OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 29 June 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 29 June 2023

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COVID-19 RECOVERY COMMITTEE
15th Meeting 2023, Session 6

CONVENER

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

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab) (Committee Substitute)
Tom Ferris (Scottish Government)
Jenni Minto (Minister for Public Health and Women's Health)
David Notman (Scottish Government)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 29 June 2023

[The Convener opened the meeting at 09:31]

Decision on Taking Business in Private

The Convener (Jim Fairlie): Good morning, and welcome to the 15th meeting in 2023 of the COVID-19 Recovery Committee. Alex Rowley has given his apologies and I welcome Jackie Baillie, who is attending as his substitute.

Item 1 is for the committee to decide whether to take item 5, which is consideration of a draft legacy paper, in private. Do members agree?

Members *indicated agreement.*

Recovery of NHS Dental Services

09:31

The Convener: Item 2 is for the committee to conclude its evidence taking on the inquiry into the recovery of national health service dental services. I welcome to the meeting Jenni Minto, the Minister for Public Health and Women's Health; Tom Ferris, the chief dental officer and deputy director for the dentistry, optometry and audiology division; and David Notman, the unit head for the dentistry, optometry and audiology division at the Scottish Government. Thank you for joining us.

Minister, would you like to make some short opening remarks before we move to questions?

Jenni Minto (Minister for Public Health and Women's Health): Thank you, convener, I would.

Thank you for inviting me to support the important work of the committee and provide an update on the Scottish Government's commitment to NHS dental services through the pandemic and to sustaining provision and patient access to those services in the long-term. I will be happy to answer any questions that the committee has in connection with the Scottish Government's written response of 25 May.

As you have noted, convener, I am supported by the chief dental officer, Tom Ferris, and senior policy official David Notman, who were in post throughout the pandemic and will be able to provide further information and policy context that might be of use to members.

If I may, I would like to reflect briefly on the significant journey that NHS dental services have been on since the onset of the pandemic and the subsequent recovery of NHS dental services. The committee will be aware that NHS dental services were disproportionately impacted at the earliest point, with full cessation of services on 23 March 2020 being the immediate and necessary response to the emerging pandemic emergency, and that the necessarily cautious remobilisation of services was similarly impacted because of the potential of the coronavirus to be spread by aerosol-generating procedures in the dental setting.

During that challenging period, the Scottish Government put in place £150 million of emergency financial support and personal protective equipment when public health concerns and infection prevention and control measures prevented the sector from operating normally. We see preservation of the sector as the first stage of ensuring that we can adequately recover NHS dental services.

The Scottish Government implemented a significant policy intervention in February 2022 that removed the basic examination fee and replaced it with an increased fee for an enhanced examination, including for under-18s. That policy change meant that all patient examinations, including those for children, provide a dental contractor with a higher fee for a longer examination appointment, resulting in a reduced need to deliver a high volume of care. That change reflected the sector's representations to the Scottish Government during the pandemic, and also the engagement during the development of the oral health improvement plan, when clinicians said that they were unable to provide the modern dental care that they felt their patients required under the high volume arrangements because the payment model was not reflective of new techniques or clinical discretion.

The effect of providing the enhanced examination is that clinicians are now able to spend more time with their patients and are able to provide them with improved preventative care. The intention of that reform builds on the oral health improvement plan, or OHIP, to further support patients in receiving the right care at the right time.

The recovery of NHS dental services from the pandemic period is shown in official figures published by Public Health Scotland. NHS dentistry delivered more than 3.8 million patient contacts in 2022-23, which compares with 2.8 million the previous year and 1.5 million at the height of the pandemic in 2020-21. Although we are not where we would like to be, we have achieved a great deal.

In my opening statement, I want to provide something of a context for recovery. Although Scottish Government support has taken the sector some of the way towards full recovery, there are external economic, workforce and capacity factors in dental labs that will require a longer timeframe to fully address. It is also worth reflecting briefly on the underlying conditions at play in the sector, as the cost of materials and staff is significantly impacting on the ability of practices to remain viable. Although the Scottish Government can and has made specific interventions, the committee should note that it is not within the gift of Government to fully insulate NHS dentistry from those challenges.

Our keystone is payment reform, which I know that the committee will want to go into in more detail. We see that as a significant step forward. The Scottish Government is presently engaged in sensitive negotiations with the British Dental Association Scotland around setting fees under the reformed model that delivers the OHIP, with a strong focus on preventative care. I hope to be in a position to provide further details to the sector—and the committee, if that is helpful—upon conclusion of that negotiation.

Running alongside the implementation of payment reform is a range of mitigations, with the main focus on island and rural areas. The committee will be aware of specific interventions through the Scottish dental access initiative and recruitment and retention incentives that are targeted for certain board areas. We are also working closely with affected boards on different models of care, so that we have greater resilience in the future.

In summary, although we have made progress, the Scottish Government still has significant work to do to support the sector and is focusing on delivering reforms that ensure sustained and equitable services for the long term. With the help of committee members, I would like to explore the challenges and possible solutions as we move forward.

The Convener: Thank you for that extensive response. We will turn to questions now.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning to the minister and her colleagues.

We have taken evidence from various stakeholders over the past two weeks. We have heard from NHS boards, representatives of patient interests and dentists in the profession. Minister, in your letter to the convener of 25 May, you said:

> "The policy of the Scottish Government throughout the pandemic has been to preserve and protect NHS dentistry. In my view we have successfully done this."

I am bound to say that I do not think that the evidence that we have heard reflects that statement. For example, we heard last week from the dentists that 52 per cent of the capacity in NHS dentistry has been lost since Covid. In fact, many of the issues with NHS dentistry existed pre-Covid but were accelerated and exacerbated by the pandemic. There are many areas in Scotland now where there are no NHS dentists at all. Kinross in the convener's constituency, which he will be familiar with, is an area where you cannot get an NHS dentist. Newburgh in Fife, in my region, is another area and there are lots of other examples.

Where people are registered with NHS dentists, they are waiting extreme periods of time to get appointments for routine work. We have also heard that, although we have new entrants coming into the profession, graduates do not want to do NHS work; they want to go into private practice, because they will have more time to spend with patients.

The picture that we have had painted for us is a very unhappy one. Would you like to revise your comment in your letter that everything is fine?

Jenni Minto: Thank you for that very long question. I think that the actions that the Scottish Government took going into the pandemic to support dental services were absolutely needed. If that work had not been done and that investment had not been made, I cannot imagine where we would be sitting now. We still have a lot of dental practices—I accept that there are some concerns, but we are discussing with the dental groups the need to stabilise the profession. That is exactly what our discussions have been about.

As I think has been referenced in some of the evidence that you have received, I can remember seeing the queues round dental practices 20 or so years ago, and I do not believe that we are at that point. Reflecting on where we have got to and on the support that has been given to dental practices throughout the pandemic, and building on the evidence that we received from dentists when we did the survey and the OHIP work, there is a recognition that we need to continue to work with the profession so that we get the right levels of treatment and the right access for people. That is what recovery looks like: it is when we can see that we have the right number of dental practices providing the right services, so that people can get access to them and so that we stabilise the profession. My colleagues have been working incredibly hard with the dental sector to ensure that. The introduction of directors and the connections within NHS boards, and the support that we have provided to them in various areas across Scotland specifically to maintain access to dental services, is incredibly important.

Murdo Fraser: But it is not happening, is it? All the evidence that we hear, both at the committee and as local representatives, is that access to NHS dentistry is still reducing. There are still practices that were doing NHS dentistry that have now stopped and there are people coming to us all the time saying that they want to get an NHS dentist and cannot find anyone who will take them on their books.

Jenni Minto: I think that you also received evidence from NHS Borders, which was clear about the work that it has done directly with practices and the support that the Scottish Government has been able to give through SDAI grants—£100,000 for a new practice and £25,000 for further practices. There is work going on. We have to be careful not to paint such a dark picture across the whole area. The dental directors within each health board have a very good relationship with their dental practices. That relationship, together with contacts with my officials, ensures that we understand where the problems are. In Tayside, for example, there have been specific requests in specific areas where the need to attract more people has been recognised; as a result, that work is being done and those in Tayside are now included in the ability to get SDAI grants. I accept that we have a distance to go in a lot of areas, but I think that we are making progress.

Murdo Fraser: Well, we will see in due course whether progress is being made.

Let us consider the pattern of change. You are absolutely right: I remember that, 20 years ago, there was a big issue with a lack of NHS dentists, and there were queues outside practices. There was then a big ramp-up in the training and recruitment of dentists, a lot more dentists came into the profession and that was a great success.

Over the past five years or more, however, NHS dentists have been progressively moving to do more private work. During Covid that, suddenly accelerated and people are increasingly having to turn to private dentistry because they cannot get an NHS dentist. People who are in a fortunate position can perhaps afford to do that, but many people cannot afford it and they are therefore falling through the gaps, so we have a real issue of inequality.

What is the Scottish Government's vision for dentistry? We have always had a mixed economy here: there have always been dentists doing private work and NHS work. The growth has been in private work, while NHS work has shrunk. How does the Government see the profession going forward? If we are going to retain NHS dentistry—given that, as we know, a lot of the young people who are coming into the profession are more attracted to doing private work—will that be achievable only with a substantial injection of additional cash? If so, where is that coming from?

Jenni Minto: About 45 per cent of the population of Scotland can access dentistry free on the NHS. That is very important to remember. As you know—

Murdo Fraser: If they can find one.

Jenni Minto: Sorry?

Murdo Fraser: Sorry: if they can find a dentist.

09:45

Jenni Minto: It is also possible for people to get dental care by phoning their local NHS health board and I know that boards and their directors of dentistry are looking to improve that facility.

The Scottish National Party made a manifesto commitment to free NHS dentistry and our policy prospectus says that we want to stabilise the profession and make it sustainable. That is where we are going and it is still our commitment. We are in really difficult financial circumstances, but I hope that we can move towards a free NHS dental service, hopefully within this parliamentary

session. It is important to recognise that we have been taking steps to achieve that by providing free dental treatment for people up to the age of 25—so, under 26s.

Murdo Fraser: We heard from dental practice owners that under 26s are asking for cosmetic treatments such as teeth whitening, which is putting a burden on practices. I wonder whether that is the best use of limited resources. You mentioned the commitment to extend free services to everyone. How credible is it that that will be delivered? The whole system is creaking at the seams and there is not enough money to fund what we are offering at the moment. Is it realistic to think that, within three years, we can give free NHS dental care to everyone, that that care will actually be accessible and that there will be the dentists to deliver it?

Jenni Minto: As I understand it, teeth-whitening treatment is not normally available on the NHS for people under 26. It would be available only in specific circumstances. I was also slightly surprised when I heard that evidence and wanted to understand what was behind that.

I have referred to the really difficult financial constraints that we are facing just now, but our vision must be to have the best possible oral health. If we can provide that to the people of Scotland, it will be a really important way of preventing additional spending later. It is my job to try to work out how that can happen. My officials are working with me and with the dental sector to look at the different ways in which we can achieve that.

The Convener: We move to questions from Jackie Baillie about preventative dentistry and childsmile.

Jackie Baillie (Dumbarton) (Lab): I think that we would all describe childsmile as a flagship programme. It was introduced by the last Labour Scottish Government and has helpfully been continued by the SNP.

We are seeing growing inequality, particularly in children's oral health, between the least and most deprived areas. There was already a problem, but that problem has been exacerbated by Covid and we are now seeing registrations of very young children drop dramatically. Only 25 per cent of children under two years old are registered, which is desperately worrying, given the impact of this issue in later life. We do not think that childsmile has returned to pre-pandemic levels. What are you doing to address concerns about children's oral health?

We know, too, that there are concerns about adults, so what specific measures are you taking to address inequalities in adults' access to dentistry?

Jenni Minto: I, too, was concerned when I saw how many young children were not registered with a dentist. I commend everyone who has worked on childsmile, which has clearly led to vast improvements. I am pleased that the Scottish Government has invested a further £1.9 million over two years, which will allow more than 400,000 oral health packs to go into settings such as nurseries or dental practices and ensure that children get that important education. We must not forget the baby box, which supports oral health, too.

I think that your question was on the specific targets that we have met. I talked earlier about the improved fee for dentists, which allows them to see children, and that is incredibly important. More than 600,000 child examinations have been carried out, which is a really good start. In the evidence that the committee took from Public Health Scotland, there was some indication that perhaps going out to nursery schools had not ramped up to the same pre-Covid levels, so that is clearly something that we need to ensure happens.

In addition, we cannot forget the community oral health challenge fund, which has specifically focused on and targeted communities of greater need. For example, child services in Ayrshire have done specific work with children with additional needs to make them aware of their oral hygiene.

It is those direct relationships with communities that will make the difference. In so many areas of my role, it is all about the relationship between Government, the professions and the third sector organisations, which have played a very important role. The committee took some evidence on inequalities and ethnic minorities and, again, the health boards and their directors of dentistry have been working very carefully and closely on that. That tripartite relationship will improve how we get on. It is about investment, but it is also about advertising to ensure that that happens, and that is where we are making improvements.

Jackie Baillie: Do you think that the kinds of interventions that you have described, particularly for children, are enough to restore registration levels? If so, have you set a target for the percentage of registrations that you expect to have and by what time you will reach it? Obviously, targets drive performance improvements. Equally, have you set targets for closing the inequality gap, a gap that is, in fact, growing?

Jenni Minto: As I understand it, registration has actually increased, certainly among adults. I hope that the work that we are doing to ensure that oral healthcare and brushing happens in settings where children are will have a knock-on effect. I am not aware of any targets, but maybe Tom Ferris can come in on that.

Tom Ferris (Scottish Government): Every year, the national dental inspection programme measures the oral health of children in primary 1 and P7. Our targets are for 75 per cent of P1 children and 80 per cent of P7 children to have no sign of obvious decay by 2024. The most recent measure that we have is for 2022, when 73 per cent of our P1s had no sign of obvious decay. The pandemic might have had an impact on that and the level might be dipping a bit, but we do have a target.

On the inequality measure, we were working on the slope index of inequality, where we look at the difference between the most affluent and most deprived quintiles. We want to see that difference reducing across boards. That work happens from very early on, and it will commence with the next school term as we ramp childsmile back up to where it was.

As has been said, the level is almost back to where it was, but there are still some schools and nurseries where this is not quite happening, so we need to build relationships again with those individual headteachers. If we have issues in relation to that, I have education policy colleagues in the Scottish Government who can address them. We have also previously worked with the directors of education in the Convention of Scottish Local Authorities, who have been really helpful in driving the attention towards schools working with us to improve oral health.

Jackie Baillie: I am trying to get a sense of the urgency with which this is happening. If the registration level for zero to two-year-olds is still sitting at only 25 per cent, that will have a knock-on effect. We know that if we do not prevent disease, it costs more money to treat it later on. Therefore, I am keen to get a sense of when you expect those targets to be achieved. Are you doing any kind of additional remediation to recover from Covid?

Tom Ferris: There is an arm of childsmile that works with new parents just after a child is born. They are usually referred by a health visitor, and those families are facilitated to register with a dentist.

If any young child attends NHS 24 because they are in pain, that will be followed up by the local health board to ensure that the family gets the care, either by registering with a general dental practitioner or by going to the public dental service. Any child identified through the school inspection process as being at high risk will be followed up by the health board or a health improvement team to ensure that the family has support, that they get into childsmile and that they get registered with a practice or the public dental service. There are various touch points at which we contact families and engage with them to get them registered.

I accept that registrations for those aged zero to two are low—they are always the cohort of the population with the lowest levels of registration—but where they are is not great, and we need to put a lot of effort into changing that situation.

Jackie Baillie: I think that it is lower now than it has ever been.

Tom Ferris: I agree.

Jackie Baillie: Speaking more widely about prevention, I very much welcome the fact that the dentists who gave evidence to the committee mentioned prevention with virtually every breath they took. However, they described a funding model that is “high-volume, low-fee” and “disease-centred” and said that they feel they are not able to do the kind of prevention work that they want to. One dentist highlighted the ability to bring together a group of children to do education work on prevention, saying that the fee model did not allow them to do that.

I am keen to know what improvements you will make to enhance dentists’ ability to carry out prevention work, and I would also like to know what the Government will do, at the population level and beyond the touch points that you have described, to improve access to dentistry and ensure that more preventative work is done.

Jenni Minto: I watched that evidence session, and I agree that flexibility of staffing in dental practices is one of the key things that we have to talk about. We also need to talk about what that flexibility would allow them to do on a different scale. However, going back to what I said earlier, I think that we have to move forward with getting the right fee structure, and we are in negotiations with the BDA on that.

Childsmile is provided in dental practices, too. That is important, because it introduces children to a dental practice and means that the anxiety that some children have about the dentist can be avoided. I am happy for our discussions with the BDA and other dentists to move to looking at the flexibility of staff, because that is incredibly important. However, it is part of a longer-term look at how we structure support for dentists.

I am very aware that prevention is key. Indeed, in my introduction, I said that if we do not get prevention right, it will end up costing us in the longer term.

Jackie Baillie: I do not want to put words in your mouth, but what I seemed to hear is that the ability to be more flexible around prevention is not part of the current discussion about fees.

Jenni Minto: The current discussion about fees is looking at the volume of the fees and at how we can make that more patient helpful, but it is also looking at how things can be made easier and less bureaucratic for dentists.

David Notman (Scottish Government): Without alluding too much to the current negotiations, I just want to say a bit more about the payments model, which will be a radical revision of what we currently do in dentistry. The model has a great deal more focus on prevention than we have at the moment, and we are going to look specifically at a more preventative focus in the fee-per-item model than we have at present. In short, although discussions are going on, we are also cognisant of the need to be more prevention focused, and that is reflected in the model that we are developing.

Jackie Baillie: The dentists described the model as preventing them from doing the kind of dental work that I have described. We will need to wait and see what you come up with.

10:00

John Mason (Glasgow Shettleston) (SNP): The letter that you sent before the start of the inquiry said:

> "The Scottish Government takes the view that the present blended system of payment, comprising fee per item, capitation, allowance and direct reimbursement payment should remain."

I note that Mr Notman used the word "radical", but the dentists have suggested that that is just tweaking the system and that they would like something more radical. One suggestion is to move them on to a system that is more like that for general practitioners. When I speak to GPs, I find that they are not entirely happy with the system but they seem to be a bit happier than dentists are. Would that be an option?

Jenni Minto: The Government has said that we want to continue the blended model, which has an element of capitation, so that dentists get paid per patient who is registered. I acknowledge that, if the dentist has not seen that patient for, I think, three years, that fee per patient reduces. That is a strong model. Thereafter, there is a fee per item of work that is done. We are looking at changing that, simplifying it and making it less bureaucratic for the dentists. That is the right way to go.

I note your point about GPs but, with regard to dental care, we have to consider the models that exist across Scotland. We believe that the blended model works best for practices the length and breadth of Scotland and our islands. David, do you want to add anything?

David Notman: I accept the point that is being made. The empirical evidence shows that a purely capitation-style model invariably leads to an undertreatment problem. We have empirical evidence across the United Kingdom from the early 1990s when that was done in dentistry, but we also have empirical evidence from the Covid period.

We did the right thing in March 2020: we suspended the fee-per-item model and allowed an emergency support system to support dentists that, in effect, is similar to capitation. The difficulty that we find is that, if you pay individuals—economic agents and their independent contractors—regardless of what they do, we go to the bottom in patient care and treatments. The disadvantage of the fee-per-item model is that, if we accelerate it too much, we tend to get overtreatment of patients.

The reason why the Government narrative is a blended system of fee per item, capitation and allowances is because, that way, we get the strengths of each individual component of payment while mitigating the weaknesses. Therefore, it is not our position that we should move across to what is described as the general medical services model, on the basis that a pure capitation model in dentistry would lead to a reduction in NHS treatment and a significant and perpetual increase in oral health inequality. The payment model has to be a blended system to ensure that we can maintain treatment to NHS patients. We can do that only through retaining the fee-per-item model within that wider construct of different payments, including capitation.

That is our argument in a nutshell. I also venture to the committee that we need to be incredibly careful. We have more than 1,000 dental practices in Scotland, all of which have different business models and many of which are wedded to the payment system that the Scottish Government offers at present. Radical change—moving away from fee per item and replacing it with capitation—would be financially destabilising. There are 400 to 500 practices in Scotland that have more than 90 per cent NHS care. Such a move would, potentially, be very destabilising to the sector and lead to a set of outcomes that we do not even want to consider, although it would have been within our discretion.

That is a quick summary of the Government's position with respect to capitation.

John Mason: I am at risk of going over this ground again. The minister said that we have a strong model and that the situation would get a lot worse if we moved to a different system, but the reality is that my dentist had not been in touch with me since before Covid until I wrote to them. That dentist has stopped doing reminders.

My level of dental care cannot get lower, and that is in Glasgow—a city. We had people along from Shetland who said that their system is not working. They have one practice and a director of dentistry. Why is a director of dentistry needed for one practice? I do not understand that.

We have heard evidence that the present system is not working. Mr Notman suggests that it would be worse if we moved to the capitation model, because practices might move away from the NHS or be destabilised, but we are picking up a strong drift away from the NHS—that is not necessarily in the numbers but in the fact that, for example, the practice that I go to has stopped sending reminders and others have deregistered patients, although my practice has not. We seem to be getting that across the board.

When people speak to medical students, those students are wondering not whether they will work in the NHS but whether they will go into hospital or GP practice, which is an issue. However, when people speak to dental students, those students say, "We don't even want to go into the NHS." Do you accept that something is fundamentally wrong?

David Notman: I accept that we have challenges. We have talked a bit about registration. The national picture is that we have retained a very high registration level of NHS patients, which I argue is the base position on access.

We have also seen something of a recovery. We put in place short-term recovery measures through Public Health Scotland, and a significant increase has occurred across the key treatment groups. As the minister said, we are up at about 4 million patient contacts, against 5 million to 5.5 million before the pandemic. That gives you the context of where dentistry is. On participation, which is the number of patients who are seen in a two-year period, we are now on track for a similar position to that before the pandemic.

With the greatest respect, I say to the committee that I would not describe the national picture in the darkest possible terms. The national picture is reasonable, although it is not without challenge. However, we have some serious local challenges. I accept that accessing dental services is a more significant challenge in certain parts of Scotland than it is across the nation as a whole. The Scottish Government's job is to put in place the national framework to support boards with local provision and we are trying to do that.

I accept that different narratives are playing out, but I bring us back to the fact that the national stats show that we have done a great deal to bring dentistry back to a position that is not incomparable with that before the pandemic. In the local sphere, I accept that some patients are struggling with access and that we need to address local problems.

John Mason: I will ask one more question, which is on a slightly different tack. Do we know the state of the nation's oral health? You have told us that you check kids' teeth in P1 and P7 and you know that a percentage have or do not have decay. Do we know the position for adults?

Tom Ferris: We have no adult equivalent of the child inspection programme, but we are trying to build that into the reformed system. The greatest indicator of someone's risk of future disease is past disease. We are trying to build key indicators into the reformed system so that we can extract such data on an anonymised basis and use it to inform the clinician of the oral health of their case list and for aggregation up to practice level, board level and national level.

We are trying to get such information with the least bureaucracy possible and as part of people's day-to-day work. We are trying to build in the key indicators that will come from the enhanced examination that is being done. We can extract that data, which Public Health Scotland can use to build out the stats.

It is a weakness that we do not have such information. We have the Scottish health survey, which has self-reported stats about the number of teeth, dentures and attendance. That is fine as far as it goes, but we need something better. We need metrics to prove the position, but we also need outcomes. At the moment, we count virtually every widget that we do, but what is the point of a lot of that stuff? We really need to understand what the outcome is of doing those widgets. It is an outcome metric that we are looking for and we are working on that as part of the new reforms.

John Mason: That is very positive, so it is a good note for me to finish on.

The Convener: David Notman, I will ask you very quickly about something that you have just said. You are saying that, across the country generally, you have a lot of dentists who are wedded to the existing system. However, we have heard members of the Scottish Dental Association and the Scottish Dental Practice Owners say that they have been completely excluded from talks and negotiations about reform. Are you not hearing that people want reform?

David Notman: I think that they are two different things, in a way. The point that I was making was that the fee-per-item model is a very strong incentive mechanism for dentists to provide NHS care. If we look at the stats, we find that a large proportion of practices have a high-volume model. It also gives dentists discretion over income—they can decide how much dentistry they

want, or do not want, to do. From my perspective, a large proportion of practices in the Scottish population want to provide NHS dentistry and the fee-per-item model provides them with the incentive to do so.

It is a slightly separate question with respect to the SDA and the SDPO. We have very regular discussions with BDA Scotland, which is the representative body for the profession in Scotland. We also have intelligence through the boards with the directors of dentistry; we have quite a lot of networks within dentistry to give us that level of intelligence. With the oral health improvement plan in 2018, we had about 20 to 25 road shows in Scotland and a huge consultation exercise with all dentists that received more than 500 responses. Most of the oral health improvement plan is feeding into the discussion around reform and how we take forward the recovery of NHS dental services. We have a very substantial network across Scotland in terms of understanding the difficulties that dentists have. That would be my sense of things in terms of where we are with discussions with the profession.

The Convener: Okay. Am I right in thinking that the BDA does not represent all high street dentists?

David Notman: The Government has to take a view and our view is that the BDA is the representative body. It can provide us with what I would describe as a delegated mandate. It has a clear delegated mandate from dentists who are members of the BDA, based on a membership fee, to discuss issues with the Scottish Government. Ministers have to set the line as to who they would regard as a representative body. It may very well be that the BDA does not have all GDPs as members, but it is able to provide evidence to us that it has a delegated authority from GDPs who are members.

Tom Ferris: The Scottish dental practice committee of the BDA represents all primary care dentists, because the members come from the local dental committees of health boards. Membership of the LDC at health board level is not dependent on being a BDA member, so there will be LDC members at health boards who are not members of the BDA but who are local GDPs. There are subsequent elections forward on to the SDPC, which forms that representative body for us. That covers the length and breadth of all the boards and different areas of Scotland, so we get a full gamut of GDPs on that committee who come to us and bring their side of the story. It is important that there is that kind of democratic mandate behind the BDA that allows us to know that we are dealing with an organisation that is truly representative. I think that we need to hear that from other organisations that would like to inhabit a similar space.

The Convener: It seems a very cluttered space. If anyone sitting listening to that just now did not know anything about dentistry, they would not have a clue what you were talking about because there were so many acronyms in there.

Tom Ferris: It is the same for medicine and GPs—just substitute M for D.

The Convener: The only point that I am trying to push is that we have had people in front of us saying that they are completely unheard and are excluded from the conversation. Perhaps that might be considered after we have concluded our evidence taking and we have come back to you. There are clearly people in private dental practice who, despite the fact that they have NHS roles to play, think that they are simply not being heard. We should consider that.

10:15

Brian Whittle (South Scotland) (Con): Good morning, minister. I have been listening with interest to what has been said and reflecting on the view of dentistry that has been portrayed, which is markedly different from the evidence that we have heard before. As a committee, we have to assess the evidence that is before us. As my colleague Jackie Baillie said, dentists have repeatedly talked about wanting to look at prevention, which you will know is a passion of mine. They have also said that there is no immediate strategy or capacity to clear the backlog or take immediate action on poor oral health. In fact, last week, we heard from dentists that, under the current system, the backlog will never be cleared. The concern for me is the huge gulf between the evidence that we are hearing today and the evidence that we have heard over the past couple of weeks.

I will mention a couple of things. One is that, because of the big gaps between dental appointments, the treatment that dentists are having to provide is much more complex, which is an indication of a problem. The other is that dentists get paid when treatment is finished, which is a problem when it takes longer to complete treatment. For example, if there is an initial appointment, a filling that is done after three months and another filling that is done after another three months, the dentist is not paid for six months. Dentists say that the system cannot continue.

If we are going to fix this, which I think that we all want to do, we have to understand the reality. The evidence that the committee has heard has painted an NHS dentistry system that, as John Mason said, students have said that they do not

want to work in. We know that current NHS dentists are drifting towards the private sector. Help us here, minister. How do we close the gulf between what you are saying and the evidence that we have heard?

Jenni Minto: Thank you for the question, Mr Whittle. There are a few elements to it. We have been quite clear that we recognise that we have a distance to go to make the dental service the one that we want it to be. On the backlog, the committee has heard evidence that—and I have certainly experienced this at my dental practice—although we all grew up expecting six months to be the normal time to return to the dentist, dentists can make that decision. It might be the case that you do not need to be seen for nine months or 18 months, although some people might need to be seen more regularly. In their clinical decision making, dentists have the capacity to decide that, which might help to reduce the waiting times.

We must remember that, throughout the pandemic, we lost a whole cohort of dentists in training, because they were not able to have their practical experience. We have acknowledged that, although we are back up to the level of 160 dentists a year coming through the system, it will take a few years to recover from that.

Another piece of work that we have done is to look at where we can get other dentists from, but there is a bit of a road block for that. In my area, we used to get a lot of dentists from the European Union, but, since Brexit, the number has reduced. I have written to my fellow health ministers in the four nations of the United Kingdom to ask whether we can find a way to speed up the entrance of dentists, which would help with capacity.

I have also looked at what other mitigations can happen, by working with health boards to see whether they have solutions there. I have touched on staff flexibility as well, by looking at what different members of dental teams in practices are actually doing.

Sadly, I do not think that we can fix it next week, but we have been putting in a number of mitigations. Those include additional funding, which the director of dentistry at NHS Borders talked about in the committee's first evidence session on NHS dentistry.

Brian Whittle: Minister, it does not matter how many dentists are in training. If they do not want to go into NHS dentistry, it will make no difference whatsoever. Over and above that, we have heard that a lot of dentists' staff are moving to private practice, purely for financial reasons because private practice can pay more.

We have to understand what the problem is before we can fix it. My concern is that we are hearing one side of the argument, and then what we hear from you differs so much from that that I am not sure what the reality is, although I am not sure what my colleagues think.

We have heard that the NHS is under huge pressure across the board, and dentistry seems to be at the worst end of that. It is to the point where someone said that it is in danger of falling over. We have to accept what the reality is. You talk about the idea that we need more dentists, but what we need is more NHS dentists. How do we get more NHS dentists to practice?

Jenni Minto: I appreciate that you have had evidence saying that young dentists do not wish to go into the NHS. We have also had conversations and we hear the other side of that. There is still a cohort of dentists who wish to get their training in an NHS practice. I think that we have to be very careful about painting just one side of the picture. There are people who wish to go into NHS dentistry.

What we have been trying to do with the payment reform is to make it more attractive for new dentists to come in. In the hospital in Dunoon in my constituency, there are two dental surgeries. They work with fourth-year students from the University of Glasgow, with support from a retired dentist.

It is about looking at these things and trying, as I have said before, to be flexible so that we can bring them in. We believe that the negotiations that we are having with the BDA are moving us all towards a flexible model of support for NHS dentistry.

Brian Whittle: I have a final question. We have heard not only that there can be a long delay in getting payment for treatments that have been done but that some treatments on the NHS actually cost the dentist money to deliver. Are you looking at that issue?

Jenni Minto: Yes. We have heard that as well. We are in a cost of living crisis, with high inflation, and the fees of the labs that are doing dental work have gone up. We have recognised that issue and worked with the BDA in regard to it.

The other thing that we must remember is that things do not stand still. Yesterday, I was at a meeting where we were talking about life sciences and the amazing work that is happening to come up with new supportive technology; that will help in the preventative field as well. That work is expensive, but, in the long term, we hope that it will reduce the requirement for additional care. I am sure that we can all remember having to get putty and other things in our mouths to determine what work needed to be done, whereas now that can be done with a digital scanner, which improves throughput. The issue is working out

how we can do that, and that is also part of our conversations with the wider dentistry sector.

Stuart McMillan (Greenock and Inverclyde) (SNP): Minister, you mentioned that there were 130 dental students.

Jenni Minto: One hundred and sixty.

Stuart McMillan: One hundred and sixty. Does the Scottish Government have any plans to increase that number?

Jenni Minto: I cannot answer that question offhand, so I will hand over to Tom Ferris.

Tom Ferris: We will be considering the intake of the dental schools. We need to be mindful of whether it is really dentists that we need. David McCall came to the committee and was quite eloquent about skill mix. We need to take skill mix seriously—it is not something that dentistry has really embraced. The regulations around it are a bit cumbersome and we need to fix those. It might be that we need more hygienists and therapists as well as dentists. We need to get the numbers right. I do not think that we just need more dentists; we need more of the whole team. Dentistry nowadays is a team sport and the Government needs to facilitate that.

There are quite advanced plans for a hygienist qualification to be delivered in a further education college in Lanarkshire. That will be the first time for a couple of decades that we will have had a hygiene qualification in Scotland. That is really important. I have spoken to the therapy schools about whether they could increase input. One of the models is based in the University of the Highlands and Islands, which has a hub and spoke arrangement, with small pockets of students—the minister alluded to that. There might be other areas of Scotland where there is a reduced dental workforce, and those areas might be the best places for some of the schools. That conversation is being had.

At the level of the General Dental Council, there are 5,700 international dentists who want to come to work in the UK. The process to make that happen is hugely bureaucratic and cumbersome. As part of the conversation that the minister will have with her counterparts, she will be asking how we can speed up and streamline that process and how can we get dentists to come to Scotland and give them an educational and developmentally supportive way into the NHS in Scotland. In return for that, I would imagine that there would be an element of tie-in to providing service to the population.

Stuart McMillan: I will come back to the 5,700 dentists—it is interesting and helpful to know about that.

I asked the question because we have heard evidence on the number of dentists and practices that have become solely private. Even if the outcome of the discussions is regarded as successful on all sides, I fear that the majority of those dentists will not go back into the NHS but will remain private, which means that there will continue to be a shortfall in NHS dentistry provision across parts of the country. It is hugely important to increase the number of dentists coming into the scheme who will provide those services.

Tom Ferris: That is part of the international dentist work—we need to make Scotland an attractive place to come to work. Not many of them come to Scotland. If I am honest, some people say that the international dentists come across and go into practices and that there is a bit of exploitation there—they are seen as workhorses. If they come to Scotland, they need to understand our system and feel supported by it. We need to ensure that in discussion with NHS Education for Scotland. We did that 20 years ago when we brought a cohort of 50 Polish dentists across—about half of them are still working in Scotland. That was a great programme and we learned a lot from it. We probably need to do that again.

Stuart McMillan: I know that my dental practice has someone from the EU who came in and who is still there—and it is greatly appreciated.

On the 5,700 dentists, what other aspects have you considered to entice people to Scotland?

Tom Ferris: Those 5,700 people have applied to come and register as dental therapists. That means that they could do the bulk of what a dentist does but not all of it. That is the easiest way in to registration and getting into the UK. If we could do that for Scotland, it would be great. We could work with that cohort of dentists to ensure that they go through the exams that they have to sit to allow them to register as dentists in Scotland—we could provide an educational programme to get them to that end point. If a young dentist has made the effort to cross continents to come and work in Scotland, we must support them so that they can be the best dentist that they can be. That is what we would want to do.

A part of the conversation for ministers to have at UK level is about having a notion of provisional registration, whereby we say, “Yes, you are a dentist from overseas, you are provisionally registered to work in the UK, you can work in Scotland and build a portfolio and, if you satisfactorily provide evidence that you are working safely, you will automatically become registered as a dentist”. That would be so much better than going through all the other hoops.

10:30

The other thing that we have been considering is an international BDS—bachelor of dental surgery—which is already happening at a university in England. An international dentist does the final two years or 18 months of a British BDS course, and then they sit our final exam. That brings an automatic registration to work in the UK. It is another really supportive and streamlined way of getting the international workforce into work in Scotland.

That is all up for discussion. I speak to the three other chief dental officers, and we debate the best way to approach the issue. I hope that ministers taking the lead in saying that we need to get together at ministerial level will help to drive that forward.

Stuart McMillan: Those generally sound like useful tools in the armoury to help to deal with the situation that we face. However, to go back to a point that the minister, quite rightly, raised earlier, the financial situation is tough, so how would those initiatives be paid for?

Tom Ferris: I would make a bid to the Government for funding to make them happen. If we need to grow the workforce, we have to find the resource to do that. It is not going to happen any other way.

Jenni Minto: The weird and wonderful ways of Government finance.

Stuart McMillan: I asked a question last week on the issue of directors of dentistry, and John Mason touched on the situation in Shetland earlier. What exactly is their role and what do they contribute? Potentially, do they cost a lot of money for very little by way of return?

Tom Ferris: No, I—

Sorry, minster, do you want me to answer?

Jenni Minto: I was going to say that I could do a brief summary, and then you can do the detail.

I do not believe that they are a waste of money. They are key to ensuring that the NHS boards understand the level of service that they have in their board areas and have a connection with the work that happens in hospital settings. As David Notman talked about, the Scottish Government is providing a framework to ensure that we have the right support for dentistry in the health boards. That raises the profile of dentistry in the health boards, which is incredibly important.

I have met the BDA to talk about the operations that have to happen in a healthcare setting—in a hospital—and its understanding of the impact that the pandemic has had on those operations and on waiting lists. Having that conversation has raised the issue in the priorities for us to look at as a Government.

Therefore, no, I do not think that directors of dentistry are a waste of money; they are an incredibly important resource across Scotland.

Tom Ferris: They were phenomenally helpful during the pandemic. They came into being just before the pandemic, and they were probably barely used to the role before we were thrown into what happened during the pandemic. They give us a single point of contact at a health board, which we previously did not have. If the CDO needed to know something at a health board, he or she had to work out which person to go to. Now, there is a single point of contact, and they know the system really well. That improves communication backwards and forwards.

I think that Mr Mason is being a bit unfair about Shetland. Yes, there is one practice, but there is a public dental service and there are hospital dental services, which have to do everything. The director of dentistry in an island board probably has far more functions than someone in, for example, Greater Glasgow and Clyde, who has a team to support them. They are just as valuable in an island and a rural health board as in an urban health board.

The Convener: Consider yourself suitably reprimanded, John.

Stuart McMillan: I have one final question.

The Convener: If you are very quick.

Stuart McMillan: On the issue of tie-ins, whether for graduates or the potential 5,700 international dentists, what length of time would you consider to be the preferred option for a tie-in for new dentists?

Tom Ferris: I have not thought that far ahead, but we currently have a bursary that is available to undergraduates. They are tied in for the number of years that they receive that financial support plus one. That is the way that we currently work it. It might be something like that.

Stuart McMillan: Could that tie-in be increased?

Tom Ferris: I suppose that we could set it at any level. The question is whether it becomes less attractive if the tie-in is greater. We want people to come and work in Scotland, enjoy it and want to stay.

The Convener: I am going to move on. Minister, we are over time, but we have a couple of supplementary questions if you are happy to hold on for a couple of minutes.

Jenni Minto: I am sure that that is fine.

Brian Whittle: I will go back to something that you said, Mr Ferris, about encouraging people from overseas to come and work here. You said that we had brought in 50 Polish dentists. I have a moral issue with that in that we are sucking talent from everywhere else and, while we are doing that, we are allowing our own talent to leave or to work privately and not in NHS dentistry. Do you see what I am getting at? Should we not focus more on how we retain our own talent within NHS dentistry?

Tom Ferris: We are doing both. The point of the current reform is to make NHS dentistry an attractive, financially viable place for people to work. As someone said, the people who have left the NHS might not come back—although some might—but we hope that the reform will stop further drift. That is what we want to see.

We want to make the NHS system a decent one that people want to work in, but we also have a workforce issue. The number of dentists who used to come in from the EU made a significant contribution to our workforce and we miss that because it has disappeared. Therefore, if there are other dentists from overseas who want to come and work, we need them.

I understand your point about whether we are taking those dentists away from their own healthcare systems, but I have spoken to several people who have experience of education and training in healthcare overseas and they say that it is really not a problem, especially in Asian countries—India and Pakistan—and the middle east. They train a significant number of dentists. They train too many, so we are not denuding those countries of healthcare workforce.

Brian Whittle: They are not in the EU, though.

Tom Ferris: No, but we need to find a way to get them in. If we can get the conversation going with the other three UK jurisdictions about how we get international dentists in on a streamlined pathway, that will be all to the good. They want to come and work here. There will be a benefit to them because we will provide education and training for them, and they will support our population by delivering care.

Jenni Minto: They will also support our population, which we need to increase.

The Convener: I presume that all four nations of the UK are having similar issues with recruitment for dentistry. Tom Ferris, you said that there are 5,700 people who potentially want to come here to practise dentistry at varying levels. What is the hold-up? We have an urgent problem, so why is there a difficulty?

Tom Ferris: The hold-up is probably the anachronistic legislative framework within which the General Dental Council works. That is in the gift of the Department of Health and Social Care, which is why we must impress on the UK minister with responsibility for dentistry that that needs to be fixed.

England has just as many pressures in dental workforce as we do. It might have more acute workforce problems in some areas, especially coastal areas, which have real difficulty in filling posts. Therefore, it is in England's interest, too, that we find a streamlined and quick way of getting a willing workforce to come and work safely for us.

The Convener: Thank you very much. We have gone over time, and I appreciate your generosity in that.

That concludes our consideration of the agenda item and our time with the minister. The committee will consider later in the meeting the evidence that we have heard.

I thank the minister and her colleagues for attending, and I suspend the meeting.

10:39

Meeting suspended.

10:40

On resuming—

Annual Reports

The Convener: Agenda item 3 is consideration of the draft annual reports for the parliamentary years from 13 May 2022 to 12 May 2023 and from 13 May 2023 to 12 May 2024. The purpose of the reports is to set out our activities during the relevant reporting periods.

Members will see that we are considering an annual report for the previous parliamentary year as well as for the current one. That is because, as members will be aware, the Scottish Parliament yesterday agreed to motion S6M-09720 to wind up this committee. As a consequence, this will be our final meeting before the committee is formally dissolved on 14 July 2023.

I will leave general remarks about the reporting year to the end of this agenda item. First, I propose to go through the reports page by page to identify any corrections. Any member who has a comment about any paragraph should raise their hand when I reach the relevant section. Any typos have already been picked up and will be addressed later.

We will go through the reports page by page, starting with the "COVID-19 Recovery Committee: Annual Report 2022-23".

Are there any changes to pages 1 or 2? We are agreed on those. What about pages 3, 4 and 5?

John Mason: Paragraph 9 on page 5 says "tackling misinformation". Could we add "and disinformation"? We looked at both, one being perhaps unintentional and the other intentional.

The Convener: Okay. Is that agreed?

Members *indicated agreement.*

The Convener: Are there any comments on pages 6 to 13?

There being no comments, we move on to the next report, which is the "COVID-19 Recovery Committee: Annual Report 2023-24". We will go through the same process.

Are there any comments on any of pages 1 to 6? There are not.

Are members content with the two annual reports?

Members *indicated agreement.*

10:45

The Convener: Thank you. I confirm that the annual reports are agreed to. The clerks will make minor revisions to the statistics and any other relevant factual information prior to publication in due course.

I take this opportunity to thank all the stakeholders who have participated in the work of the committee, in particular, from my point of view, the long Covid people who came in under great difficulty—some of them were clearly struggling. I want to single them out, as their participation greatly benefited our consideration and scrutiny of the issues relating to Covid and to recovery.

I thank the current and former members of the committee for the collegiate way in which they have undertaken their scrutiny. At the height of the pandemic, it was of great benefit to the Parliament to have a dedicated committee to scrutinise the relevant legislation and our transition to a recovery period. It will now be for the other subject committees to take forward the scrutiny of Covid recovery as it relates to their remits, and we will make recommendations on that when we come to consider our legacy report.

Do any members wish to make any other remarks before we conclude this agenda item?

Murdo Fraser: I echo your thanks to everybody who has contributed to the committee. I thank our clerking team, the Scottish Parliament information centre and all those who have helped us. I also thank you, convener. Your stint as convener has been a very short one, but you can put it on your CV for future reference that you convened a parliamentary committee, albeit for just a few weeks. Thank you for leading the committee in collegiate style.

I also thank our committee advisers, whom we have not seen for quite a long time, but who were initially regular attenders at the committee: Professor Peter Donnelly, Professor Susie Dunachie and Professor Helen Stagg. Members will recall that they came more or less on a weekly basis to give us updates at the height of the Covid pandemic, and their input was extremely useful to us. We should record our thanks to them. I do not know whether we are going to write to them formally to express our thanks, but I think that we should do so.

As a personal reflection, I was the first convener of the COVID-19 Committee in the previous session. If I remember rightly, the committee was established in May 2020, and here we are, just over three years later, bringing this particular journey to an end. I hope that that is an indication that Covid is behind us—and I hope that my saying so does not give a hostage to fortune.

Nevertheless, there are some very important lessons that we need to learn from Covid. A lot still needs to be done and put right, post-Covid, in the public sector and in public services, and I hope that the important work that the committee has

been doing will be continued by other subject committees as we go into the next parliamentary year.

The Convener: Indeed. Thank you, Murdo.

There are no further comments from members. I would like to offer my personal thanks to the members of the clerking team, who have been absolutely brilliant and have made me look almost competent. I will also mention Alex Rowley, who has been a fantastic member of the team, and Siobhian Brown, the previous convener, who was given a ministerial post, which is why I am now sitting in this chair.

That concludes the public part of our meeting.

10:48

Meeting continued in private until 11:06.

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