CVDR/S6/23/13/1

COVID-19 Recovery Committee

13th Meeting, 2022 (Session 6), Thursday 15 June 2023

Recovery of NHS dental services inquiry

Introduction

1. This aim of this inquiry is to scrutinise what action the Scottish Government is taking to return the provision of NHS dental services to pre-pandemic levels of activity. The inquiry will focus on tracking progress on this commitment, highlighted in the Scottish Government's NHS Recovery Plan (2021-2026), with consideration of the following issues—

    - Implementation of funding to improve ventilation and other equipment available to practices delivering NHS dentistry services;

    - The extent to which NHS dentistry services have recovered to pre-pandemic levels since the NHS Recovery Plan was published; and

    - How access to services is being targeted and monitored in communities that experience health inequalities.

2. This is the first formal evidence session of the inquiry, in which the Committee will hear about people's experiences of NHS dental services and will take evidence from the following panels of witnesses—

    Panel 1—Public perspectives and experiences of the recovery of NHS dental services

    - Margaret McKeith, Assistant Director, The ALLIANCE
    - Professor David Conway, Professor of Dental Public Health, University of Glasgow and Honorary Consultant in Dental Public Health, Public Health Scotland
    - Dr Manal Eschelli, Project Coordinator, West of Scotland Regional Equality Council

    Panel 2— Health boards' experiences of the recovery of NHS dental services

- Adelle McElrath, Director of Dentistry (Interim) and Dental Practice Adviser, NHS Borders
- Antony M. Visocchi, Director of Dentistry, NHS Shetland
- Dr Declan Gilmore, Director of Dentistry, NHS Tayside

Background

3. The Scottish Parliament Information Centre (SPICe) has published a blog on the recovery of NHS dental services to support this inquiry: NHS Dental Services in Scotland – Braced for change.

Correspondence with the Scottish Government and Health Boards

4. At the outset of the inquiry, the Committee wrote to the Scottish Government seeking an update on the current position regarding the recovery of NHS dental services in Scotland. The Committee requested information on the following—

- How much of the Scottish Government's funding for ventilation and equipment was distributed to dentists in grant payments in each health board?
- What engagement has the Scottish Government had with the sector to seek feedback on the ventilation and equipment funding it made available?
- What impact have multipliers and sustainability payments had on the recovery of services?
- What evaluation has the Scottish Government undertaken of the funding it made available to dentists to improve ventilation and equipment (including the eligibility criteria, uptake distribution and implementation); and evaluation of the impact of sustainability payments and multipliers?
- What metrics is the Scottish Government using to monitor and measure access to dentistry services in the recovery period? What do these figures show?
- Has the Scottish Government realised its ambition to return NHS dentistry services to pre-pandemic levels? If not, when does it anticipate this ambition will be realised?
- What action is the Scottish Government taking to target the recovery of services in communities where participation levels are lowest?
- What are the barriers to realising the recovery of NHS dentistry services and how is the Scottish Government addressing these?
- What is the status and progress on Oral Health Improvement Plan pre and post pandemic (i.e., Jan 2018 – April 2023)?

5. The Scottish Government's response has been published on the website.

6. The Committee also wrote to all the health boards, seeking further information in relation to NHS dental services within their health board area including—

- How much COVID-related funding did you receive from the Scottish Government to fund the following measures:

    - Ventilation improvements
    - Equipment
    - Variable speed drilling equipment

- What was the uptake (percentage or number of practices; and amount paid out) of the above funding by General Dentist Service (GDS) dentists?

- How many practices in your health board area have withdrawn or reduced NHS provision for patients – for example, registering and treating only children:

    - No. and % withdrawn completely
    - No. and % reduced provision

- What impact, if any, has a reduction in NHS GDS provision had on the Public Dental Service?

- How many patients are registered with the PDS in your Health Board area? Has the number risen since 2020? If so by how much?

- What other funding do you receive to support dentistry in your Health Board area (for example, funding related to PDS, Childsmile and any initiatives to improve recovery of services and access to dentistry for your population)?

7. Responses received from the health boards have been published on the website. The Committee considered the responses and agreed to invite three health boards to give evidence at this meeting. The responses from these health boards are provided below in the annexe of written evidence.

Written evidence

8. The **annexe** includes written evidence provided by the following witnesses—

    - Professor David Conway
    - NHS Borders
    - NHS Shetland
    - NHS Tayside

Survey

9. The Committee launched a survey to understand dentists' views of the recovery of NHS services. The survey was aimed at dentists who provide NHS services and ran from 5 May 2023 until 31 May 2023. The Committee received 225 responses and a summary of responses is provided in Paper 2**.**

Next steps

10. The Committee will continue to take evidence on the inquiry at its meetings on 22 June and 29 June.

Committee
Clerks June
2023

ANNEXE – WRITTEN EVIDENCE PROVIDED BY WITNESSES

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

30 May 2023

Note of affiliations:

Employment:
Professor of Dental Public Health, University of Glasgow and Honorary Consultant in Dental Public Health, Public Health Scotland (joint post). Additional role as Co-Lead for Dental/Oral Health Research, NHS Research Scotland.

Memberships:
British Dental Association
British Association of Study of Community Dentistry
Faculty of Public Health
Higher Education Academy
Socialist Health Association
North Kelvin Community Councillor

Work in relation to recovery of NHS Dentistry Services:

During the earlier stages of the COVID-19 pandemic led Public Health Scotland COVID-19 surveillance in dental settings [**1,2**]. In the 35 weeks to April 2021, dental teams across NHS Scotland were involved in delivering over 10,000 tests to asymptomatic COVID-19 screened patients – contributing to public health response to the pandemic.

Since summer 2021, led the COVID-19 Recovery Dental Analysis project funded by Public Health Scotland, involving a partnership of research academics from University of Glasgow Dental School, University of the West of Scotland, and Public Health Scotland dental analysis team. This on-going work focuses on assessing the impact of COVID-19 on population oral health and dental services (and associated health inequalities). The project outputs intend to monitor and inform Health Boards and Scottish Government on the trajectory of recovery from the pandemic.

Written submission

This report on recovery of NHS dentistry services is submitted ahead of the evidence session on 15th June 2023 which is focusing on the following issues. The report will cover each in turn.

1. Implementation of funding to improve ventilation and other equipment available to

practices delivering NHS dentistry services;

2. The extent to which NHS dentistry services have recovered to pre-pandemic levels since the NHS Recovery Plan was published; and

3. How access to services is being targeted and monitored in communities that experience health inequalities.

1. Implementation of funding to improve ventilation and other equipment available to practices delivering NHS dentistry services

This is beyond my area of expertise and the role/remit of Public Health Scotland. NHS National Services Scotland was responsible for implementation and monitoring of this funding.

2. The extent to which NHS dentistry services have recovered to pre-pandemic levels since the NHS Recovery Plan was published

Response to this section covers information on child and adult oral health, on national oral health improvement programmes, and on NHS dental services in both primary care (General Dental Services / Public Dental Service) and secondary care (Hospital Dental Services). Data sources are fully referenced and largely produced by Public Health Scotland Dental Team and by the University of Glasgow / Public Health Scotland COVID-19 Recovery Dental Analytical project. These outputs have included contributions to the National Dental Inspection Programme reports [**3**], regular (quarterly) publications of primary care dental treatments [**4**], alongside provision of monthly Dental Recovery Indicators management data directly to Health Boards (which monitors primary care and hospital dental services and oral health improvement programmes).

2.1 Population oral health - children

The National Dental Inspection Programme monitors the oral health of children in Scotland for Health Boards and at the national level every year. Public Health Scotland supports NDIP through analysis and publishing the annual reports [**3**].

Usually, each year, two school year groups are involved: i) at entry into Local Authority schools in Primary 1 and ii) in Primary 7 before the move to secondary education. The Inspection Programme has two levels: a Basic Inspection (intended for all Primary 1 and Primary 7 children) and a Detailed Inspection (where a representative sample of either the Primary 1 or the Primary 7 age-group is inspected in alternate years). Due to the pandemic, NDIP did not take place in the school year 2020-21. In the year 2021-22, the programme continued to be impacted by the COVID-19 public health measures, including access to schools and the transfer of dental staff to other duties e.g., the COVID-19 Vaccination Programme. Due to the COVID-19 public health measures that were in place until January 2022, it was agreed that dental staff would only undertake a Basic Primary 1 inspection. The public health measures impacted principally on the numbers of children able to be seen as part of the Basic inspection, with one NHS Health Board (NHS Western Isles) unable to inspect any children, five Health Boards were unable to see all their

Primary 1 children. Despite the limitations approximately 76% of all Primary 1 children were seen compared to around 88% during a normal year. The report's main findings were:

- 73.1% of the Primary 1 children inspected in 2021-22, were estimated to have no obvious decay experience. This compares with 73.5% of Primary 1 children that displayed no obvious decay experience in the pre-pandemic NDIP Report of 2019-20.
- The proportion of children estimated to have severe decay or abscess increased from 6.6% in 2020 to 9.7% in 2021-22.
- Inequalities remain, with 58.4% of Primary 1 children estimated to have no obvious decay experience in the most deprived areas (SIMD 1), compared with 85.8% in the least deprived areas (SIMD 5) in 2021-22. These inequalities are similar to those reported in the pre-pandemic report levels reported of 58.1% in SIMD 1 and 86.9% in SIMD 5.

The reasons behind the stalling in improvement of population child oral health are not yet understood. There had been year on year improvement previously observed prior to the pandemic, where the levels of dental caries (decay) in Primary 1 children reduced by 20 percentage points from 2005-06 to 2019-20 and for Primary 7 children the level reduced by 30 percentage points from 2004-05 to 2018-19. These improvements have been previously attributed to the Childsmile – national child oral health improvement programme for Scotland, which was also impacted by the pandemic (see Section 2.3).

2.2 Population oral health - adults

The purpose of the Scottish Health Survey is to provide national level information about the health of the Scottish population and the association of risk behaviours with health. The survey was conducted first in 1995, repeated in 1998 and 2003, and since 2008 has been conducted annually. Due to the disruption caused by the COVID-19 pandemic the data collected in the 2020 survey (undertaken via the telephone) was published as experimental statistics and is not included in survey trend analysis [**5**].

The survey comprises: a set of core questions and measurements; and varying modules of questions relating to specific conditions and risk factors. For example, the topics covered in the 2019 survey included general health, cardiovascular disease, diabetes, mental health and wellbeing, dental health / service, alcohol, smoking, diet / obesity, and physical activity.

Face-to-face interviews in the survey consist of Computer Assisted Interviewing (CAI) and self-completed paper questionnaires. Survey data are weighted prior to analysis to account for non-response and for the different selection probabilities of individuals and addresses. The weights are designed so that the weighted age/sex profile of the survey sample matches the mid-year household population estimates.

Key findings in relation to adult dental/oral health trends in recent years are that: the proportion of the population with no natural teeth (edentulous) was 8% in 2017 reducing to 4% in 2021; with the corresponding proportion of the population having

20 or more natural teeth increasing from 76% to 81%. Relative inequalities have remained relatively stable over the same period for edentulous levels: 15% among those from the most deprived areas (Scottish Index of Multiple Deprivation SIMD-1) and 3% in those from the least deprived areas (SIMD-5) in 2017; and 10% in SIMD-1 and 2% in SIMD-5 by 2021 (although the absolute difference in population edentulous levels in SIMD 1 and 5 reduced). There were no obvious changes over the pandemic years 2020-21 in levels of numbers of natural teeth. Survey respondents reporting toothache in the last month had remained relatively stable over the period 2017 to 2021 (12% and 13% respectively).

2.3 Oral health improvement programmes - Children

Childsmile – the national oral health improvement programme for Scotland is a multicomponent preventive programme operating at upstream (policy), midstream (community) and downstream (clinical) levels. It follows a proportionate universal approach—delivering both universal interventions to all children and additional targeted interventions focused on children predicted to be at higher risk of dental caries from the most socioeconomically deprived backgrounds, with the twin aims of improving child oral health and reducing associated inequalities in the population [**6**]. Childsmile's main focus has been on preschool children (aged up to 5 years). The four main interventions of the programme for this age group are: 1) dental health support worker (DHSW) home and community support (targeted from birth to children and their parents/carers in greatest need as identified by health visitors, for prevention advice, to help facilitate attendance in primary care dental practice, and to link families with community assets); 2) nursery (kindergarten) fluoride varnish applications (FVAs) (targeted to children from the age of 3 years from the more deprived communities, applied twice per year by extended duty dental nurses); 3) primary care dental practice visits (available from birth for all children attending where toothbrushing instruction, diet advice and FVAs are offered); and 4) nursery-supervised toothbrushing (universal to all preschool establishments in Scotland, including daily toothbrushing with fluoride toothpaste and distribution of toothbrush/toothpaste packs for home use). Following piloting, these interventions were collectively rolled out nationally from 2010/2011.

A comprehensive monitoring and evaluation programme for Childsmile funded by Scottish Government, led by University of Glasgow Dental School and in partnership with Public Health Scotland and University of Dundee Health Informatic Centre (along with NHS Health Boards) has shown that the key successes of Childsmile have been related to the long-term sustainability of the programme (across many Scottish Government administrations since 2005), and with improvements in child oral health between 2005 and pre-pandemic found to be strongly associated with the universal supervised toothbrushing programme in nurseries which had also delivered considerable NHS cost savings related to reduced treatment costs [**7,8,9,10**]. Prior to the pandemic, persistent inequalities in child oral health were recognised as an ongoing challenge for the programme [**7,11**].

Due to the pandemic, the Childsmile programme was paused in the school year 2020-21 and was only partially restarted in the school year 2021-22. The impact of COVID-19 on the Childsmile programme was regularly monitored by the number of Childsmile toothbrushing monitoring nursery visits and the number of nurseries

participating in fluoride varnishing across Scotland. It is important to note that the number of Childsmile toothbrushing monitoring nursery visits do not indicate whether supervised daily toothbrushing is happening in nurseries (this will be known at the end of the school year), however, it does give an indication of the routine Childsmile programme monitoring activities both pre- and since the pandemic started.

The monthly median percentage of nurseries visited for toothbrushing monitoring for the three-month period to Feb 2023 the monthly median was 70% of pre-pandemic (year to Feb 2020) monthly median (13.7% - recent; 19.5% pre-pandemic).

The monthly median percentage of nurseries visited for fluoride varnishing for the three-month period to Feb 2023 is 81% of pre-pandemic monthly median (34.3% - recent; 42.1% pre-pandemic). Currently, there are efforts to ensure this component of the programme is more targeted to children from the most deprived communities.

2.4 Oral health improvement programme – older adults and other vulnerable groups

Caring for Smiles is the national oral health improvement programme for dependent older adults. Local NHS Board oral health teams train staff in care homes to support older people with their daily oral care. Other health and social care staff are also offered training in a variety of settings, including care at home services and hospitals. Care homes closed to external visitors in March 2020 so the in-person elements of the programme were paused, although oral health staff still continued to support care homes remotely. Training activity has been monitored quarterly over this period and has slowly recovered to pre-pandemic levels (with the number health and social care staff trained being n=1595 in Oct - Dec 2022, and n=898 in Jan-Mar 2020, with n=1096 trained for the entire period Apr 2020 - Dec 2021). [Note - the staff trained may include health & social care staff from a range of settings including, but not limited to, care homes for older adults, care homes for younger adults, care at home, hospitals and colleges (e.g. nursing students)].

There are other national adult oral health improvement programmes, targeted at prisoners (Mouth Matters), people experiencing homelessness (Smile4life) and adults with additional care needs (Open Wide). These programmes are more recently established (from 2014/15 and 2019 for Open Wide), and their activity (including training) on a national basis has not previously been formally monitored or reported (even prior to the pandemic). However, anecdotal feedback from oral health teams indicated that in-person training and support was paused during the pandemic and has only slowly recovered. The Scottish Government has recently established an Oral Health Improvement Leadership Group and it is expected that monitoring of activity will become more formal and structured in future.

2.5 NHS Primary care dental services

Most of the population in Scotland access routine dental care through the primary care setting of the NHS General Dental Service (GDS). The majority of GDS is provided by independent contractor dentists ("High Street dentists") who have arrangements with NHS Boards to provide GDS.

The Public Dental Service (PDS) provides access to primary NHS dental care for patients who cannot obtain treatment from a general dental practice. This includes vulnerable patients such as those living in care homes, people with learning disabilities and those who may have complex needs.

Primary Care Dental Episodes of Care. Primary care dental episodes of care relate to claims are submitted by NHS dentists (in both the GDS and PDS) for activity monitoring or to claim payment for all dental treatments and associated fees, such as examinations, fillings, tooth extractions, root canal treatments, etc. Each claim may cover at least a single appointment or multiple appointments depending on the treatment provided.

For the following calculations of the impact on the changes in NHS dental service activity, the calculated median value is used for comparison between the 13 pre-pandemic months (January 2019 to January 2020) and the most recent three-month period in the pandemic (December 2021 to February 2022). The use of median month activity in these periods was considered a better measure of the average level of activity during each period than comparing activity in individual calendar months (e.g. January 2022 with January 2020).

Episodes of Care (claims)
The number of claims paid in the quarter ending March 2023 was 964,449; 70.0% of the pre-pandemic quarterly median (1,377,973).

Episodes of Care by GDS and PDS:

General Dental Service
The monthly median number of GDS episodes of care in the most recent three-month period to Feb 2023 was 69% of the pre-pandemic monthly median for children (71,486 - recent; 103,311 - pre-pandemic) and 64% for adults (231,711 - recent; 362,833 - pre-pandemic).

Public Dental Services
The monthly median number of PDS episodes of care in the most recent three-month period to Feb 2023 is 69% of the pre-pandemic monthly median for children (3,344 - recent; 4,826 - pre-pandemic) and 94% for adults (10,820 - recent; 11,567 - pre-pandemic).

Numbers of dentists claiming NHS activity in primary care in Scotland
The numbers of named dentists claiming NHS activity in primary care in Scotland reduced from 3,393 in financial year 2019/20; 3,272 in year 2020/21, 3,230 in year 2021/22, and 3,203 in 2022/23 (a drop of 190 over the period). Note these numbers include orthodontists, but exclude claims that were not allocated to a named individual often used by the PDS (e.g. Emergency Dental).

Selected treatments delivered in GDS and PDS
For the following calculations of the impact on the changes in NHS dental service activity, the calculated median value is used for comparison between the 4 pre-pandemic quarters (QE March 2019 to QE December 2019) and the most recent quarter (QE March 2023).

Extractions
The number of extractions paid in the quarter ending March 2023 was 138,112; 99.6% of the pre-pandemic quarterly median (138,632).

Fillings
The number of fillings paid in the quarter ending March 2023 was 412,915; 80.0% of the pre-pandemic quarterly median (516,099).

Root Canals
The number of root canals paid in the quarter ending March 2023 was 20,176; 70.5% of the pre-pandemic quarterly median (28,604).

Scale & Polish
The number of scale & polish' paid in the quarter ending March 2023 was 344,686; 59.8% of the pre-pandemic quarterly median (576,420).

Radiographs (x-rays)
The number of radiographs paid in the quarter ending March 2023 was 566,568; 98.7% of the pre-pandemic quarterly median (574,304).

Hospital Dental Service
Elective admission to hospital for dental extraction under general anaesthetic (due to gross dental decay / dental abscess) is the most common reason children are admitted to hospital in Scotland – both pre- and post-pandemic. The number of children attending (SMR01 acute inpatient and day cases) for dental extraction in the quarter ending March 2023 was 1,358; 70.5% of the pre-pandemic quarterly median (1,926), and this is reflected in growing waiting times data.

3. How access to services is being targeted and monitored in communities that experience health inequalities.

Public Health Scotland / University of Glasgow Dental School through the COVID-19 Recovery Dental Analysis project has been monitoring and analysing inequalities in access to primary care dental services in Scotland over the pandemic – through routine dental service publications – dental registration and participation report with data to September 2022 [**12**], regular (quarterly) publications of primary care dental treatments [**4**], producing a COVID-19 dental service and population oral annual report with data to February 2022 [**13**], and a peer-review publication with detailed inequalities analysis with data to May 2022 (in the British Dental Journal – *In Press*) [**14**]. Additionally, Health Board and Scotland-level management monthly Dental Recovery Indicators (covering the range of dental services) were produced and shared with Health Boards and Scottish Government.

Dental registration and participation [**12**]
Registration is defined as any patient registered with a practicing NHS dentist (GDS and PDS). Participation is defined as any patient registered with an NHS dentist who had contact with NHS Primary Care Dentistry for examination or treatment in the two years prior to the snapshot date. The latest publication shows registration and

participation activity data for the latest snapshot date (30 September 2022) and for long term trends.

Due to the anticipated risks of transmission associated with receiving dental care, during the first lockdown period in Scotland, all National Health Service dental practices were not able to see patients on their premises. Across Scotland over seventy Urgent Dental Care Centres (UDCCs) were established for the provision of emergency dental treatment.

The remobilisation of primary care NHS dental services was undertaken in several time periods, as follows:
● From 20 May 2020: Capacity in UDCCs was increased, and provision expanded to include patients with acute and essential oral health care needs.
● From 22 June 2020: All dental practices reopened for face-to-face consultation with patients requiring urgent dental care treatments that could be provided using non-aerosol generating procedures (AGPs).
● From 13 July 2020: Dentists were able to see patients for the full range of routine non-AGP dental care. From 17 August 2020, aerosol associated treatments were permitted for urgent dental care only.
● From 1 November 2020: Practices were able to provide the full range of NHS treatments to all patients in need of both urgent and non-urgent care. Dentists were also able to provide domiciliary care.
● From 1 April 2022: Dentists were allowed to de-escalate their infection prevention and control measures in line with national guidance to alleviate system pressures and allow an increase in patient throughput.

Inequalities in access to dental care
A key measure of access to dental services among children is dental registration levels. The inequality gap in dental registrations between children from the most and least deprived areas of 13% in 2010, which had reduced to 3% by 2022. This is a positive improvement in overall access to primary care dental services for children.

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

There is limited evidence as to the reasons behind these inequalities and they are likely multifactorial with socioeconomic, behavioural, and service factors contributing. Both registration from an early age and participation for children are important for receiving Childsmile prevention interventions and preventing dental disease. As the Childsmile programme fully remobilises following the pandemic these trends could potentially improve.

COVID-19 Annual Report 2022 [**13**]
Inequalities in access to NHS primary dental care across Scotland to Feb 2022 have been assessed and published previously. This was undertaken using the monthly median percentage of the population who had contact with primary care NHS dental

services (regardless of registration status), by SIMD quintile, then comparing the pre-pandemic period with the three-month period to Feb2022. Changes in inequalities were further examined between the most recent three months and pre-pandemic periods by calculating the absolute (slope index of inequality – SII) and relative (relative inequality index – RII) inequality metrics and comparing these metrics over the two periods.

At the population level, inequalities in access to NHS primary dental care were evident prior to the pandemic. In the month of January 2019, 10.2% of those living in the least deprived areas (SIMD 5) had contact with primary care NHS dental services compared to 8.1% in the most deprived areas (SIMD 1).

The average Slope Index of Inequality (SII) in the most recent three-month period was 59.7% of the SII in the pre-pandemic period (SII 15.95 - recent; SII 26.7 – pre-pandemic), indicating a reduction in absolute inequalities, which would be expected due to the reduced levels of activity across all SIMD quintiles. However, the Relative Index of Inequality (RII) is 27.6% higher in the most recent three-month period compared to the pre-pandemic period (RII 0.37 - recent; RII 0.29 - pre-pandemic), indicating an increasing of relative inequalities. Therefore, while there has been a reduced number of patients seen overall, as dental services recover there has been an increase in inequalities (relative to the already existing pre-pandemic inequalities), with those from the most deprived areas (SIMD 1) less likely to have contact with a primary care NHS dentist than those from the least deprived areas (SIMD 5).

Peer-review publication [**14**]
Introduction: This study aimed to quantify the impact of the COVID-19 pandemic on access and inequalities in primary care dental services among children and adults in Scotland.

Methods: Access was measured as any NHS Scotland primary care dental contacts derived from administrative data from January 2019 to May 2022, linked to the area-based Scottish Index of Multiple Deprivation (SIMD) for children and adults, and related to population denominator estimates from National Record Scotland. Inequalities for pre-pandemic (January 2019 – January 2020) and recent (December 2021 – February 2022 and March 2022 – May 2022) periods for both children and adults were calculated and compared using the slope index of inequality (SII) and relative index of inequality (RII).

Results: Following the first lockdown (March 2020) there was a dramatic fall to near zero dental contacts, followed by a slow recovery to 64.8% of pre-pandemic levels by May 2022. There was initial widening of relative inequalities in dental contacts in early 2022, which, more recently, had begun to return to pre-pandemic levels.

Conclusion: COVID-19 had a major impact on access to NHS primary dental care, and while inequalities in access are apparent as services recover from lockdown, these inequalities are not a new phenomenon

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NHS Borders 25 May 2023

Dear Mr Fairlie

Recovery of NHS Dentistry Services

Thank you for your letter dated 27 April 2023 regarding the above. On behalf of NHS Borders, I can respond to your specific questions as below:

1. In line with the following Primary Care Administration (PCA) memoranda issued from Scottish Government;
   - PCA(D)(2021)3 – Ventilation allowance payment
   - PCA(D)(2022)4 – Dental sustainability
   - PCA(D)(2022)5 – Dental equipment repairs
   - PCA(D)(2022)6 – Improvement allowance

   NHS Borders received the following COVID-related funding from the Scottish Government:
   - Ventilation improvements – £106,308
   - Variable speed drilling equipment - £159,462
   - Equipment – not a separate allocation, we were to use underspend from above.

2. Within NHS Borders area, we have a total of 19 independent General Dental Services (GDS), 1 being an Orthodontic referral practice, all offering mixed NHS and private care. The uptake of the above funding locally was:
   - Ventilation improvements – 8 applications from 8 practices, paying out a total of £23,207.25.
   - Variable speed drilling equipment – 7 applications from 7 practices, paying out a total of £40,754.62.
   - Equipment – 5 applications from 5 practices, paying out a total of £24,244.14. This was a total of 11 different practices (some practices applied for more than one funding stream).

   The remaining funding of £177,563.99 was transferred to the Public Dental Services budget and is being used to purchase replacement dental chairs.

3. Since the onset of the COVID-19 pandemic, I can advise that within the NHS Borders area:
   - 0 (0%) practices have withdrawn completely from NHS provision to patients;
   - 18 (100%) practices have reduced their delivery of NHS dental care;
   - NHS Borders GDS monthly activity levels have levelled at approximately 80% of pre– pandemic levels .

   The reasons for this reduction in capacity are not uniform and do not necessarily reflect a decision to reduce commitment to NHS dentistry. 14 (78%) practices have a limited workforce and recruitment to vacant posts has had limited, or in some instances, no success.

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

   We have seen a steady increase in the numbers of patients being referred for domiciliary care. The PDS is currently the main provider for delivering domiciliary dental care to those people resident in a care home or those unable to leave their own home. In Borders we have no enhanced domiciliary care GDS practitioners who actively perform domiciliary care, therefore with the population who are likely to require domiciliary dentistry increasing – the reliance on the PDS will only increase.

   Additionally there has been an increase in patients being referred/accessing care for dental need as part of pre-- oncology/cardiology care etc. as they are unable to access care within a GDS setting.

   The mainstay of delivery of NHS dental services for priority group patients, such as people with a disability and those who are homeless, is the PDS. NHSB PDS has a large, registered cohort of patients who would be suitable for care with NHS GDS “high street setting”. This has impacted on our ability as PDS to focus on our core remit of those patients who are unsuitable or unable to access care with GDS (even if access was available). The further reduction in GDS provision means that there is little scope for suitable NHS patients being transferred to independent dental contractors (Scottish Government’s preferred provider of NHS GDS care).

   Unscheduled care – through the dental dashboard the number of unregistered patients is closely monitored. In light of the current and changing GDS situation, as a PDS we have taken significant steps to revise what data we collect and monitor, which allows use to ensure our provision of unscheduled care is adequate, current and changing for the population need. The situation in GDS may change rapidly and the PDS has to remain agile in response to a potential sudden increase in the need for unregistered unscheduled care (as evidenced in adjacent health boards.)

5. As at 31 March 2023, NHS Borders currently has 13,700 patients registered with the Public Dental Service. This figure has reduced slightly since 31 March 2020, which was 14,902 patients, with patients transferring out with PDS or are now deceased.
   We have not been registering routine GDS adults and children since 2020. We still register those select patients who clearly meet a core PDS remit and are unable to attend for routine GDS care “on the high street”. This situation is continually under review and may change with developments across the board.

   Experience shows that, should the PDS register all patients, whist having

neither the funding nor the workforce to deliver appropriate care, this merely disguises that access is an issue and negatively impacts on efforts to successfully develop a successful independent sector.

6. Whilst primary care dentistry delivered by practitioners in independent GDS represents the largest volume of dental care provided in Borders, this does not occur in isolation. The preventative programmes, especially the hugely successful Childsmile project, and other services (PDS, secondary and tertiary care) all work in partnership with colleagues in independent GDS. We rely heavily on consultant led services in NHS Lothian for those who are in need of the most complex care (Restorative Dentistry and Oral Medicine).

   The following are in regards to additional funds only. NHS Borders received funding to support the work of the Childsmile team as follows:

   For 2022/2023 and 2023/2024, the Scottish Government allocated funding to support the expansion of the Childsmile Community and Practice Programme to reach out to vulnerable families and address inequalities on oral health and access to dental support.

   - £32,100 was allocated for the recruitment of 1 WTE Dental Health Support Worker.
   - £5,300 allocated to support increased distribution of oral health packs, via childminders, and wider routes to vulnerable families - ongoing programme to widen points of access to oral health packs.

   All of the above were, of course, welcomed and gladly received. Our feedback would be in two regards. Firstly, the one-off nature of the allocation, which could be argued as running contrary to national long-term oral health improvement projects. Secondly, in times of such challenge to recruitment, vacancies supported by non-recurring funding have not proved attractive.

With Best Wishes

Yours sincerely

Ralph Roberts
Chief Executive

NHS Shetland 26 May 2023

Dear Mr Fairlie

Thank you for your enquiry. Please find below the responses from NHS Shetland

1. How much COVID-related funding did you receive from the Scottish Government to fund the following measures:

- **Ventilation improvements**
- **Equipment**
- **Variable speed drilling equipment**

Reply:

In line with the following Primary Care Administration (PCA) memoranda issued from Scottish Government:

PCA(D)(2021)3 – Ventilation allowance payment

PCA(D)(2022)4 – Dental sustainability

PCA(D)(2022)5 – Dental equipment repairs

PCA(D)(2022)6 – Improvement allowance

(All available here: https://www.scottishdental.org/), NHS Shetland distributed funds to local independent General Dental Service (GDS) practices as follows:

Measure	**Received**
Ventilation	Zero
Sustainability	Zero
Dental equipment repairs	Zero
Improvement allowance	Zero

Shetland NHS Board is the common name of Shetland Health Board

2. What was the uptake (percentage or number of practices; and amount paid out) of the above funding by General Dentist Service (GDS) dentists?

Reply:

Shetland has one independent NHS GDS practice, offering mixed NHS and private care.

NHS Shetland received no application for funding as detailed above from that practice;

	Number of practices	Amount paid out
Ventilation	1	Zero
Sustainability	1	Zero
Improvement	1	Zero

3. How many practices in your health board area have withdrawn or reduced NHS provision for patients – for example, registering and treating only children:

- **No. and % withdrawn completely**
- **No. and % reduced provision**

Reply:

- Since the onset of the COVID-19 pandemic, the sole NHS independent GDS practices have not withdrawn from the delivery of NHS dental care.
- Since the onset of the COVID-19 pandemic, the sole NHS GDS independent practice (n = 1, 100%) independent GDS practices has reduced their delivery of NHS dental care.
- The reasons for this reduction in capacity are no clear. Whilst it has been affected by a reduction in workforce, it would appear that this has been due to a conscious decision to reduce commitment to NHS dentistry.
- Once the GDS dentist workforce returned to and then exceeded pre-COVID numbers, there was no corresponding increase in NHS activity to compare to the Pre-COVID baseline; average NHS activity for 2022-23 was 46% of pre-COVID baseline

4. What impact, if any, has a reduction in NHS GDS provision had on the Public Dental Service?

Reply:

The Public Dental Service (PDS) in Shetland is, unable to recruit despite having a reduced service in real-terms (see below re *Budget – Reduction in Real Terms*).

This, and the increased demand for the delivery of urgent care to those not able to access the independent sector are impacting negatively on the staff in post (burn out) and the ability of the service to deliver care to other priority groups.

Data from Public Health Scotland (PHS) shows that an increased proportion of claims sent to

Practitioner Services are for occasional treatment (a proxy for emergency care)

Currently, NHS Shetland Public Dental Service is operating at a reduced service - non-routine, high-priority, emergency only care. PDS Specialist services are being maintained alongside this when and where possible.

A return to a comprehensive service not expected without a fundamental review of how dental service provision on Shetland is delivered and funded.

Independent General Dental Service (GDS) Provision

The situation with the only GDS practice within NHS Shetland is precarious. As of 31 Jan 2023, the practice has 3.0 WTE dentists working. In addition, the NHS activity of these dentists is currently at 36% of pre-COVID NHS activity (Feb Pd Mar). The highest activity level since March 2020 has been 54% of baseline pre-COVID activity. The average NHS GDS activity for 2022-23 was 46% of pre-COVID baseline

These ongoing matters with regards patient access and care within the GDS on Shetland, consequently, the pressure on NHS Shetland Public Dental Service will be heightened.

Workforce

There has been a marked decrease in the number of dentists in both the PDS and GDS sector providing NHS care.

The GDS practice has not operated to full capacity (4.0 WTE) since early 2019

The PDS WTE workforce in 2016 was **11.0**. In July 2022 this had decreased to **8.3**

The current PDS WTE workforce for 2022/23 (as per budget) – **5.3** dentists (1.0 WTE is currently out for recruitment)

This lack of sustainable workforce with the expiration of short term contracts has opened a wider gap in resources, resulting in increasing unmet need in Shetland.

The following figures are based on dentists currently providing routine NHS care in Shetland;

Dentist Numbers	**WTE**
PDS Historically	8.3
PDS Current (allowed by budget)	5.3 (currently 4.3)
GDS Current	3.0 (currently 36% pre-COVID activity)
Total PDS & GDS Current (actual)	7.3
Required (to meet national average ratio)	**15.1**
Difference (including GDS)	**6.8**
Difference (excluding GDS)	**9.8**

Budget – Real Terms Reduction

At the end of FY 21-22, Shetland Dental Service's budget was at break-even point. However by the end of Q1 FY 22-23, if the service was to maintained at the same level as 2021-22, the forecast was for a 200k overspend.

The main reason for this predicted deficit is non central funding for the AfC pay rise for dental staff of at a cost of £198,787. This reason aligned to past years with dental funding not being included in NHS Shetland's baseline funding increases.

Therefore the dental service has had to subsume any salary increases within the existing budget rather than receiving additional central funding to offset this increase, which is the case for all other services within NHS Shetland. A tipping point has been reached where the increase pay costs cannot be subsumed in a standstill budget.

Due to active savings and workforce positons remaining vacant, the dental budget is now forecast as breaking even for 2022-23.

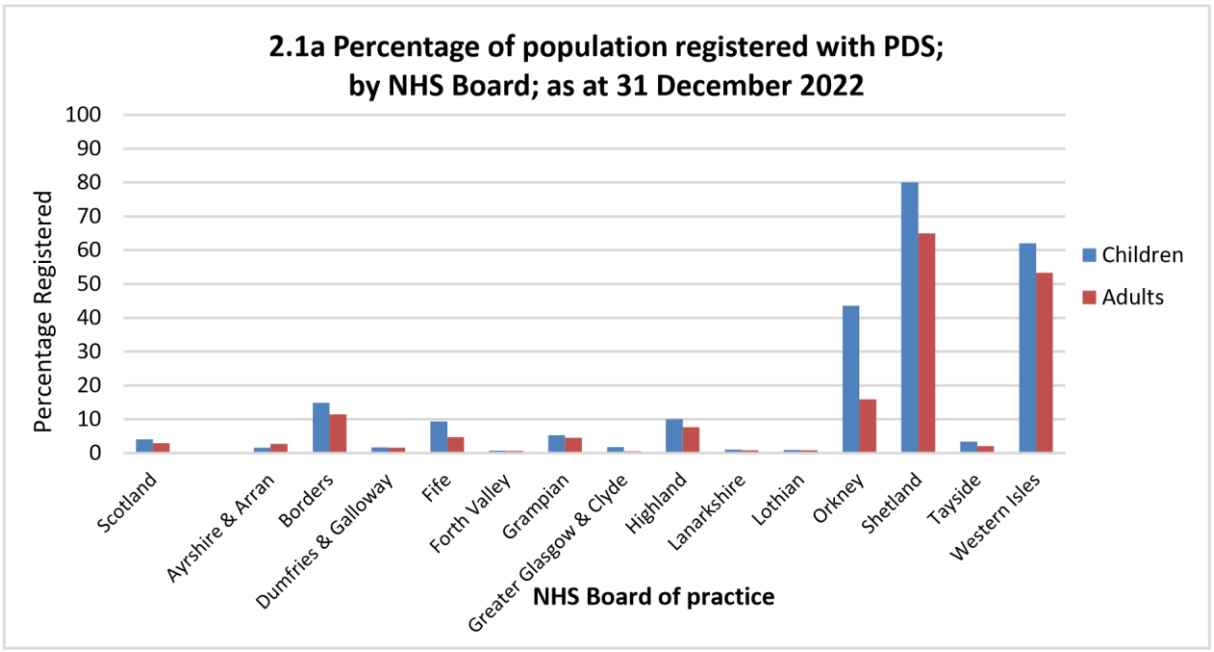
Consequently, without any additional funding, there is currently a reduction in the service (by 3.0 WTE) to 5.3 WTE (currently 4.3 WTE in post); a reduction of 36%-52%. In July 2022, NHS Shetland dental service has also lost a Dental Therapist, reducing this capacity from 2.0 WTE to 1.0 WTE.

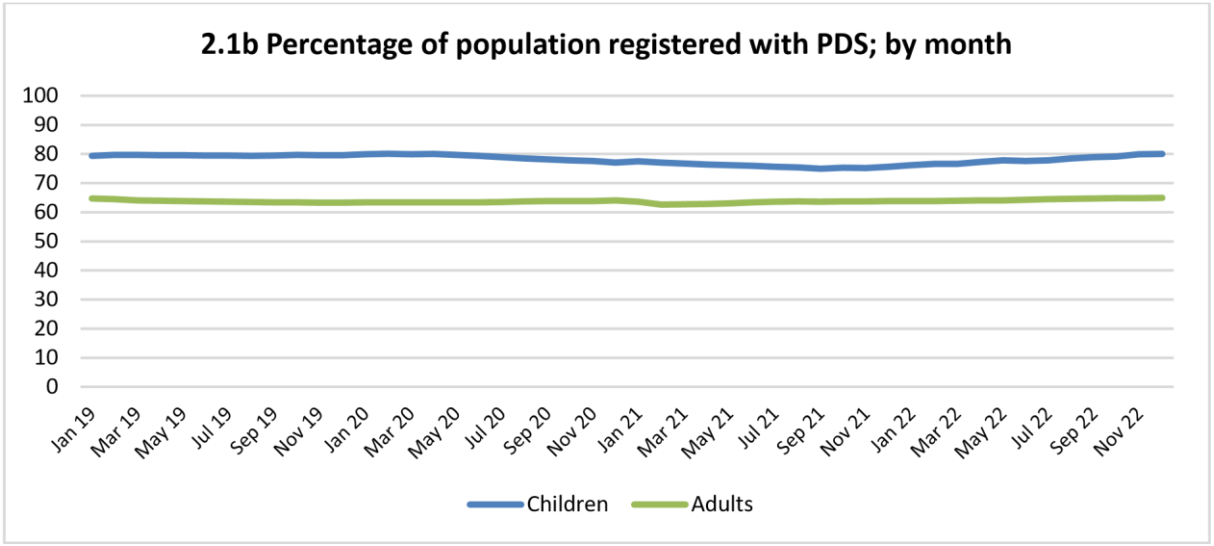
Without this matter being addressed, the budget will continually be insufficient for the needs and a real-terms reduction of the service will continue.

5. How many patients are registered with the PDS in your Health Board area? Has the number risen since 2020? If so by how much?

Reply:

Data from Public Health Scotland (PHS) indicates that the numbers registered with the PDS in Shetland are showing no discernible change.





The PDS in Shetland is under direct instruction from the Director of Dentistry to register only those that would fit a non-access PDS remit.

Historically, the PDS registered all patients. The opening of a new NHS SDAI supported practice in 2016/17 has not impacted the service delivery on Shetland as hoped.

Concurrently, the PDS is not funded or structured in a way that is able to cope with the registrations and the patient demographic that the service is being asked to care for. These registration figures merely disguises the fact that that access is an issue. On Shetland, we have a PDS that is primarily propping up a failing GDS independent sector, whist having neither the funding nor the workforce to deliver appropriate care, this.

Recently, a new island model has been proposed to CDO/SG in order to re-focus NHS

dental provision for Shetland to a comprehensive, self-determined and sustainable Health Board delivered service for the whole community

Amended Approach

It has been clearly demonstrated that the PDS/GDS model found in larger, mainland Health Board areas (80:20 patient registration split) does not work in remote and rural areas, especially Island communities, where the GDS is not established and robust. Without an established GDS, Shetland is at a significant disadvantage of being at the behest of the limited independent contractors, their business decisions and their fortunes.

For NHS Shetland, it is recommended that a return to the pre-2006, directly Board managed combined service, would provide sustainability and self-determination of the dental service for the Shetland population. It is also recommended that this approach is pursued regardless of any service provided in the GDS.

Proposed 3-Phase Approach - Summary	
Phase 1 Immediate	Return to Pre-COVID level of service from NHS Shetland PDS.
	Additional **3.3 WTE** dentists in NHS Shetland PDS
	Increase in Budget - **£ 306,751**
Phase 2 1-3 Years	Establish the foundations of a comprehensive, self-determined and sustainable Health Board delivered service for the whole community
	Additional **6.8 WTE** dentists in NHS Shetland PDS
	Increase in Budget - **£ 1,006,400**
Phase 3 3 Years +	To **consolidate, enhance** and **expand** NHS Shetland PDS provision for long term sustainability and resilience
	Plan to integrate the services provided in Lerwick to complement the three other NHS Shetland dental sites, to fit with Oral Health Strategy 2023-2027 and to integrate the service into the planning and development of the new hospital facilities being planned at present
	Additional **3.0 WTE** dentists in NHS Shetland PDS
	Increase in Budget - **£ 444,000**

6. What other funding do you receive to support dentistry in your Health Board area (for example, funding related to PDS, Childsmile and any initiatives to improve recovery of services and access to dentistry for your population)?

Reply:

The following are in regard to additional funds only. NHS Shetland received funding to support the work of the Childsmile team and for Winter Preparedness funding

However, as this funding was allocated on the basis of NRAC, insufficient amounts were received to make any meaning and long term difference. No new posts could be funded as, for example, the increased funding did not reached the threshold of an additional salary. Consequently, this funding could not be used as intended

Furthermore, due to the baseline budget issues (see reply to 5.), any increased funding received by NHS Shetland was required to off-set the overspend and did not get the opportunity to be used as intended

All of the above were, of course, welcome and gladly received. Our feedback/concerns are three-fold;

1. the one-off nature of the allocation, contrary to national long-term oral health improvement projects.

2. in times of such challenge to recruitment, vacancies supported by non-recurring funding have not proved attractive.

3. to allocate funding solely on the basis of NRAC does not allow a critical level of funding to be reached in areas of small population sizes. Therefore, the funding allocated was ineffectual for the intended purpose

Yours sincerely,

Antony M. Visocchi

Director of Dentistry, NHS Shetland

NHS Shetland - Dental Service SBAR

Review and Realignment of Dental Service Provision in Shetland

24 February 2023

Situation
This paper is to provide an explanation of the current situation with regards NHS Shetland Dental Service and that, without a fundamental review and additional funding, there will be a continued reduction of dental service provision for the population of Shetland in real terms.

Currently, NHS Shetland Dental Service is operating at a reduced service - non-routine, high priority, emergency only care. PDS Specialist services are being maintained alongside this when and where possible.

A return to a comprehensive service not expected without a fundamental review of how dental service provision on Shetland is delivered and funded.

This is also required to align to the NHS Scotland 2023/24 Annual Delivery Plan and 2023/26 Medium Term Plan;

Drivers for Recovery 1	Primary & Community Care Improve access to primary and community care to enable earlier intervention and more care to be delivered in the community
1.6 Increase capacity for providing in-hours routine and urgent dental care for unregistered and deregistered dental patients. Response should include quarterly trajectories for at least 2023/24.	

Background
In Shetland at present, the is an inadequate GDS independent sector which means that the, the PDS is being overly relied upon to provide NHS care for;

- Historically Registered Patients (GDS patients but registered in PDS)
- PDS Services (PDS Criteria Priority Groups)
- Enhanced/Secondary Care Services
- Access for Unregistered Patients

The PDS undertaking far more GDS work that the service is currently resourced for. NHS patient registrations are as follows;

NHS Shetland Territory population	22,920
Registered NHS Patients across NHS Shetland territory	22,695 = 99%

NHS Registration (NHS Shetland PDS)	15,594 = 68%
NHS Registration (GDS independent practices)	7,101 = 31%

However, registration does not equate to access

To date, the approach has been to endeavour to replicate the model of dental service deliver on mainland board areas (approx. 80% GDS; 20% PDS). This has involved pursuing a larger
GDS, most notably but the opening of an SDAI grant practice to address unmet need, in 2016 The following figures are based on dentists currently providing routine NHS care in Shetland;

Area	Dentist:Patient Ratios
GDS in Shetland	1:2,367
PDS in Shetland	1:3,626
Overall Average in Shetland	1:3,109
National Average	1:1,513

In order for the community of Shetland to access dental care to the same level as the national average, it can be clearly seen that there needs to be a more than doubling of current dental workforce.

These figures representing a significant increase in the inequality of patients living in a remote and rural/Island community accessing NHS dental care.

Assessment

Independent General Dental Service (GDS) Provision

The situation with the only GDS practice within NHS Shetland is precarious. As of 31 Jan 2023, the practice has 3.0 WTE dentists working. In addition, the NHS activity of these dentists is currently at 36% of pre-COVID NHS activity (Feb Pd Mar). The highest activity level since March 2020 has been 54% of baseline pre-COVID activity

These ongoing matters with regards patient access and care within the GDS on Shetland, consequently, the pressure on NHS Shetland Public Dental Service will be heightened.

Workforce

There has been a marked decrease in the number of dentists in both the PDS and GDS sector providing NHS care.

The GDS practice has not operated to full capacity (4.0 WTE) since early 2019

The PDS WTE workforce in 2016 was **11.0**. In July 2022 this had decreased to **8.3**

The current PDS WTE workforce for 2022/23 (as per budget) – **5.3** dentists (1.0 WTE is currently out for recruitment)

This lack of sustainable workforce with the expiration of short term contracts has opened a wider gap in resources, resulting in increasing unmet need in Shetland.

The following figures are based on dentists currently providing routine NHS care in Shetland;

Dentist Numbers	WTE
PDS Historically	8.3
PDS Current (allowed by budget)	5.3 (currently 4.3)
GDS Current	3.0 (currently 36% pre-COVID activity)
Total PDS & GDS Current (actual)	7.3
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Budget – Real Terms Reduction

At the end of FY 21-22, Shetland Dental Service's budget was at break-even point. However by the end of Q1 FY 22-23, if the service was to maintained at the same level as 2021-22, the forecast was for a 200k overspend.

The main reason for this predicted deficit is non central funding for the AfC pay rise for dental staff of at a cost of £198,787. This reason aligned to past years with dental funding not being included in NHS Shetland's baseline funding increases.

Therefore the dental service has had to subsume any salary increases within the existing budget rather than receiving additional central funding to offset this increase, which is the case for all other services within NHS Shetland. A tipping point has been reached where the increase pay costs cannot be subsumed in a standstill budget.

Due to active savings and workforce positons remaining vacant, the dental budget is now forecast as breaking even for 2022-23.

Consequently, without any additional funding, there is currently a reduction in the service (by 3.0 WTE) to 5.3 WTE (currently 4.3 WTE in post); a reduction of 36%-52%. In July 2022, NHS Shetland dental service has also lost a Dental Therapist, reducing this capacity from 2.0 WTE to 1.0 WTE.

Without this matter being addressed, the budget will continually be insufficient for the needs and a real-terms reduction of the service will continue.

Budget Proposal

In order for the dental service provided by NHS Shetland to be maintained at the 2021-22 level, additional funding is being sought. The immediate additional funding has been calculated by looking at the under-funding, undertaking a WTE assessment and

allowing for increased costs.

It has also been requested that the outcome of this review is that future funding is **recurring, is index linked to any future salary uplifts and for the dental service to be included in future NHS Board annual funding increases**. Failure to secure this increased baseline funding as recurring, will result in our service being faced with the same deficit every 1-2 years.

Reduced Income Generation

Pre-COVID, we have been reliant upon this to provide part of NHS Shetland Dental Service overall funding stream.

However, patient changes were abandoned during the first 12 months of COVID. When they were reinstated, so little work was possible, that very little patient charges were generated. Of the income that was and is still being generated, only small items of treatment are able to be completed (due to the pressures on the service) and therefore only small fees are being taken into the service.

This has amounted to a reduction in revenue of £93,769.00 from 2021/22 and 2022/23.

The continued provision of non-rotuine, emergency-only and access care within NHS Shetland PDS is effectively also limiting the ability of the service to increase income generation

Recommendations

Mission Statement:
To re-focus NHS dental provision for Shetland to a comprehensive, self-determined and sustainable Health Board delivered service for the whole community

Amended Approach

The Community Dental Service (CDS) and Salaried General Dental Service (SGDS) were predecessors of the organisation of the Public Dental Service, introduced in 2006.

The CDS had two key roles;

- The provision of dental care for those individuals unable to obtain care through the general dental services (GDS); normally the most vulnerable members of our community
- dental public health - dental inspections and epidemiology of school children delivery of oral health promotion and clinical preventive programmes to groups with poor oral health

The SGDS had the same role as GDS independent contractors in that they saw the same patient groups for routine care. SGDS was introduced in order to fill a gap an independent contractor provision (normally in remote and rural areas).

SGDS dentists were remunerated on a salary basis and managed by the NHS board alongside

CDS

It has been clearly demonstrated that the PDS/GDS model found in larger, mainland Health Board areas (80:20 patient registration split) does not work in remote and rural areas, especially Island communities, where the GDS is not established and robust. Without an established GDS, Shetland is at a significant disadvantage of being at the behest of the limited independent contractors, their business decisions and their fortunes.

For NHS Shetland, it is recommended that a return to the pre-2006, directly Board managed combined service, would provide sustainability and self-determination of the dental service for the Shetland population. It is also recommended that this approach is pursued regardless of any service provided in the GDS.

Proposed 3-Phase Approach - Summary	
Phase 1 Immediate	Return to Pre-COVID level of service from NHS Shetland PDS.
	Additional **3.3 WTE** dentists in NHS Shetland PDS
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	Additional **6.8 WTE** dentists in NHS Shetland PDS
	Increase in Budget - **£ 1,006,400**
Phase 3 3 Years +	To **consolidate, enhance** and **expand** NHS Shetland PDS provision for long term sustainability and resilience
	Plan to integrate the services provided in Lerwick to complement the three other NHS Shetland dental sites, to fit with Oral Health Strategy 2023-2027 and to integrate the service into the planning and development of the new hospital facilities being planned at present
	Additional **3.0 WTE** dentists in NHS Shetland PDS
	Increase in Budget - **£ 444,000**

<u>3 Phase Plan - Staged Funding Increase</u>

- Total additional funding requirement – **£1,757,151** (over 0-3+ years)
- 'Drawdown' of additional funding as and when required
- Funding that is then drawn down is then added to the baseline recurring funding
- Indirect funding through NES for On-Island Training
- Indirect funding through NES for Student Outreach

<u>Additional One-Off Funding Sources</u>

- Recovery of SDAI Grant Moneys
- Re-basing exercise to re-direct the unspent GDS money (currently at 36% of preCOVID activity) in Shetland to the PDS Budget

3 Phase Plan – Details

Phase 1
Immediate

Objectives

- Restoration of PDS Service to Pre -COVID levels - 8.3 WTE Dentists
- Review and support change in focus of overall dental service delivery on Shetland for the long term i.e. Board Delivered Service being the fundamental/predominate route of delivery
- Maintain Level of Enhanced Services on Island (oral surgery, orthodontics, special needs, restorative dentistry)
- Maintain SG Screening and Prevention Programmes and build on their successes (Childsmile, NDIP, Carin g for Smiles)
- Increase Level of Enhanced Services on Island

Requirements

- Additional 3.3 WTE dentists in NHS Shetland PDS
- Increase in Budget - £ 306,751
  (immediate adjustment of baseline, recurring and index linked)

Establishment of an NHS Shetland Dental Training Budget

- To provide PDS Dental Officer posts in Shetland a USP (level the playing field with mainland posts)
- To encourage dentists to stay by supporting career progression (professionally and financially)
- Possible Direct arrangem ent with Education Establishment and SG
- Only paid as and when required ("draw -down" arrangement)
- Maximum agreed training budget yearly
- £25,000 -£30,000 per annum per trainee (training, travel and accommodation)
- Partially provided as 'indirect' funding thr ough NES (course fees)
- Separate from the main funding agreement
- Applied for by NHS Shetland employee and approved in line with service needs

Phase 2
1-3 Years

Objectives

- Increase Level of Enhanced Services on Island
- Increased Dental Care Professionals (DCPs) delivery of routine care (e.g. Orthodontic Therapist training on Island)
- Establishing a Clinical Dental Technician service (cost reduction and increased revenue source)
- Increase upskilling of existing workforce
- Visiting specialist services; maintain, expand, facilitate on Island enhanced practitioner training
- Improve training facilities (new graduates, DCPs and undergraduate students) to allow an element of the service to be a training base (to partially address recruitment and retention)

Additional Initiatives

- Establish permanent undergraduate outreach (this will require indirect funding via NES)
- Rolling 3/12 Locum positions – offering 'sabbaticals' to others
- 2023 Woodside Model
- Vocational Dental Practitioners – Applied for Aug 2023
- Core Trainees
- Rotational Posts with Other HBs
- Joint SDO posts with NHS Shetland & NHS Orkney
- NHS Shetland Dental Bursaries – initial discussions with local firms undertaken

Requirements

- Additional 6.8 WTE dentists in NHS Shetland PDS
- Increase in Budget - £ 1,006,400
  (As 'drawn-down', to be added to baseline, recurring and index linked)

Phase 3
3 Years and Beyond

Objectives

- To consolidate, enhance and expand NHS Shetland PDS provision for long term sustainability and resilience
- Visiting specialist services; maintain, expand, facilitate on Island enhanced practitioner training
- Improve training facilities (new graduates, DCPs and undergraduate students) to allow an element of the service to be a training base
- Consolidation of Lerwick based NHS Shetland PDS to one location in order to effectively deliver the desired outcomes
- To fit with Oral Health Strategy 2023 -2027 and to integrate the service into the planning and development of the new hospital facilities being planned at present

Consolidated Lerwick Requirements (New Gilbert Bain Hospital)

- 8-10 Dental Surgeries (including IHS facility)
- 1-2 Oral Hygiene Education Rooms
- 1 x 2-chair Open-Plan Clinic (with divider) for OMFS out-patients, GA/sedation assessments, student outreach clinics/supervision
- Triage Area
- Local Decontamination Unit
- Instrument Storage
- Integral Extra-Oral Radiography Area
- 'Soft' Room for SN
- Dental Lab
- Patient Waiting Room
- Separate Waiting Area for Special Needs
- Small meeting room for staff, patients and parents /guardians
- Reception Area
- Toilets
- Staff
- Facilities
- Office Space (total of 12 users)
  (Capital Funding from NHS Shetland)

Requirements

- Additional 3.0 WTE dentists in NHS Shetland PDS
- Increase in Budget - £ 444,000
  (As 'drawn-down', to be added to baseline, recurring and index linked)

NHS Tayside 31 May 2023

Recovery of NHS Dentistry Services

Declan Gilmore, Director of Dentistry for Tayside will attend to give stakeholder evidence on behalf of NHS Tayside.
The following information has been requested by the Committee:

1. **How much COVID-related funding did you receive from the Scottish Government to fund the following measures:**
    - **Ventilation improvements**
    - **Equipment**
    - **Variable speed drilling equipment**

In line with the following Primary Care Administration (PCA) memoranda issued from Scottish Government: PCA(D)(2021)3 – Ventilation allowance payment, PCA(D)(2022)5 – Dental equipment repairs and PCA(D)(2022)6 – Improvement allowance, NHS Tayside distributed its £855,000 total allocation to local independent General Dental Service (GDS) practices as follows:

Total Allocation = £855,000	
Ventilation	£332,000
Variable speed drills	£523,000
Improvement allowance/equipment repair	Remainder of unspent funds

Allocation was £855,000, composing of £332,000 for ventilation and £523,000 for Handpieces. The Board was then allowed to permit spend of any leftover funding on equipment repair/replacement.

2. **What was the uptake (percentage or number of practices; and amount paid out) of the above funding by General Dentist Service (GDS) dentists?**

	Number of practices	Amount paid out
Ventilation	Taken up by 41/74 practices or 55.4%	£137,544.68
Variable speed drills	Taken up by 31/74 practices or 41.9%	£174,763.42
Improvement allowance	Taken up by 40/74 practices or 54%	£244,725.45

3. **How many practices in your health board area have withdrawn or reduced NHS provision for patients – for example, registering and treating only children:**
   Number and % withdrawn completely and number and % reduced provision

Tayside status:

- There have been no (0%) complete withdrawals from NHS dentistry.
- There have been 2 practice closures since then (Hillbank and {My} Dentist Fintry)

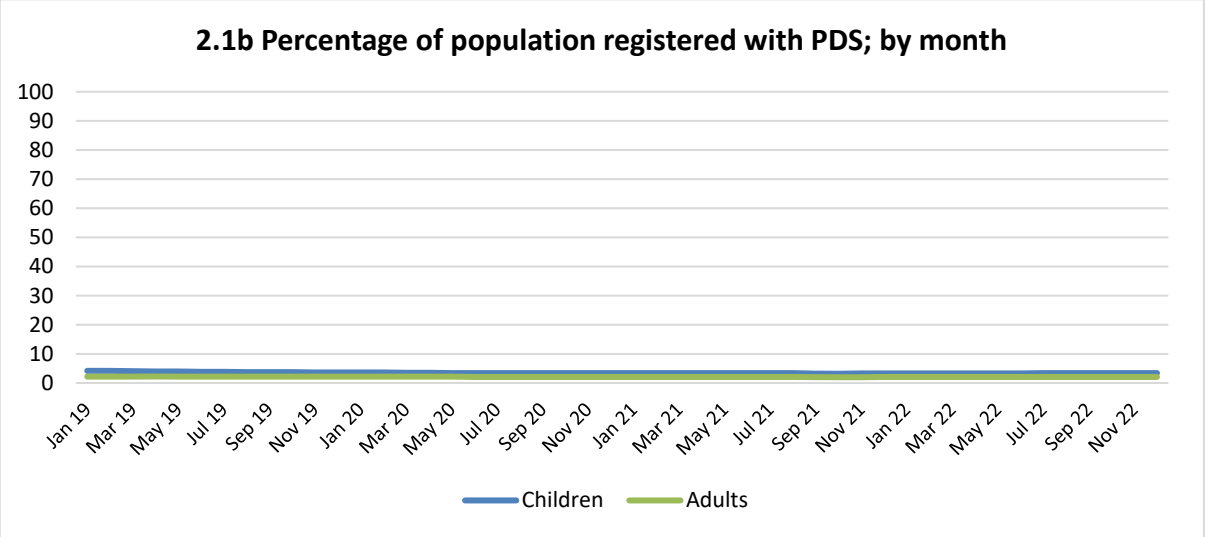
- There have been 2 practices (or 2.7% of the then 74) convert to seeing children only on the NHS.
- There is also 1 practice currently transitioning to seeing children only (this will translate to 4% of the current 72 practices in Tayside).
- Of 72 practices 36 are working at 90% or below their pre-Covid activity levels.

4. What impact, if any, has a reduction in NHS GDS provision had on the Public Dental Service?

The increased demand for the delivery of urgent care to those not able to access the independent sector are impacting negatively on the staff in post and the ability of the service to deliver care to other priority groups.
There is an increased demand responding to calls from unregistered and deregistered patients.
Extra demand is placed within the clinical setting as PDS clinicians provide urgent dental care thus reducing the time available to provide care for their core remit patients.
Data from Public Health Scotland (PHS) shows that an increased proportion of claims sent to Practitioner Services are for occasional treatment (a proxy for emergency care).

5. How many patients are registered with the PDS in your Health Board area? Has the number risen since 2020? If so by how much?

Data from Public health Scotland (PHS) indicates that the numbers registered with the PDS are showing only minor changes.



Year	2019	2020	2021	2022	2023
PDS registration numbers for Tayside	10,610	9,995	9,632	9,357	9,919

The PDS in Tayside is under direct instruction from the Director of Dentistry to register only those that would fit a non-access PDS remit.
PDS have neither the funding nor workforce to register GDS patients.

Previous experience indicates that this negatively impacts on the development of a successful delivery of general dental services within the independent sector.

6. **What other funding do you receive to support dentistry in your Health Board area (for example, funding related to PDS, Childsmile and any initiatives to improve recovery of services and access to dentistry for your population)?**

£99,500 received for Childsmile Expansion Funding a one-off non-recurring payment. SDAI Funding - this has just been awarded to certain areas within Tayside Health Board and measuring any positive impact on access to NHS dental care within GDS will take some time.