludes the public part of our meeting.

11:42

Meeting continued in private until 11:55.

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