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Recovery of NHS Dental Services

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Introduction

This morning members will have the opportunity to discuss NHS dental services in Scotland with:

- Professor David Conway, Professor of Dental Public Health, University of Glasgow, Honorary Consultant in Dental Public Health, Public Health Scotland.

- Margaret McKeith – the ALLIANCE

- Dr Manal Eschelli – West of Scotland Regional Equality Council

This panel will be best placed to discuss the broader public health, inequality and access issues.

The second panel will comprise representatives from three geographical health boards:

NHS Borders – Adelle McElrath

NHS Tayside – Dr Declan Gilmore

NHS Shetland – Antony M. Visocchi

All health boards responded to the specific questions on funding provided for equipment etc during the pandemic. They will also be able to comment on the recovery of services in their board areas and discuss how the Public Dental Service (PDS) operates locally. The PDS is run directly by health boards, employing dentists and dental professionals directly. It is designed to cater to patients with access issues and additional needs. It also provides an emergency service and can register patients as high street dentists do.

Because of the shift in focus between the two panels, the paper will be divided into two sections with two sets of (hopefully complementary) themes.

Parameters of the inquiry

This is a very short, focused inquiry into NHS General Dental Services. It coincides with a high level of public and political interest in dentistry in Scotland: the status and recovery of services, reforms and access for patients.

The purpose of the inquiry is to scrutinise progress made in the commitments set out in the NHS Recovery Plan 2021 – 26 which states that:

> "For NHS community dentistry our immediate focus will be on returning the sector to at least pre-Covid levels of activity as soon as is practicable. The impact of the pandemic on NHS dentistry services has been particularly hard

because of the aerosol particles generated by many dental procedures and the additional risk of spreading the virus that this brings. We are working on a four nations basis on revised infection, prevention and control (IPC) guidance, with a review of the guidance due to report in September 2021. We have invested £5 million to improve the ventilation capability of dental surgeries, and £7.5 million in new dental equipment. Both of these measures will reduce that risk and therefore help us to increase capacity in our dental surgeries. Both these initiatives will increase the capacity of dental practices to see more NHS patients under the present restrictions."

The NHS Recovery Plan also includes other commitments related to future reform:

> "Over this parliament we will remove all NHS dental charges and work with our frontline dentists to deliver service reform that ensures that are sustainable long into the future. We're committed to maintaining at least the range and scope of procedures that are available through an NHS dentist, and building on our established Oral Health Improvement Plan (2018). Our first step in removing charges is to remove charges for anyone aged under 26. By improving access to primary dental care we can help reduce pressure on acute dental services in the future."

In keeping with the Committee's remit, the briefing papers will be structured around three broad themes: Response (during the pandemic), Recovery (of services) and Reform (in light of the pandemic and requirements for future preparedness).

The Inquiry questions, as set out in the Approach paper to the Inquiry fit well with these broad themes:

- **Whether funding has improved ventilation and other equipment (response, recovery and reform)**
- **Whether NHS dentistry services have recovered to pre-pandemic levels (recovery)**
- **How access to services is being targeted in communities that experience health inequalities (recovery and reform)**
- **Is NHS dental services resilient to future pandemic threats? (reform)**

Additional background reading

Members have been sent some background reading:

- The Dental Workforce in Scotland 2021 | Turas Data Intelligence (nhs.scot) report
- HealthCare Improvement Scotland Citizens' Panel report
- Report on access to dental health services in Scotland commissioned for the Health Committee (2005)

A SPICe blog was also published on Tuesday 6 June – 'NHS Dental Services in Scotland – Braced for Change', providing a background to how dental services are organised in Scotland as well as outlining some of the issues facing services post pandemic. So, this information won't be repeated in this briefing.

The blog does not cover the views of dentists, 225 of whom responded to the survey sent out by the Committee. The responses received came from dentists working in most health board areas, providing a good overview across the country. The island boards have very few independent dental practitioners offering NHS General Dental Services (GDS). A summary of responses is provided in Paper 2 with the meeting papers.

Background (Panel 1)

The Community Engagement unit for Healthcare Improvement Scotland (HIS) (formerly the Scottish Health Council) hosts a Citizen's Panel of around 1000 randomly selected members of the public. Their views are sought on a range of health and social care issues. So far, 11 Panel reports have been published, and the eighth one, published in March 2022 sought views on Dentistry services via a survey sent out in November 2021. At this time, COVID-19 restrictions were still in place and dentists were given updates to standard operating procedures and infection control guidance.

The ALLIANCE also launched a survey which closed just over a year ago in May 2022. There is no published report on this survey yet. It was funded by the Scottish Government's Primary Care Directorate, and the report was shared with the government. The survey was part of the ALLIANCE's Primary Care Lived Experience Programme and asked people to Share their experiences of dental services in Scotland over the last three years (2019-22).

Professor Conway was involved in screening of asymptomatic COVID-19 patients. Since 2021 he has led the Covid-19 Recovery Dental Analysis Project, funded by Public Health Scotland. This work is focusing on the impact of COVID-19 on population oral health and dental services and the associated health inequalities.

Theme 1 – Impact of the pandemic on access and barriers to services

The work carried out by the ALLIANCE and Health Improvement Scotland's (HIS) Engagement Unit provide some insight into what is important for people in relation to dental care. In terms of access, the HIS survey demonstrated the range of attitudes to attending a dentist. 15% said they would only attend if an emergency and 10% would seek private treatment. The cost of dental treatment was noted by 44% as a barrier to attending, as well as a difficulty in getting an appointment (29%). 21% of people said they were anxious about visiting a dentist. Both studies were carried out either during restrictions or shortly after they had been lifted but questions did not refer to the restrictions/pandemic.

A number of recommendations were made following the Citizen's Panel (CP) survey:

1. “That any reform of dental care by Government and the NHS continues to support people to be pain free and to have healthy teeth and gums rather than focus on, for example, cosmetic treatment.

2. That access to treatment for patients, including to check-ups, is prioritised by dental teams as COVID-19 safety restrictions lift; and that NHS and Scottish Government continue to support dental teams to do this. The Scottish Government should also be mindful of the cost of dental treatment as a barrier to accessing dental services in future policy decisions.

3. That NHS and Government continue to support dental teams to provide timely care as best they can within the current COVID-19 restrictions.

4. That any reform of NHS dental services ensures visits to patients’ dentists remain a significant part of the service.

5. That dental teams ensure all patients are aware of how to make a complaint should they need to, and that Scottish Government, NHS Scotland and the General Dental Council continue to support local resolution of complaints whenever appropriate.”

The ALLIANCE conducted a more in-depth study, but with fewer people who self-selected, meaning the views are not as representative as the CP survey. The ALLIANCE compiled their report in August 2022 entitled “Experience of Accessing Dental Services in Scotland”. The study has not been published at the time of writing.

Dr Manal Eschelli from West of Scotland Regional Equality Council (WSREC) supported the Alliance’s engagement for the study.

Members may wish to ask:

- **Do you think that the experience of the long (2 year) restrictions on routine dental services has had any negative impact on attitudes and access to services? If so what, and how should this be addressed?**

- **Was the response during the pandemic appropriate and proportionate – what could have been done better?**

- **Were the public well-enough informed about accessing dental services during the pandemic?**

- **What are the barriers to accessing dental care – were these exacerbated by the pandemic and if so, how?**

- **How could some of the barriers discussed be addressed, and whose responsibility should it be – dentists, the government or health boards?**

Theme 2 – Impact of the pandemic on population oral health

Professor Conway provides some information and data on the impact of the pandemic on oral health, and also describes in his submission what is in place for assessing oral health in children and adults.

Data provided states in relation to children:

- "73.1% of the Primary 1 children inspected in 2021-22, were estimated to have no obvious decay experience. This compares with 73.5% of Primary 1 children that displayed no obvious decay experience in the pre-pandemic NDIP Report of 2019-20.

- The proportion of children estimated to have severe decay or abscess increased from 6.6% in 2020 to 9.7% in 2021-22.

Information and surveillance regarding adults is done via the Scottish Health Survey, which gathers data on the number of natural teeth and the experience of toothache in the month prior to the survey. On these, the pandemic appears to have had little effect.

Members may wish to ask:

- **How significant is the slight increase in decay in P1 pupils recorded between inspections in 2019-20 and 2021-2?**

- **From the evidence in the Scottish Health Survey findings, adult oral health does not seem to have suffered during the pandemic – how would you account for this?**

- **What cultural factors affect oral health in children and adults, and are these widely recognised? If not how should they be addressed?**

- **Do you expect these impacts to persist, requiring further intervention?**

- **Is it possible to assess yet whether the pandemic has permanently changed how people engage with services.**

Theme 3 – Impact of the pandemic on preventative services and recovery of these

Professor Conway provides information on oral health improvement and prevention programmes in his submission. He states:

> "Childsmile – the national oral health improvement programme for Scotland is a multicomponent preventive programme operating at upstream (policy), midstream (community) and downstream (clinical) levels. It follows a proportionate universal approach—delivering both universal interventions to

all children and additional targeted interventions focused on children predicted to be at higher risk of dental caries from the most socioeconomically deprived backgrounds, with the twin aims of improving child oral health and reducing associated inequalities in the population."

The Committee's survey of dentists presented observations about the impact of the pandemic on population health and habits – such as changes in diet and vaping, which appears to be leading patients to be presenting with more advanced dental health issues. Increased vaping by young adults is causing periodontal damage and burns requiring treatment.

Respondents (dentists) also reported an increase in anxiety and aggression in patients, with an expectation of urgent treatment.

Members may wish to ask:

- **Is Childsmile administered and organised via the public dental service?**
- **How was the Childsmile programme impacted at the community and clinical levels during the pandemic?**
- **Is there any difference between the Childsmile programme delivered at a community level and by participating high street dentists? For example, would dentists target families from deprived area, or do they receive referrals from health visitors?**
- **Is the programme now working as it did, and is it effective in its aims to reduce dental decay and instilling long-term tooth-brushing habits?**
- **How is engagement in the programme from nurseries, schools and other childcare providers monitored?**
- **How is the programme monitored as delivered by high street dentists?**
- **Could you describe some of the national adult oral health improvement programmes and comment on their effectiveness? Are high street dentists or the public dental service/health boards involved in these programmes?**
- **You (Prof Conway) mention 'slow recovery of training and support' for the programmes – why is this, and how urgent is it that programmes for adult oral health are reinvigorated?**

Theme 4 – Impact of the pandemic on inequalities

For children in particular, inequalities in dental care are growing. Professor Conway states that the reasons for the stalling in improvement in population child oral health are unclear.

> "Inequalities remain, with 58.4% of Primary 1 children estimated to have no obvious decay experience in the most deprived areas (SIMD 1), compared with 85.8% in the least deprived areas (SIMD 5) in 2021-22. These inequalities are similar to those reported in the pre-pandemic report levels reported of 58.1% in SIMD 1 and 86.9% in SIMD 5.

As was highlighted in the blog, Professor Conway also observes:

> "Despite the rise in registrations, there are growing health inequalities between children from the most and least deprived areas actually attending the dentist regularly (dental participation rates). This gap grew from 7% in 2010 to 12% in 2020, and now to 20% in 2022. Inequalities in attendance levels among children have been exacerbated due to COVID-19, although this gap was widening prior to the pandemic.

Professor Conway also states that there has been an increase in inequalities among adults:

> "as dental services recover there has been an increase in inequalities (relative to the already existing pre-pandemic inequalities), with those from the most deprived areas (SIMD 1) less likely to have contact with a primary care NHS dentist than those from the least deprived areas (SIMD 5).

While the Committee's survey of dentists did not explicitly ask about inequalities, it did ask about the impact of the pandemic on oral health and treatment. A number of respondents stated that oral health has declined:

> "We are based in a deprived high treatment need area and the dental health of our population has declined dramatically. Therefore, patients that would have normally come to their check ups pre covid with maybe 1 or 2 problems, now have multiple. Therefore the number of appointments I need to give each patient to get them stable could be 5 x more than pre covid." (Committee's survey of dentists)

Respondents also noted longer waits for secondary care and an increase in later stage cancers. If NHS services remain under pressure, inequalities could increase, especially if more treatment is required, waits will be longer, and those that can afford pay to receive treatment more quickly.

As one noted:

> “Patients now require much more extensive treatment than they would have required at the time the problems initially arose- this is a vicious cycle contributing to an ever increasing backlog”

Members may wish to ask:

- **What impact did the pandemic have on inequalities in dental care?**
- **Are services recovering and inequalities set to decrease?**
- **How might you explain the worsening inequality in children’s oral health, given the purported success and targeting of the Childsmile programme?**
- **Do you recognise the observations from dentists who responded to the Committee’s survey that backlogs, changes in diet and vaping could all contribute to increasing inequality?**
- **Why do you think inequalities in dental care persist?**
- **In hindsight, were the restrictions and interventions imposed on dental services during the pandemic appropriate and proportionate, given the impacts and slow recovery?**

Theme 5 – ongoing work to assess impacts

Members may wish to ask:

- **What work is going on in Scotland to assess the impacts of the pandemic on oral health?**
- **What further research is required to assess impacts and recovery of services?**
- **Is the Scottish Health Survey sufficient to assess the state of adult oral health?**
- **Are there any data gaps that could help to explain increasing inequality?**

Theme 6 – lessons learned for future policy and population oral health

It may be still be too soon to fully assess and understand the impacts and effects of the pandemic, the restrictions and the recovery of services on population oral health, but members might wish ask the panel what they would prioritise to ensure that

dental services are resilient and that inequalities are reduced/not made worse by any infection control measures.

The Scottish government has a clear ambition to return services to pre-pandemic levels.

> "For NHS community dentistry our immediate focus will be on returning the sector to at least pre-Covid levels of activity as soon as is practicable." (NHS Recovery Plan 2021-2026)

As can be seen from the SPICe blog, this has not yet happened. Additionally, the evidence from dentists and health boards makes clear that the landscape – expectations from patients and the additional remedial work required, together with difficulties in recruiting staff – has changed.

Members may wish to ask:

- **Given the work you've done during and since the pandemic – research and with the public, what should be prioritised in policy to address inequality, pandemic preparedness and population oral health?**
- **Is the ambition to return dental services to pre-pandemic levels achievable or reasonable as an ambition, given the changes observed in behaviour, expectation and staffing pressures?**
- **How should the recovery of services be monitored and measured, if not by registration and participation, or items of activity carried out?**

Background (Panel 2)

This panel will provide more concrete information on the funding provided to health boards to support dental services during the pandemic. Funding was also intended to mitigate the inability of dentists to carry out certain procedures to lessen the length of time imposed between patients for ventilation. The restrictions clearly had material, measurable impacts on services and access to services, both high street dentists and the public dental service.

Further reading

How NHS Tayside dealt with the COVID-19 pandemic within Urgent Dental Care Centres: clinical staff views and experiences

COVID-19 summary page, Scottish Dental - This page summarises the COVID-19 resource pages relevant to dentists in Scotland between March 2020 and April 2021 in relation to government guidance, remobilisation, infection control and other resources.

NHS geographical health boards receive funding to support general dental practitioners in their area. They also publish a list of local dentists offering NHS treatment, so signposting patients if they need to register with a dentist. However, NHS (General Dental Service) dentists are paid via NHS National Services Scotland (NHS NSS) Practitioner Services Division for the items of work they carry out on a patient, rather than being contracted to the local health board as GPs are. They submit monthly invoices to Practitioner Services.

Patients pay 80% of the cost of treatment, up to a maximum of £384 per course of treatment. If the cost is deemed to be more than this, the dentist can apply for the limit to be raised, but must seek prior approval from NHS National Services Scotland (NHS NSS) Practitioner Services Division.

Treatment activity by dentists is collated and published quarterly by Public Health Scotland (PHS). Professor Conway has helpfully supplied the most recent data from PHS on activity, the public dental service and the numbers of dentists. More information on how dental services operate can also be found in the SPICe blog.

Professor Conway also provides a brief timeline of the remobilisation of dental services with key dates from May 2020 to the final lifting of restrictions in April 2022. (page 7 of submission)

It is worth noting that new codes were introduced early on in the pandemic, so called triage codes, where there was not necessarily face to face contact with the patient, but advice was given by telephone, or prescriptions issued. These codes have remained in place and have resulted in additional claims since June 2020.

Responses to the Committee’s survey were received from all health boards.

Dentists are paid for their work by Practitioner Services Division of NHS National Services Scotland, and they submit monthly invoices. They are paid for items of activity, rather than their time, so, for example, as the government has agreed that check up inspections are more thorough, these also become more time consuming. They are also able to apply for certain allowances and grants, and are paid capitation and continuation fees depending on the number of NHS patients they have on their lists. These incentivise dentists to remind patients to attend for check ups at least every two years. Payments and fees are covered by the Statement of Dental Remuneration which are regularly updated. This NHS NSS guide sets out the fees for treatment in a slightly more accessible way.

Health boards also provide financial support to high street dentists. They also employ dentists and other dental professionals to the public dental service, the service intended for patients who have particular access issues – residents of care homes, people with learning disabilities, homeless people – as well as providing emergency care.

During the pandemic, but not immediately, (in July 2021) the Scottish Government sought to support dental services and dentistry through a range of financial support. This comprised funding to health boards, for which practices could apply, to improve ventilation in surgeries to reduce fallow periods between patients, funding for equipment, and funding for variable speed drilling equipment. There were conditions attached to the funding, such as tie-ins to continuing NHS work. This is not a unique thing, as dentists have to commit to continuing with NHS work if they receive funding, and some payments are based on the percentage of NHS work they do.

Health boards administer the public dental service and the hospital dental service (secondary care) as well as Childsmile.

These archive pages from Scottish Dental remind us that normal services were resumed in November 2020. Public Health Scotland describes the timeline and the establishment of seventy Urgent Dental Care Centres established for the provision of emergency treatment when dentists were unable to see patients on their premises because of the risks of transmission, and the phases in return of services:

> "The remobilisation of primary care NHS dental services was undertaken in several time periods, as follows:
>
> - from 20 May 2020: Capacity in UDCCs was increased, and provision expanded to include patients with acute and essential oral health care needs;
>
> - from 22 June 2020: All dental practices reopened for face-to-face consultation with patients requiring urgent dental care treatments that could be provided using non-aerosol generating procedures (AGPs);
>
> - from 13 July 2020: Dentists were able to see patients for the full range of routine non-AGP dental care;
>
> - from 17 August 2020, aerosol associated treatments were permitted for urgent dental care only;

- from 1 November 2020: Practices were able to provide the full range of NHS treatments to all patients in need of both urgent and non-urgent care.”

Theme 1 – Funding provided to dentists for ventilation and other equipment

Health boards were allocated funding in 2021 and 2022 to support the recovery of services. Notifications of this funding comes via Primary Care Administration (PCA) publications. Scottish Dental and NHS NSS provides a timeline of these that is uptodate, and includes letters and email from the Cabinet Secretary.

PCA (D)(2021)3 advised that practices could claim for ventilation equipment, up to a maximum of £1500 per individual surgery within each practice. The amount awarded was based on the percentage of time a practitioner spends per week doing NHS work. So, if a dentist spends 50% of their time on NHS work and has two surgeries, s/he could apply for £1500. If only one surgery, then it would be £750. A condition also applied, that dentists had to undertake to continue to do NHS work till April 2024 (nearly 3 years from publication of letter/grant availability).

A total of £5 million was made available for ventilation improvements, allocated to the health boards as detailed in their submissions to the Committee.

PCA(D)(2021)6 was issued on 7 September 2021 for electric speed adjusting hand pieces. **Funding of £7.5 million was made available for the purchase of electric (‘red band’ hand pieces) and motors** which can allow the hand pieces to operate at speeds of less than 60,000 rpm, minimising aerosol generation.

PCA(D)(2022)4 was issued in March 2022 and reminded practices of the availability of ventilation and hand piece funding and announced a one of sustainability payment, to meet the costs of a Legionella Risk Assessment, and to provide additional nurse and hygienist sessions, and additional hours provision. **A further £5 million was made available through this PCA, to provide this sustainability payment**, a change to the General Dental Practice Allowance (GDPA) paid to all dentists delivering NHS treatment. There are conditions of entitlement to the GDPA written into the Statement of Dental Remuneration (p127)

The payment was for practices with at least 500 NHs patients per dentist.

The £5 million made available for ventilation could now also be used for other equipment, such as dental chairs, dental lights and x-ray units.

PCA(D)(2022)5 was issued in April 2022 and announced a new improvement allowance for practices to meet the costs for the replacement or repairs to dental equipment.

Most dentists who commented on these questions and responded to the survey said that the funding was not adequate to upgrade their ventilation, and that they had to bear any additional costs. Others said that while it made a difference during the pandemic, there was no ongoing advantage to the changes to ventilation. Also, that the funding came shortly before services were fully resumed.

Not all practices applied for the funding for ventilation and equipment, and the health boards provided the number/% of practices that did in their submissions.

Members may wish to ask:

- **How was it decided how much funding was allocated to each health board? The number of NHS practices in the board area, or some other calculation?**
- **Did the funding improve the ability of practices to see more patients?**
- **Did the funding improve long-term resilience in the system?**
- **Was the funding provided in a timely way, with the appropriate eligibility criteria applied?**
- **Was the funding straightforward to administer?**
- **Should there have been funding provided for other measures to improve the rate of recovery?**
- **What do dental services require in terms of funding, support or reform to enable them to be more resilient?**
- **Did health boards support high street dentists with PPE during the pandemic or in the recovery phase?**

Theme 2 – Health board dental services response and recovery (PDS and HDS)

Health boards said in their submissions to the Committee that the Public Dental Service (PDS) was under greater pressures because of urgent care during the pandemic, and more recently as patients are unable to register with high street practices.

NHS Dumfries and Galloway stated:

> "Of the 30 dental practices across Dumfries and Galloway, there are currently none taking new NHS registrations. With the number of deregistered patients rising and a further 12400 to follow in the coming months, the Public Dental Service (PDS) has been significantly impacted as it continues to have sole responsibility for urgent and emergency care for all unregistered and de-registered patients. This continues to affect the service's ability to provide routine dental care to registered and referred Special Care Programme patients, registered salaried patients and also impacts on the quality and range of clinical experience being provided within the Outreach dental clinics as well as staff morale and wellbeing."

NHS Borders stated:

> “The Public Dental Service (PDS) in Borders is, in line with GDS practices, experiencing significant challenge in recruiting to vacant posts. This, and the increased demand for the delivery of urgent care to those not able to access the independent sector are impacting negatively on the staff in post (burn out) and the ability of the service to deliver care to other priority groups”

NHS Tayside state that more time is being taken up by emergency care, reducing the time for the core patients of the PDS – care homes, people with additional needs etc.

In Shetland there is a lack of GDS (high street) dentist provision, so reliance on the PDS is higher than other areas. The balance assumed by the model in any board area, is 80% GDS to 20% PDS. In Shetland it is more like 70% to 30%. Their submission to the Committee presents a detailed assessment and analysis of the situation on the islands, and a 3-phase approach to enhance the PDS, acknowledging that the rural and remote nature of Shetland does not attract the higher numbers of GDS dentists, and that the health board should proactively manage an enhanced PDS service.

We did not ask health boards about the hospital dental services (HDS). However, members might wish to ask the health boards represented here what impacts the pandemic and the recovery phase, as well as pressures across dental services, have had on the HDS.

Urgent Care Centres were established early in the pandemic for people

Members may wish to ask:

- **What impact did the restrictions during the pandemic have on services provided by health boards?**
- **What additional funding did health boards receive to support extra demand?**
- **What work is being undertaken to implement changes to the PDS and HDS in response to the experience and impact of the pandemic?**
- **What are the challenges for health boards in recovery of dental services?**
- **What is the role of health boards in improving and protecting access for patients to NHS dental services?**
- **Have issues elsewhere in dental services or the pandemic and recovery phase had an impact on the hospital dental service?**

Theme 3 – Inequalities in dental care

Following on from the earlier panel, members might wish to pursue issues raised about inequalities in dental care with the health boards represented.

Members may wish to ask:

- **What is the role of health boards in reducing inequalities in dental care and treatment?**
- **What is your health board doing to mitigate the effects of rising inequality persisting beyond the pandemic?**

Theme 4 – Staffing

Recruitment and retention was frequently mentioned as a main, if not the main pressure on the recovery of services by health boards and dentists alike. Pressures on current staff lead to low morale and burn out, leading to staff leaving the dental professions, so exacerbating short staffing.

Members may wish to ask:

- **Can you describe what impact the pandemic had on the availability of dental professionals – dentists and others registered to work in dentistry such as nurses and hygienists?**
- **How is staffing affecting the recovery of services?**
- **What support, if any, do health boards provide to high street dentists in recruitment and retention of staff (or do you compete for the same pool to staff the PDS and HDS?)**
- **What is required to ensure that both General Dental Services and health board services become resilient to any future shocks**

Theme 5 – Lessons from the pandemic and future resilience

Members may wish to ask:

- **Thinking about response, recovery and reform, what are the key actions health boards need to take to secure the future of accessible and affordable dental services?**

- **In the same vein, what are the key actions the government should take to ensure accessible and resilient services, and which avoid a ‘two-tier’ system?**

Anne Jepson, Senior Researcher, Health and Social Care, SPICe Research

12 June 2023

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