Health, Social Care and Sport Committee

NHSGGC - Response to Consultation on Dentistry in Scotland

We have limited access to data which would fully support responses to these questions. Currently we are reliant on obtaining much of the data in house or must wait for quarterly monitoring information to be released by Public Health Scotland (PHS). The PHS data lacks granularity to monitor or report at an HSCP level, which would be essential for NHSGGC. Scottish Government advised boards the General Dental Services (GDS) management data would be released by National Services Scotland in October 2024, however this has not occurred.

NHS Provision

- **Have dentists increased NHS provision in the last 2 years? If not, could you described any barriers which have prevented this happening?**

The overall number of practices and listed dentists in NHSGCC has decreased slightly over the last 2 years.

The number of practices has changed from 274 (Nov 2022) to 266 (Nov 2024). Some practices owned by Dental Body Corporates have merged and other practices have closed post-COVID.

The number of General Dental Practitioners (GDPs) has reduced from 845 (Nov 2022) to 820 currently (Nov 2024). It is not possible to determine the whole time equivalent (WTE) numbers of dentists, or what the NHS/non-NHS split would be in their workload.

Several practices have taken the decision to change their business model and have converted to a private model. Also, in some areas such as Inverclyde, there are no practices accepting new NHS patients. If a dental practice decides to change their business model or approach to providing NHS care for any reason, as independent practitioners, they are at liberty to do so as long as the dentist abides by the listing requirements and the conditions laid out in the General Dental Services Regulations.

One of the major barriers cited by practice owners is the recruitment and retention of staff. This has been a driver for the recent closure of two practices.

- **Is there evidence of new dentists setting up practices and offering NHS services? If not, why not?**

As detailed above the overall number of practices in NHSGGC has reduced over the last few years. Practices across NHSGGC have continued to deregister patients, but the overall rate has slowed since the implementation of Determination 1, Nov 22 – Nov 23 there were 29,009 patients deregistered, for the period Nov 23 – Nov 24 there were 19,588 patients deregistered for a variety of reasons, however, this was mainly due to the closure of practices resulting in bulk deregistration of patients.

- **Do you have any views on the Scottish Dental Access Initiative and whether it has been successful in facilitating the establishment or expansion of NHS dental provision?**

Within NHSGGC, Inverclyde has a defined access problem and has now been recognised as eligible for Scottish Dental Access Initiative (SDAI) funding to support unmet clinical need. There has been no uptake of this to date. However, we have recently received two expressions of interest. If a decision is taken to progress to formal application and planning, this could lead to significant improved access for patients in the local area to NHS general dental services.

- **Has there been any increase in registrations with the public dental service in your board area?**

The Public dental Service (PDS) only register a patient if they meet the clinical criteria required for a patient within the PDS i.e. priority group patients, including those with additional support needs, adult and paediatric learning disabilities, medically compromised and children who are unable to be seen routinely by GDS. The latter will include higher levels of treatment complexity and behavioral factors. Treatment is provided in clinics, schools and nurseries, care homes, outpatient day centres, hospital settings, domiciliary visits, prisons, and undergraduate outreach clinics and not all of these will be registered patients.

The PDS continue to see increasing numbers of patients for unscheduled care due to lack of access to GDS and an increase in demand for hospital based dental services post pandemic due to the increase in clinical complexity. This prevents the PDS providing care to its own core and priority patient groups. The implication that PDS can accommodate increasing numbers of unregistered and deregistered patients is of concern as current staffing, estates and funding constraints mean the PDS are struggling to provide anything other than emergency care for their own cohort of patients.

Under the current reporting mechanisms data on patent registration numbers with the PDS are not readily available. A previous response to the Convenor required a request to be made to PHS, which was undertaken to provide PDS registration for all board areas. Owing to the response timescale, a similar request to PHS could not be completed.

Payment Reforms

- **To what extent do the new fee levels, introduced in the 2023 payment reforms, reflect increased costs for dental services?**

Although Determination 1, the new payment reforms, it has been generally accepted by the profession there were some changes to payments which have caused a greater concern, particularly in relation to Domiciliary Care which has resulted in some further amendments to the regulations since the November 2023 launch.

Scottish Government appears to have recognised specific items with low level of fees that were raised by the profession, and this appears to have been broadly welcomed. The generally increased material costs for businesses have not been taken into account fully. For example increased rent and rates; these have not been revisited for several years and rent reimbursement is still based on historical values. These running costs will be further exacerbated by recent Budget announcements especially around National Insurance rates.

- **How successful or otherwise is the new fee structure in facilitating the prioritisation of patient access? Please set out any examples within your answer.**

This is difficult to ascertain at present. The view is that any practice(s) that had decided to opt out of the NHS post-pandemic have probably done so. The payment reforms may, just, have made those that were undecided reassess.

Patient access is a slightly separate issue with most practices probably wanting to take new NHS patients but struggling to do so due to well recognised and reported shortage of dentists and other staff. Many dentists reassessed work patterns post pandemic and reduced their hours or changed their business model. Many practices report recruitment of dental nurses very difficult as the wage levels demanded cannot be sustained within the fee structure of the NHS and allow most practices to run as viable and profitable businesses that can then re-invest back into the practice.

<u>Staffing</u>

- **Are there ongoing challenges with the recruitment and retention of dental professionals in Scotland? If so, how might these be addressed?**

Recruitment and retention of all categories of dental staff (dentists, dental nurses, hygienists/therapists) remains incredibly challenging for all parts of the service (GDS, PDS and HDS). For NHSGGC, there is often a reliance on the PDS to address gaps in service, such as urgent and unscheduled care for unregistered and de-registered patients. Reform of the PDS contract would be required to provide more flexible ways of working. Aligning the PDS with the Specialty Doctor contract would allow greater flexibility for PDS with regard to hours, capacity and would provide an opportunity for weekend working and may be a key means of addressing future flexible needs.

However, the risk is that these reforms come without sufficient funding to support them, and the Board is left to pick this up. It is also understood PDS contract reform will fall within the gift of the Boards to progress and is not considered a priority within SC Work Streams.

National reform of the PDS contract to allow us to offer more competitive salaries and the more flexible working arrangements offered by GDS.

Dental laboratories have an aging workforce: there is currently only 1 location in Scotland who offers training, and the numbers are limited. It is anticipated that access to and increasing costs of dental laboratory services will remain a significant concern to GDS, PDS and Hospital Dental Services (HDS).

A national dental focused workforce plan which increased throughput of both dentists and Dental Care Professionals (DCPs) to be trained would be welcomed.

Prevention and improvement

- **Is there evidence to suggest dentists are doing more to focus on prevention in NHS dentistry?**

Within the dental reforms implemented in Determination 1, there is an item code for enhanced prevention: Section II – Preventive Care and Periodontal Treatment; code 2-(a) Enhanced preventive care, advice, and treatment (including Childsmile).

The PHS quarterly monitoring reports present the total claim numbers under item 2-(a) but this is reported nationally, not at board/HSCP level. Furthermore, it is not possible to determine what improvements in outcomes may be realised for patients.

- **To what extent is the Oral Health Improvement Plan, 2018, still driving reforms in dentistry?**

The Pandemic and subsequent recovery for dental services had a marked impact on delivering actions set out in the OHIP. For example, interruption to the training and listing of dentists to Enhanced Skills Domiciliary Care.

There are a number of elements within Determination 1 that can be linked to the OHIP; primarily around the changes in what an 'examination' is, and to the delivery of prevention and periodontal care. It is understood there will be further reform of dentistry. It would be hoped the OHIP will continue to inform further development around prevention and risk assessment, reducing inequalities, an ageing population, and digital infrastructure/integration to support patients and the delivery of care.

- **What are your hopes and expectations of what the Scottish budget 2025-26 may deliver in relation to dentistry when it is published on 4 December 2024?**

Prioritisation of funding for health with additional investment to address the backlog in care particularly in areas with long waiting times.