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18 October 2023

Dear Clare,

I am writing to you as Convener of the Health, Social Care and Sport Committee as requested by Jim Fairlie MSP, Convener of the COVID-19 Recovery Committee, in response to his letter to me of 5 July 2023 following the recovery of NHS dental services inquiry.

I welcome the opportunity to provide an update to the Health, Social Care and Sport Committee, and offer an update on the progress we have made with NHS dental payment reform to date. The Annex of this letter provides responses to the specific questions posed by the COVID-19 Recovery Committee.

It was agreed during the inquiry that there is presently a range of challenges facing the dental sector. The effects of the pandemic, Brexit and other external factors such as rising inflation and the unprecedented cost of living crisis are all having an impact. While overall levels of NHS dental activity continue to increase – with official statistics showing a further 8% increase in examinations and 6% increase in courses of treatment compared to the

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previous quarter[1] - this difficult backdrop has undoubtedly impacted on the provision of NHS dental services in certain areas of Scotland.

It is against this backdrop that the First Minister's Policy Prospectus set out the Scottish Government's primary objective to sustain and improve patient access to NHS dental services. As the Committee will be aware, the Scottish Government has been developing NHS dental payment reform for some time now. Following the conclusion of negotiations with BDA Scotland on the new fees this will be implemented for NHS dentists as of 1 November 2023, and full details of the revised system, including education materials, were issued to the sector on 21 September.

Our priority in delivering payment reform is to ensure that fee levels are reflective of the increased costs of modern dentistry, providing longer term sustainability and encouraging the dental sector to increase its existing NHS provision. Our approach to securing access has been based on extensive consultation with the sector, including a sector-wide survey of dentists, continued input from a specialist dental professional group, regular engagement with BDA Scotland and intelligence from other dental professionals, and discussions with colleagues in the wider UK. More detail on our reform consultation exercise is outlined in the answer to Q2 in the annex.

The foundation of the reform builds on the commitments from the Oral Health Improvement Plan (2018), which was developed following one of the biggest consultations with the dental sector in recent times. The new fee structure includes 45 broad care and treatment items which incorporate the existing 700 codes and intend to make the clinical delivery of care to patients easier, ensuring that dentists can offer a comprehensive range of NHS treatments. The reform is predicated on moving the sector to a high-trust/low bureaucracy model of payment that reduces the administrative burden for dental teams and affords far greater levels of clinical discretion to practitioners.

In delivering a fee structure that intends to retain contractors in the NHS and maintain the delivery of care to patients, it has been necessary to increase the remuneration for dentists under the overall care and treatment fee framework. This will necessarily have an impact on the amount of money that non-exempt patients will pay towards their treatment costs. I should stress that this increase is not a direct policy decision, and the and the legislative relationship under the 1978 Act between fees and patient charge (patients pay 80% of their NHS dental care, up to a maximum of £384) has not changed.

I took a decision to prioritise the sustainment of patient access to care in the overall fee structure provided to NHS dentists. I would however note that whilst NHS costs to patients will increase, these need to be set against the equivalent costs in private dentistry. Patients unable to access NHS dentistry and requiring private treatment typically pay between 6 and 10 times the NHS cost – which is why securing access for patients is so important and must be our priority.

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[1] Public Health Scotland - NHS Dental Treatments Report Quarterly – Quarter Ending June 2023

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Whilst I fully appreciate the concerns this may raise, I can assure the Committee that those that are currently exempt from NHS charges - including children and young people up to the age of 25 and 20-25% of the adult population - will remain so, and other financial support measures such as the NHS Low Income Scheme are available for patients to apply for.

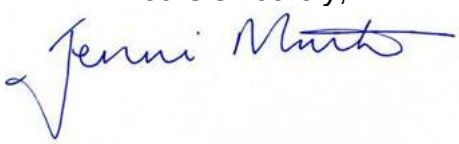
Aside from equitable and sustainable remuneration, reform offers many other clinical benefits to dentists and patients. It is the first step towards a truly modern NHS dental service which appropriately assesses, responds to and supports the oral health needs of every patient in Scotland. Through the fee structure there will be increased incentives to ensure dentists focus on prevention instead of disease, reflecting modern dentistry. Patients will benefit from treatment items being brought in line with current best practice guidance, particularly around periodontal (gum) treatment, helping maintain and improve oral health. The reform also provides greater visibility of NHS care to patients through the reduced range of treatment codes, meaning the new system will be much easier for patients to understand.

In conclusion, the decisions that Scottish Government has taken are clear in our objective and design to sustain NHS dental services through the payment system reform. These changes reflect the biggest change in the remuneration of NHS dentistry in Scotland – and the UK – in a generation. Whilst we are seeing challenges, it is important to provide context - Scotland is the only country in the UK actively tackling access issues through significant generational reforms, despite being in a relatively stronger position than the other UK nations, with 95% of the population registered with an NHS dentist and higher levels of provision (defined as the number of dentists per 100,000 of the population).

Challenges do remain, and reform should not be viewed as a panacea, however by taking action to address the existing situation on the ground and through a rigorous assessment and review approach, Scottish Government will seek to address sector matters appropriately.

Payment reform is therefore the first step on a longer journey as we move through the reform process to secure our commitment to sustainable and equitable NHS dental service for all patients in Scotland, and I look forward to working with the Committee, sector and patients to ensure the long-term future of NHS dental services.

Yours sincerely,



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ANNEX

Q1. The Committee seeks clarification that the Scottish Government remains committed to implementing payment reform by 1st November 2023.

As intimated in the covering letter, Scottish Government is committed to implementing NHS dental payment reform on 1 November 2023.

Q2. The Committee strongly encourages the Scottish Government to engage with the SDA and SDPO, and the wider dental sector, before introducing its reforms.

Scottish Ministers have to take a view on who the main representative body for the sector is, for the purposes of effective engagement and negotiation, and we consider this to be the British Dental Association (BDA) Scotland. This is because the BDA is able to provide evidence to us that it has a delegated mandate from General Dental Practitioners, who pay a membership fee, to discuss issues with Scottish Government on behalf of the sector.

The SDA and SDPO groups have not provided evidence that they have a delegated authority or electoral process, and it would therefore be inappropriate to consult with these groups exclusively. Both groups, however, receive information as the sector receives it, and have an opportunity to provide comments or feedback to the Scottish Government on any aspect of this.

In addition to regular consultation with BDA Scotland, the Scottish Government has consulted extensively with the wider dental profession on payment reform:

Oral Health Improvement Plan (2018)

Payment reform was a key output from the Oral Health Improvement Plan (OHIP) and we have used this as the foundation for the new model.

The 2016 consultation exercise which informed the OHIP included engagement with dental professionals across the country, as well as members of the public. The consultation resulted in 427 responses from dentists and 564 attendees at a series of roadshow events. This input from the sector was key in developing the Plan.

The key commitments from the OHIP which will be delivered through payment reform are:

- The Scottish Government will streamline items of service payments to GDPs.
- The Scottish Government will introduce a clinically-proven programme of periodontal care for patients with periodontal disease and those with high risk of developing it.
- The Scottish Government will develop the standard of NHS oral health information on self-care, treatments available, costs and services to be made available to the public by dental practices and dentists.

Sectoral Survey

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In July 2022, the Scottish Government conducted an initial consultation exercise with the entire dental sector that looked specifically at reducing the fee code complexity of NHS dentistry. The survey received over 500 responses from dentists across Scotland, which helped inform the new Determination I.

Chief Dental Officer Advisory Group

An advisory group was set up to inform the reform programme, comprising of 17 members including General Dental Practitioners, Dental Care Professionals and Specialists. 4 workshops took place between October 2022 and December 2022, where members provided clinical advice on the range of NHS treatment items that should be included in the revised Statement of Dental Remuneration.

The advice provided by members helped to shape the new model. The outputs from the workshops, chaired by the Scottish Government's Deputy Chief Dental Officers, were published online.

Other Intelligence

The Scottish Government continues to engage and regularly meet with NHS Board Directors of Dentistry, and Dental Practice Advisors in the reform space – and also maintains productive and open relationships with CDO England, Wales and Northern Ireland.

Q3. The Committee considers that the proposed payment reforms should be prioritised for scrutiny by the Health, Social Care and Sport Committee and it intends to highlight this in its legacy report.

I note the Committee's decision.

Q4. The Committee recommends that the Scottish Government provide costings for – and consults on – different service model options, including those that it does not prefer, in partnership with the sector so that the opportunity is not missed to consider a full range of options for the future of service delivery.

The Scottish Government programme of payment reform is predicated on retaining independent dental practices as the mainstay of NHS provision. The Scottish Government therefore does not view alternative service delivery models as a credible approach – there are over 1,000 independent contractor practices providing the mainstay of NHS provision. The purpose of payment reform is to engage effectively with the existing sector by incentivising dentists to provide NHS dental services.

On payment reform itself I direct the committee to the points set out in a Professor Nigel Pitts literature report[2] which point to fee-per-item models as drivers of activity, particularly in preventative-based models of care. The publication looks at various different payment options, including capitation only and pay for-performance-based systems, in Northern Ireland. The research supports our stance that blending several system types is an ideal solution to obtain better health outcomes for the patients, while maintaining access to dental care and respecting the financial stability of dental practices.

It is our view that the blended model combines the benefits of each individual component of payment whilst mitigating their weaknesses, and we have seen firsthand evidence of these. For example, we saw the disadvantages of a capitation only model when we suspended the fee-per-item model and allowed an emergency support system (a capitation style model) to support dentists in March 2020. Whilst activity was already suppressed, the data showed that activity was reduced to much lower levels than we would expect and what was possible at the time. On the contrary, the disadvantage of a fee-per-item only model is the risk of potential overtreatment of patients.

In addition to the above points, we have already referenced that there are over 1,000 dental practices in Scotland, all of which have different business models and many of which are wedded to the current payment system. Radical change - moving away from the blended model and replacing it with capitation - would be financially destabilising. Notwithstanding this, the feedback we have received is that dentists prefer being able to determine their own income and workload through the item of service model.

In the Covid Recovery Committee's letter they reference evidence that suggests the Scottish Government should consider 'reviewing and reducing the services that are provided on the NHS'. Reducing the NHS dental offering is not an option we are considering, given the huge impact this would have on oral health inequality. Reducing NHS dentistry to what essentially would be a 'core service' would push more people in to private dentistry, which typically costs 6 to 10 times more than NHS dentistry. This is simply unaffordable for a lot of patients and would increase the oral health inequality gap, impacting particularly on those affected by socio-economic health inequalities. The NHS offer we provide to patients is comprehensive and accessible, and we are clear that we will not be reducing this offering.

In summary, the Scottish Government considers the current blended model of fee-per-item payments and capitation and allowance payments is the best payment model option for the NHS dental sector. The critical problem that the Scottish Government needs to address is how best to maximise patient care and access to NHS dental services within a challenging financial position, and ensure value-for-money to the public sector. It is our view this can only be done by maintaining the blended system of payment.

Q5. The Committee seeks clarification on whether the Scottish Government remains committed to its manifesto commitment to "make services free at the point of use for

[2] British Dental Journal – Volume 231 No. 12 - 17 December 2021 – Page 775 - Dental Policy Lab 1 – towards a cavity-free future

all" by the end of Session 6. If this commitment remains, the Committee seeks clarification on when this policy will be fully implemented and how the Scottish Government intends to progress this policy beyond its current provision for people up to the age of 25.

Q6. The Committee invites the Scottish Government to provide further information to Parliament and to consult with its stakeholders on the funding package that will accompany its policy ambition to make services free at the point of use for all, as well as its plans to address the underlying recruitment and retention issues as part of its delivery plan.

Q7. The Committee considers that the manifesto policy commitment should be prioritised for scrutiny by the Health, Social Care and Sport Committee.

As made clear in the First Minister's Policy Prospectus, the immediate priority must be sustaining and improving patient access to services. Payment reform is therefore the first step in ensuring medium-to longer term sustainability for NHS dentistry in Scotland and considering how we take additional steps to make services free at the point of use when conditions allow.

The Programme for Government published on 5 September 2023 notes Scotland continues to face one of the most difficult public spending environments that this devolved Parliament has ever seen and we have been transparent about that in our Medium Term Financial Strategy. As such, we are currently focusing available resources on delivery of sectoral stability and equitable dental access, including preservation of our policy commitment – implemented within 100 days of this Parliament – to remove charges for all under 26 year olds and critical charging exemptions for the poorest and most vulnerable in our society.

With regards to recruitment and retention, I am very happy to update Parliament on the work we are undertaking, including in the overseas dentists space, as it progresses. In your letter you reference evidence from the inquiry which states that "dentistry students have no desire to work in the national health service at the moment", referencing the 'treadmill' nature of NHS dentistry. Whilst I fully appreciate the views given by stakeholders during the inquiry, Scottish Government has had reassurance from Deans of Dental schools and vocational trainee advisors that this is not the case.

Q8. The Committee invites the Scottish Government to consider whether NHS boards should be given a greater role in service delivery, including whether they should have an underlying duty to provide services.

Q9. The Committee considers that giving NHS Boards a greater role in service delivery, and any other options that may assist in increasing access to – and the impact of – preventative oral healthcare policies should be actively explored by the Scottish Government.

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The longstanding preferred model for the delivery of NHS dental services is the Independent Contractor model. NHS Boards have responsibility under General Dental Services regulations for the oversight of NHS dental services in their area, including ensuring the provision of NHS dental care, listing of NHS dental practices and practitioners, and practice inspections.

It is noted however that there is no 'one size fits all' approach as regards the interplay between 'high street' dentists and Board-delivered services, and that there is a need to pay particular regard to difficulties posed by the variation of geographic and economic circumstances across Scotland's communities.

NHS Boards also have some powers in relation to NHS dental service delivery within the Public Dental Service (PDS).

The PDS is a NHS Board employed service formed in 2013 from the amalgamation of the Community Dental Service and the Salaried General Dental Service. The legal basis of the service is through Section 36 of the National Health Service (Scotland) Act 1978 whereby Ministers can determine that Section 25 of the Act (General Dental Services) has either not secured the adequate provision of services (eg. areas of rurality) or sections of the population (eg. those with special care needs) are not receiving satisfactory services under those arrangements.

The PDS also provides a dental public health function through dental inspection services to educational establishments, in terms of Section 39 of the 1978 Act for the purposes of dental inspections through the Basic National Dental Inspection Programme (NDIP), which informs parents of the status of their child's dental health and signposts them to care. It undertakes an oral health improvement role (Childsmile) and carries out epidemiological research on behalf of Health Boards (Detailed NDIP) through Section 47 to assist in monitoring oral health over time and in planning services.

In your letter you note that "NHS Boards have no role in ensuring children can access preventative programmes such as Childsmile", however, as described above, this is not the case. NHS Boards are responsible for the delivery of the Childsmile programme in their area. The Scottish Government funds the programme via the 'Outcomes Framework' funding bundle. For 2022-23, the outcome for Childsmile was:

To improve the oral health of Scotland's children, specifically the achievement of the national outcomes:

- 75% of P1 children with no signs of dental disease by 2024 (this requires a ten percentage point increase on each NHS Boards last NDIP result)
- 80% of P7 children with no signs of dental disease by 2024 (this requires a ten percentage point increase on each NHS Boards last NDIP result)

I would also note that this funding supports the recruitment of Dental Health Support Workers (who are employed by the Board) in each Health Board area, which supports a

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community approach to ensuring children, particularly those in lower SIMD areas, have access to preventative oral health care.

Q10. The Committee draws the evidence from its survey to your attention and invites the Scottish Government to consider and provide further information on how it will address pandemic preparedness and the resilience of services as part of its NHS recovery and reform agenda.

The Scottish Government notes the outcome of the survey and will use the findings to inform our discussions on future pandemic preparedness. In your letter you note that I cited that we are working on a 'range of mitigations'. I would like to clarify that I did not note these as specifically in relation to pandemic preparedness but as measures to support the access challenges we are seeing in some parts of the country.

In relation to pandemic preparedness, the decision to shut high street General Dental Services practices at the outset of the pandemic was based on the lack of Personal Protective Equipment (PPE) supplies at the time. A consultation on PPE lessons learned and future pandemic PPE provision closed on 22 March 2022, and resulted in 164 responses from a wide variety of interested parties - 19 of which were from primary care independent contractors. Consultation analysis is complete and this analysis was considered as part of work on future pandemic PPE supply.

NHS National Procurement has increased the national stockpiles of pandemic PPE compared with pre-pandemic levels, intend to put in place a surge capacity mechanism and is working to minimise wastage and obsolescence through stock rotation.

Our approach to tackling a future pandemic would be dependent on PPE supplies, however it is the Scottish Government's view that we are in a better position, as regards access, for the sector to go to a multiplier arrangement at the outset.

It is important that we use the pandemic as a learning opportunity, to identify how we can address pandemic preparedness within NHS dentistry. For example, we know a lot more about Aerosol Generating Procedure transmission, and as a result of the funding Scottish Government provided during the pandemic, we now have appropriate ventilation equipment in place to reduce transmission, as well as electric speed-adjusting (Red Band) hand drills.

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