OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 22 June 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 22 June 2023

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COVID-19 RECOVERY COMMITTEE
14th Meeting 2023, Session 6

CONVENER

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

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab) (Committee Substitute)
Dr Atif Bashir (Scottish Dental Practice Owners)
David McColl (British Dental Association)
Douglas Thain (Scottish Dental Association)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 22 June 2023

[The Convener opened the meeting at 09:33]

Recovery of NHS Dental Services

The Convener (Jim Fairlie): Good morning, and welcome to the 14th meeting in 2023 of the COVID-19 Recovery Committee. Alex Rowley has sent his apologies, and I welcome Jackie Baillie, who is attending as his substitute—good morning, Jackie.

We continue our inquiry into the recovery of national health service dental services. I welcome to the meeting David McColl, chair of the British Dental Association's Scottish dental practice committee; Douglas Thain, chair of the Scottish Dental Association; and Dr Atif Bashir, chair of Scottish Dental Practice Owners. Thank you for giving up your time to join us this morning, and for your written submissions.

We estimate that the session will run until 10.30 am, and each member will have approximately 10 or 11 minutes to speak to the panel and ask their questions. I am keen to ensure that everyone gets an opportunity to speak, so I apologise in advance if have to interrupt members or witnesses in the interests of brevity.

I will now turn to questions, and I hand over to Murdo Fraser, our deputy convener.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning, gentlemen, and thank you for joining us. I will start by asking you to say briefly who you are and perhaps to explain to me the difference between the British Dental Association's Scottish dental practice committee and the Scottish Dental Association.

Dr Atif Bashir (Scottish Dental Practice Owners): I will speak about the Scottish Dental Practice Owners group. We represent the practice owners—the owners of the facilities through which NHS dentistry is delivered to the people of Scotland. The only criterion to be a member is that you need to be a practice owner. You may or may not be a dentist—you may be a nurse or a therapist—but you have to be a practice owner.

David, would you like to explain what the BDA is?

David McColl (British Dental Association): My background is that I am in my 37th year of working in an NHS practice in Govanhill in Glasgow. I am a member of the BDA, which has a committee called the Scottish dental practice committee, whose members are elected from all areas in Scotland. We represent all non-salaried general dental practitioners. The Scottish Government has a legal obligation to negotiate on items pertaining to the funding of NHS dentistry with the Scottish dental practice committee.

Douglas Thain (Scottish Dental Association): My background is that I am a dentist working in Cumbernauld—I have been a practice owner there for just over 20 years. The Scottish Dental Association was born out of the pandemic. Some dentists are not BDA members, for various reasons, so we thought that there was a gap in the market to represent their interests. We have therefore spent the past few years creating the SDA. We are a work in progress. We have 800 to 900 members at the moment, but the organisation is in its early days.

Murdo Fraser: So you are not splitters.

Douglas Thain: No.

Murdo Fraser: I am just trying to work out what the relationship is between the three of you.

Douglas Thain: I think that dentists were quite apolitical until the crunch came. Maybe there is now scope for us all to band together at some stage, but we are forward looking, rather than a splinter group.

Dr Bashir: For your information, Mr Fraser, not every dentist or dental care professional in Scotland is a member of the BDA. The pandemic was difficult for everybody. We are trying to best represent ourselves so that we can best support the people of Scotland.

Murdo Fraser: I just wanted to understand where everybody is, so that has been helpful.

Moving on to the substance of the inquiry, we are interested in looking at the impact that Covid has had on dental services across Scotland. The BDA's written submission contains a striking statistic. It states:

> "Dentistry has lost over half (52%) of its capacity since lockdown".

My first question is for Mr McColl. How long will it take us to get back to where we were, if we ever do, and what needs to happen to ensure that we do?

David McColl: There are many facets to answering that. It hinges on reform, which is what we need. Before the Covid pandemic, the system of delivery was unfit for purpose. If Covid showed anything, it was that the current system is broken. We need proper root-and-branch reform. We need to move away from an item-of-service delivery model, because it is not fit for 2023 healthcare delivery. That is where we need to be. We have a

real recruitment and retention problem, because the NHS is not seen as an attractive place to work. We cannot recruit dentists, let alone any other staff, to work in NHS practices.

Murdo Fraser: I am sorry to interrupt, but are you talking specifically about NHS practices as opposed to private practices?

David McColl: Yes.

Murdo Fraser: So there is not a recruitment issue in private practice.

David McColl: No, absolutely not. We have spoken to students who know, even as they go through university, that they do not want to work in the NHS. Therefore, the reform that we are looking for is not just payment reform; it must be holistic, complete root-and-branch reform, because we need to attract people to work in the NHS as a career.

Murdo Fraser: Witnesses should not feel that they need to repeat what other people have said, but if anyone has anything to add, please come in.

Douglas Thain: The split between the NHS and private practice is infinitely variable. Our practice is largely NHS based, all our patients are NHS registered and 80-odd per cent of the treatment that we do is on the NHS. Other practices can have fully NHS-registered patients who opt for the majority of their treatment to be done on a private basis. Other practices will have some NHS patients and some fully private patients.

The recruitment issue is most acute for practices that do more work at the NHS end of the spectrum. We have lost two associates to fully private practices over the past two years. You cannot say to young dentists who want to work in a private practice where they will see 10 to 15 patients a day for a sensible level of remuneration, "Please stay and see 40 patients a day on this crazy treadmill, because it's better for you," because it is not. Until that situation changes and people want to work in our practice, as they have done for the past 20 years, the recruitment issue at the NHS end of the spectrum will remain as bad as it is, if not worse.

Murdo Fraser: You have raised interesting points. Our committee is looking specifically at the impact of Covid, so I am interested in the extent to which that situation has happened because of Covid, or was it happening anyway?

Douglas Thain: In 2018-19, I found that I had had about as much as I could tolerate of working in the NHS, but there was no real change in sight. There was no real body of dentists that seemed interested in pushing for reform. Covid gave everyone a chance to reflect.

In the early stages of Covid, there was a brief panic across the profession as no one really knew whether we were going to be supported or how things would pan out. We closed the practice up in March 2020, and then the health board wanted to use the practice as a hub for Covid-positive patients. We had no idea where we were going from there. Social media took over and, before you knew it, hundreds of thousands of dentists were crying out for a body to support them and for leadership.

That was really where the problem came from. Initially, there was no drive to get reform in the NHS, and other more practically minded people realised that moving towards a more private way of operating was the way to go, and we went from almost zero activity to rebooting the service. For a lot of people, the private side has just taken off from there, as a way to serve patients and as a way to make their own lives better in a way that they probably had not previously had the chance to do.

As David said, there had been unhappiness for a long time, but I do not think that anybody thought that there was a chance to change things. Covid gave us that chance. There was a brief hope that reform could happen, but we seem to have lost that window now, and we are back on the treadmill. Stopping everything again for a second time and moving to a third system in as many years would not be easy for anyone. Many people have jumped ship and it would be very difficult to persuade them to get back on board.

Dr Bashir: The question was how the pandemic has affected NHS recovery. Here is the thing: dentists in Scotland are delivering a low-fee service, but that is not the important bit, because what we need to understand—what is important—is that we are delivering a high-volume, low-fee disease-centred model to the Scottish public. That is the vehicle through which we operate. Going into the pandemic—into lockdown—Scottish patients were not dentally fit enough as a consequence of the delivery model that we were utilising. When the pandemic happened and we had lockdown for two years, that resulted in a bigger backlog of treatment. Instead of changing what we do, we have simply gone back to using the same high-volume disease-centred model to try to fix the backlog. That is a very dated model.

09:45

As Doug Thain said, we have been working on the high-volume treadmill for many years. That is stressful for dentists and the support staff. However, that is not the important thing; the important thing is that it traumatises the patients.

If high-volume dentistry is delivered, it is invasive, and it creates anxiety for the people of Scotland. It traumatises them. People were anxious about going to the dentist before lockdown, and then they could not go for two years. They started to worry. They thought, "I haven't been for two years. I've got all these problems that are happening. My teeth are breaking," and so on. That gave them even more anxiety. Then they could not get appointments to see the dentist. Some people have just stepped away and they do not access the service at all. We are seeing that happen more. Some people try to access the service, but they cannot do so, which is really bad. It is really bad for the Scottish people.

The size of the backlog is related to the type of delivery that we had. It will take more than two years to get rid of the backlog. Things will—wrongly so—be more difficult for practices that have more NHS commitment or more NHS patients than for practices that have private patients. That is not a good situation for the people of Scotland.

Murdo Fraser: I am sorry, convener, but can I pursue that?

The Convener: Definitely.

Murdo Fraser: There are a lot more questions that I want to ask. On your last point specifically, Dr Bashir, you said that it would take more than two years to get rid of the backlog. I am interested in getting the perspectives of David McColl and Douglas Thain on that. I think that David took a much more pessimistic view on whether we will get rid of the backlog at all.

David McColl: The patients whom we are currently seeing are in great need of treatment and they are not people who come in for just a couple of visits. It will take a long time to see them.

We are probably all the same. The first check-up appointment will probably be around three months away. Seeing someone for a check-up is okay, but they will need an appointment for treatment. We need to work flexibly, and the system that we are working in does not allow us to do that, and it does not allow us to skill mix in the practice. Not everyone needs to see a dentist. We have therapists, hygienists and trained dental care professionals who could do some of that work. However, the system that we are working in does not allow that. We need significant reform to try to get through that.

Murdo Fraser: Finally, will we clear the backlog without reform?

David McColl: No.

Dr Bashir: No.

Murdo Fraser: Is that the view of all of you?

Douglas Thain: Essentially, that is the situation. Yesterday, I saw a 14-year-old girl as a new patient. It is quite rare to see a new patient. She needs a couple of fillings. The next available appointment is four months away, and an appointment following that will probably be another couple of months after that. We will be remunerated for the time that we spent doing her examination when the course of treatment is completed five or six months from now, and her situation will, unfortunately, get worse over the intervening months. The treatment may well end up being more complex, and it will be even longer before we see any remuneration for the work that we have done.

That goes right back to when the treatment multiplier was 1.7. When we started the treatment, we were offered that rate. However, the multiplier has dropped down to 1.1 so, by the time that the course of treatment is completed, we will be paid less than we originally thought that we would be. There has been a big window in which we have committed time, manpower and materials and received nothing whatsoever in compensation. While that has happened, patients have not been seen for three years, and their registration fee has dropped off from £1.20 a month to 12p a month or thereabouts.

The continuing care payments, which make up about half of the practice income, have dropped off a cliff. That drop was suspended for the first couple of years of Covid, but it is now active again. One of our associates was off on maternity leave. Her income from that has more than halved since she went on maternity leave.

Again, that is the baseline figure on which the practice allowance is calculated. It is a compound loss of income while we are still working hard and treating more anxious patients, with greater needs, for less return—it is almost as though the more that you do, the worse off you get. It is an impossible situation and recovering the backlog will never happen while we are in it.

The Convener: Okay. Gentlemen, I am sorry; I am really conscious of time. I will move on. Jackie, do you want to pick up where we were on staffing?

Jackie Baillie (Dumbarton) (Lab): I will pursue some of the issues that Murdo started off with, relating them specifically to staffing. Douglas Thain, you referred to NHS dentistry being a "treadmill". Will you unpack that point a little so that people understand it?

Douglas Thain: Yes. As I probably touched on, it is a case of our working at pace and not being able to slow down. We have lots of patients with needs, who have to be seen within a realistic timeframe. While we are busy doing that, it is

impossible to step aside, reform and do something better.

For example, tomorrow, I will go in to the practice to see patients with toothache. The bulk of them will not have been in the practice in the past three or four years, which means that we have had a monthly commitment of 12p from them for registration. I will be taking teeth out for £16 a tooth; we will be taking the pulps out of teeth to start root treatments—again, for which no fees will be payable until the course of treatment is completed months down the line. That will take care of a very small percentage of our 20,000 patients who have not seen us for a long time. We are also doing that work with fewer dentists than previously because the smart ones have jumped ship; they do not have the obligation that the practice owners are left with. A young dentist getting into the profession will be in a similar situation before they know it. It is akin to a treadmill in that you fall off the back when you slow down and it is hard to get back on again.

Jackie Baillie: That is helpful. Thank you.

The BDA did a survey that suggested that 59 per cent of dentists have reduced their NHS commitment and that that figure is likely to increase, and that 34 per cent were either retiring or leaving to start a new career. David McColl, can you rehearse for us why people are leaving and why dentists are reducing their NHS commitments?

David McColl: They are simply not seeing the NHS as an attractive place in which to work. That is the big problem. Students tell me that they do not want to work in the NHS. That is really disturbing, because we need an NHS dental service to survive.

The Scottish Government supported NHS dental practices really well during Covid. We need to move on from that, but that support needs to continue. As I have said, it is not just about payment reform; the NHS needs to be made an attractive place to work. Private practice is a very attractive place in which to work, because people in private practice can set their own fees and spend more time with their patients. During Covid, we effectively had a fully funded, capitated model that was not predicated on doing little bits of work for little fees, which is high-volume, low-margin work. Dentists and teams liked that. We could spend time with our patients. We need to get back to that. Patients deserve to have time spent with them.

As Atif Bashir said, we are in a disease-management process. However, we cannot actually manage disease—we are treating disease. We need to invest in prevention. That work does not need to be done specifically by dentists; it needs to be done by the dental team. We have a whole team that can deliver that. However, we need to get the Government to buy into prevention.

Jackie Baillie: Okay. Let me come back to you on one small point; I will then take us on to prevention. You did not mention training at all. Are there sufficient training places in Scotland, but the destination of the trainees is the private sector rather than the NHS?

David McColl: Correct. There is no point in training more dentists who do not want to work in the NHS.

Jackie Baillie: Sure. I just needed to understand that point so that we are clear about it.

You seemed to suggest that the model that is currently in place with the statement of dental remuneration for treatments and materials clearly disincentivises people from going into NHS dentistry because, as Douglas Thain and you have described, the activity is not matched by the sheer pace of payment. How would you change that to a prevention model?

David McColl: My view is that we need to have a fully capitated model, along the lines of general medical practice, for us to deploy our teams. At the moment, the only person who can produce any funding for the practice is the dentist, so the dentist has to be on the treadmill, as Douglas Thain says. That is not the way to run any clinic. In 2023, we need to move on from that. High-volume, low-margin healthcare does not work.

Dr Bashir: It is important that we get this one point across to you. We all care about the NHS dental service. We all believe in it, and we all want it to thrive. We have worked for many years to make the system work. However, increasingly, as David McColl said, younger dentists see the flaws in the system, which is a low-fee, high-volume, disease-centred model. I have to keep coming back to that phrase: it is a disease-centred model, not a model in which we try to prevent things from happening. We need to move to a more modern approach, which is a preventative model—that is, a model that prevents disease.

We should not insist on measuring how many treatments dentists are doing because, if dentists are engaged in treatment activity, that is not good. We should actually be measuring the reverse. However, in Scotland, we are wedded to that delivery model. The reason for that is that the system that was established was ahead of its time. We were brave when we created the NHS, which was something that no other part of the world had. However, unfortunately, dentistry has delivered the same model for more than 70 years, and that model is closer to being an antique than it is to being modern. Because of that, you cannot blame

the younger dentists for not wanting to go into it. It actually scares them, because they think that, if they go into NHS dentistry, they will have to do high-volume dentistry, which goes against everything that they are taught at university. The reason why they do not go into it is not to do with the money; it is to do with the type of delivery that it involves. That is why they step away from it. We absolutely need to change that.

When Professor Conway spoke to you last week, he addressed that issue. The childsmile programme is brilliant, and we should be proud of it. The £2 million that was spent on prevention resulted in £5 million of treatment savings. That should be our model.

Jackie Baillie: Thanks. Other people will ask you about childsmile. I will just say that I share your view of it.

I want to turn to the issue of dental corporates operating in the United Kingdom, some of which are now operating in Scotland. What impact do you think that that has on NHS dental services?

Dr Bashir: Corporates are increasingly coming into the market. I am not sure whether that is good or bad—it remains to be seen. Because of the challenges of trying to deliver the NHS dental service, many practice owners are selling their practices. In the main, those practices are being bought by corporates. However, the problem with that is that, once the corporate has taken over the practice, it faces the fact that there is a shortage of dentists, which means that it cannot deliver. That is not a good thing.

Do I personally think that it would be good to have corporate dentistry delivering the service in Scotland? No, I do not. I think that it is much better to have individually owned practices that are headed up by a principal dentist who controls the delivery. I think that people get a much better level of service through that model. However, what is happening is that corporates are coming in. We have communicated to the chief dental officer that there is a trend towards corporates taking over dental practices in Scotland. We do not think that that is good. If we want to turn that tide, we need to make some big reforms.

10:00

Jackie Baillie: I literally have seconds in which to finish my questioning. I wonder whether Douglas Thain or David McColl has anything to add. I will throw one final question into the mix, because the convener will not let me back in. Should the Government collect and publish information on the NHS commitment of each dentist or each practice so that we can get a more realistic picture of GDS coverage in Scotland?

Douglas Thain: I am not entirely sure about that, because there is a bit of a danger that it could become a witch hunt for dentists who do more private work than NHS work—not that I have anything to fear on that front.

As far as corporates are concerned, the big difference is that they are businesses. I am sure that they will fulfil their contractual obligation to the letter but, spiritually, they offer nothing more. We have already seen Bupa offload practices that do not make it any money.

Corporates are there to make money. We are there to provide an NHS service. Ultimately, the provision will all end up being corporate, because independent people like me simply cannot afford to bankroll a very non-profitable business over the short to medium term while waiting for reform to come out at the other end. The corporates can afford to buy the practices and fund the short-term shortfalls. If the NHS system is good, they win. If the NHS system is bad, they go private and they still win. The owner-operators like me stand to lose all round, unless we sell to corporates, which is not necessarily what we want to do for ourselves, our staff or our patients.

David McColl: On your question about NHS commitment, it depends on how you measure NHS commitment. Currently, NHS commitment is measured using a financial model. For example, an implant might cost £2,000. A practice would have to do hundreds of NHS check-ups to get the same measurement. You would need to be careful about how you measured NHS commitment.

Jackie Baillie: I thank the three of you very much.

The Convener: We move on to theme 2, which is barriers to recovery. Brian Whittle will ask about those.

Brian Whittle (South Scotland) (Con): Good morning, gentlemen. You have answered quite a lot of the questions that I was going to ask. What is really worrying, especially on the preventative side of things, is the inequality in the service, which we heard about last week, and how that affects Scottish index of multiple deprivation areas 1 and 2, as compared with the more affluent areas. What were your experiences of that during Covid? Why does there seem to be an increasing disparity?

Douglas Thain: Patients who have had the most experience of dental disease over their lives need the most maintenance and the most encouragement to maintain their oral health. Covid certainly caused them to suffer the most. I can think of plenty of examples of patients in our practice whose mouths have deteriorated terribly over the past three years, and in a way that they had not over the previous 20 years.

In addition, those people require the more complex treatments—the root treatments, the crowns and the dentures—provided on the NHS. Currently, those are the least profitable—in fact, they are the most loss-making—items of treatment to do and the most time consuming. Those people are losing out, and the dentists who treat them are finding it increasingly hard to find a way to make things work for them.

In more affluent areas, the enhanced examination fee, for example, allows practices to make a greater profit from seeing people on a regular basis. If a dentist sees a patient who needs nothing done and it is just a case of carrying out an examination and saying, "See you in six months," and they can do that all day long, it works really nicely. On the other hand, when a dentist such as me does an examination, we say, "See you in six months to continue the course of treatment," by which time we will still not have been paid for the exam. That is why the patients in more deprived areas tend to suffer more.

Dr Bashir: I go back to the same point—I am sorry that I keep going over this, but I care about the people of Scotland. We are failing them. If they need treatment, we are failing them. That is why they have a bad feeling. The people of Scotland do not have a good feeling about going to the dentist. Again, that is down to the delivery model, because every time they go, they get treatment. If a person lives in a deprived area, they will get more severe treatment, which will not make it psychologically easy for them to go. We absolutely need to change the focus of what we are doing, because we are failing the Scottish people.

David McColl: I go back to what I said before: the current system of delivery does not allow us to skill mix in the practice. In my practice, we have 12,500 registered patients, including a high number of children—we probably have more than 3,000 children registered. However, the statement of dental remuneration does not allow me to get group sessions in for childsmile delivery, which is what I would like to do. No one knows better than my practice what our patients need. The Scottish Government and the civil service team do not know that. We need autonomy to deliver that service and we cannot do that in the high-volume, low-margin model. We have therapists, hygienists, trained childsmile nurses and oral health educators who can deliver it. We can work in partnership with a childsmile nursery or a childsmile school to deliver it, but the NHS system does not allow us to do that. We need root-and-branch reform to make that work.

Brian Whittle: Just to clarify, I guess that the outcome of that is an increased number of children being referred to secondary care for extractions and the like, which is obviously more time consuming and more costly, and puts people back on the treadmill. That is the word that will stick with me from this evidence session.

This committee is called the COVID-19 Recovery Committee. You are painting a realistic, if reasonably bleak, picture of Scottish dentistry. David McColl said that we will not get out of the situation under the current system. The backlog will not be dealt with under the current system. Just for my personal understanding, I ask again: where do we need to go and what needs to happen to get us out of this situation and back on to a reasonable path?

David McColl: We need to make the NHS more attractive—it is as simple as that.

Brian Whittle: How do we do that?

David McColl: We need to encourage younger people. We need to get away from the treadmill effect. The low-volume, high-margin model does not work. Younger dentists coming in do not want to see 40 patients a day.

Brian Whittle: Is it not high volume, low margin?

David McColl: Yes—high volume, low margin.

Brian Whittle: Do not confuse me—I am easily confused.

David McColl: I say that all the time. We need to get away from that, and we need to make the system more attractive. Somebody coming into an NHS practice does not want to see 40 patients a day. We do not need to see 40 patients a day. We can recruit other members of the team who do not have to be a dentist to deliver childsmile. Unfortunately, in my practice, I have lost two therapists because they do not want to work in the NHS practice. I pay them at cost, because we need to deliver that.

I work in Govanhill in Glasgow, which is in the former First Minister's constituency. Because of the cohort of patients that we have, we are probably the highest referrer for paediatric general anaesthesia in Scotland. The current waiting list is really frustrating for me. If a four-year-old comes in who has eight decayed teeth and does not speak English as a first language, we have to refer them through a clunky Scottish care information gateway system that takes time, and for which there is no remuneration at all. The current waiting list to get that seen is something like 96 weeks. That is outrageous. That is not a new problem; it has gone on for more than a decade. We need Government ministerial intervention to do something about it.

Brian Whittle: You are describing a system that needs turned around, but it sounds a bit like trying to turn a tanker, in that it will take time and

planning to deliver. We cannot all of a sudden make NHS dentistry attractive for new dentists. It will take a lot of time.

David McColl: It needs radical change, not just tinkering about with items in an SDR.

Douglas Thain: I will add a point in relation to children's referrals for extractions. In less extreme cases where children need some teeth taken out at the age of four, five or six, with the right dentist with the right mindset, who is given enough time, it is doable in general practice. However, the fee that they get for that is so unattractive that they do not want to do it.

If you are going to have an anxious parent, an anxious child and an anxious nurse, and four patients complaining in the waiting room that you are running late, nobody wants to do it. If we were paid in a way that made doing that in general practice doable, people would do it. We have some associates in our practice who started doing that, but who have gradually realised that it is simply too much for them.

Again, it comes back to the need for something—whether or not it is a capitation-based payment model—that allows dentists the time to do what they are good at, rather than their being forced to do items of service just to generate enough money to stay open. Again, children's dentistry at the basic level should be a basic skill that we are all good at and proud to do, but it does not carry much kudos in the profession any more, which is a shame.

Dr Bashir: I will give the committee some examples of the kind of practical things that we can do in the here and now. We could take the current item-of-service model and take out the things that are not needed to secure oral health. That would make working in NHS dentistry a little bit more attractive.

Brian Whittle: I am sorry, but could you explain what you mean by taking things out that are not required?

Dr Bashir: We need to go back and ask what we want to deliver on the NHS for the people of Scotland. It is about what the Government wants to deliver. Do we want to deliver a service that secures oral health, or do we want to deliver a world-class dental service to the Scottish people that includes everything and where every dental need that a patient might have is met on the NHS?

Currently, the latter does not happen anyway. That is one of the reasons why patients have to—in my view, wrongly—step out of the NHS and access private care, because the item that they want is not available on the NHS. The system is currently deficient. I am therefore saying: okay, let us reduce it to a system that secures oral health in the first instance, using the same budget that we have, and use any surplus income to push into prevention. That is one thing that we could do.

The second thing that we could do, which would make the NHS more attractive to dentists, is change the contract. The contract is between the health board and the dentist, but we could shift from the health board to the practice owner. One of the issues that I have is that we cannot get the associates in my practice to do more NHS work. We want them to do more, but it is up to them whether they do more or whether they want to do more private. We lose that control—you lose that control.

Those are two very simple things that the Scottish Government could do to make the delivery more accessible and the model a little bit more attractive for new dentists coming into the system.

Brian Whittle: I have so many more questions, but there is no time.

The Convener: We will move on to questions from John Mason.

John Mason (Glasgow Shettleston) (SNP): I think that we are all on the same theme of reform, so I will stick to that.

I liked the bullet points in your written submission, Dr Bashir, which certainly covers a lot of ground. One of them, right towards the end, states:

"We are not asking for extra money".

However, all I am hearing so far is that this is going to cost a lot of money. If you go from seeing 40 patients a day to seeing 10, I presume that you need four times as many dentists or other staff, so there has to be a big increase in money, does there not?

Dr Bashir: Yes, if you maintain the same items of service. We work from a big menu and we have all these items of service that we can provide, but I am saying that—

John Mason: I understand that but, from the Government's point of view, it is writing a cheque and at the moment it is for items. If that changes, will the Government have to write a bigger cheque?

10:15

Dr Bashir: No, not in the short term. We need to make the system more effective for the Scottish people and more attractive for dentists to work in so that we can retain them in the NHS. Does anyone who is in the room agree that we should be delivering a high-volume disease-centred model to the Scottish people?

John Mason: The answer to that is that I am also speaking to general practitioners and you have said that you would like to have a system like the GP system, but the GPs are also unhappy. They cannot recruit staff or locums and so on and people have to stay in the hospitals. There is therefore a huge amount wrong with the GP system.

One suggestion is that the health boards should employ all the GPs, and that might be another possibility for dentists. Let us employ all the dentists. Would that work?

Dr Bashir: Yes. Anything is better than the current model, which we have been utilising for 70 years. I want to see a Scottish population that is the healthiest and smiliest in Europe—that is my vision and it should be our vision. David McColl, the BDA and the SDA have probably communicated to the Government that our proposal was to go to a more affordable—

John Mason: I want to let some of the others in, because you have said quite a lot.

Dr Bashir: Okay.

John Mason: Mr McColl, are you speaking to the Government and, if so, what is the Government saying?

David McColl: Yes, we are speaking to the Government about a blended model of delivery. NHS practice is unsustainable under the current model. It needs more money in it. The NHS budget in Scotland is £19 billion, whereas six years ago, it was £12 billion. However, that extra money has not gone proportionately into primary care, which is the problem. That is why there is a problem with GPs—we cannot recruit, because people cannot see a future down the line.

Primary care has always been a subset of healthcare. All that funding has gone into secondary care and we need to address that.

John Mason: Mr Thain, I do not know whether you are aware of what is happening in other countries, but one suggestion is that we should have a world-class health service. Where is the world-class dental service?

Douglas Thain: It is certainly not here. You talked about employing dentists. Maybe if we did that, the country would discover the true cost and what a dental budget should be if we offered a salary at the level that would attract people to being an NHS dentist and would find the sheer number of people that would be required so that employees could work at a pace that did not mean they ended up resigning or going off sick and so on. Lots of other countries have different models.

John Mason: Do we need to go to a private model?

Douglas Thain: I think that it should be a combination of a state-funded and privately funded system.

John Mason: Do we know of any country that has a completely state-funded system and very little private dental care?

Douglas Thain: Not to my knowledge. We have a state-funded system that funds comprehensive care that looked reasonable in 1990. It is a comprehensive but outdated statement of dental remuneration. The best items of service that we can provide are not on the SDR and never will be, including orthodontics, implants, preventative dentistry and children's care. None of that is done at the level of what is considered to be international best practice. Periodontal disease is another area in which the NHS item of service is miles from where it should be. We have a McDonald's budget and we are trying to provide a sit-down meal on it. It is just not working.

John Mason: Is the Government listening to you or only to the BDA or what?

Douglas Thain: No one listens to me. [*Laughter.*]

John Mason: We are listening.

Douglas Thain: The thing is, we are our own worst enemies, in some ways. We made it work as far as we could until, say, 2019 or 2020. Now, it is safe to say that, in many ways, the good will of the profession has been lost. People have lost faith that meaningful reform will come—that we can do the best for our patients. Patients are turning against practices—it is probably safe to say that for dentistry as well as healthcare. In general, we get the blame for not seeing patients. We have had letters from people who are not patients making formal complaints that we have not yet seen them. That is a new level of complaint to contend with.

John Mason: I cannot remember exactly who gave evidence to the committee last week, but it was academic people. When I suggested that we could make quite a radical change and perhaps move to something like GP practices, they said, "Oh, that's too big a jump." Is there any sense from the Government about its view on that?

Douglas Thain: When we have spoken to the chief dental officer about that in the past, he has said that the problem is that they do not know how to measure health outcomes in dentistry, whereas they can measure input. That has been the barrier. We can see exactly what dentists do, so there must be ways of measuring the output. Trust us for a few years, measure people's oral health and see whether what we have done has made things better, not worse.

John Mason: It should not be any different to how we measure GPs' output. Is it not just the same problem?

Douglas Thain: Yes, but they seem to be trusted to do what they think is best.

John Mason: Do you want to come back in, Dr Bashir?

Dr Bashir: No, I will let David McColl come in.

David McColl: We had such a system during Covid. It was along the lines of general medical practice. The civil service team did not measure it properly, and they were not proportionate in their response on the practices that were not doing enough.

Ten per cent of the members of any profession are aberrant. They sit out and they do not play the game. Nothing can be done about that. It is the same in politics, although the figure might be slightly higher than 10 per cent. That is just the way it is.

There is a measure. In a fully capitated and weighted system, if practices do not want to treat patients but will just sit there, take funding and do nothing, they will not last, because patients are not daft; they will go to another practice that will deliver the care. Self-levelling will happen. Trust us for a few years and it will level out and will allow us to deliver the care to the cohort of patients that we have.

There can be no panacea across Scotland. As Brian Whittle has said, deprivation differs between areas at level 1 or 2 and those at level 5. The same delivery model is not needed for everything.

John Mason: Do you know how much extra it cost the Government to put money into the dental service during Covid?

David McColl: That depends on how the Government costed it. It will pretend that it spent a lot of money on personal protective equipment for dentistry. It says that, in addition, it spent £150 million. The problem was that it had to cover the patient charge revenue, which is about £75 million a year. The quirk in dentistry is that people have to pay 80 per cent of the cost of their dental treatment. During Covid, that patient charge revenue of £75 million was not there so, in order to sustain NHS practices, the Government needed to fund that.

John Mason: So you got extra money and you did not see me, because I have not been to the dentist for three years.

David McColl: I did not see you, because I was busy seeing other people. [*Laughter.*]

John Mason: Right, I will leave it at that.

Stuart McMillan (Greenock and Inverclyde) (SNP): We have heard about profit and loss making. We have heard that dentistry is a business but you care about people. You have said that the problem is not new but has existed for the past decade, and that dentistry needs to be made more attractive. I have a few questions about making it attractive. First, what is the average salary for an NHS dentist, in comparison with a dentist who does private work?

David McColl: I do not have those figures. However, I can tell you that the average associate in Scotland earns less than the average associate in England, so it is not an attractive place to work. We also have higher tax in Scotland, as you know, so we cannot recruit people from England.

Douglas Thain: I must admit that I do not do enough private work to have a baseline, and I do not speak to enough dentists who are fully private to have much of an opinion on what they make.

Stuart McMillan: Okay.

David McColl: I do not think that it is so much about the revenue and salary as about terms and conditions and what people are trained to do.

Nowadays, people want their teeth to be whitened. They want composite bonding. They want their teeth to be straightened. That is where we are. I met your First Minister when he was the Cabinet Secretary for Health and Social Care, when the Government brought in free treatment for under-26s. I said that the communication on that must be key, because I did not want that argument with a patient who was coming in because they wanted straight white teeth on the NHS, and I said that that is what we would get with people under 26.

It is about conditions. We must accept that we are in this mixed market economy of what the NHS can deliver and what private treatment can deliver. We have to accept that, embrace it and realise that it has to be deliverable through NHS practices. That is the only way forward, because we cannot have a two-tier system with fully private practices and fully NHS practices. We need to accept that that mixed market economy exists.

Stuart McMillan: I asked that question because of the submissions that we have received.

John Mason touched on the issue of money a moment ago. In his submission, Dr Bashir said:

"We are not asking for extra money".

Mr McColl, in paragraph 3 of your submission, you say that we have

"a contract that is unfit for purpose, underfunded, overstretched and facing the challenge of deep and widening oral health inequalities."

Another point made by the Scottish Dental Practice Owners is that

"They are also business owners and entrepreneurs who invest in Scottish Public health."

From what I have heard today, and certainly from reading the paperwork, I do not doubt at all that the three of you and the colleagues who you represent want to do the best for your patients. I do not think that anyone would doubt that, but money has been the focus of much of what I have heard.

Dr Bashir: Could I come in on that, Stuart?

Stuart McMillan: Sure.

Dr Bashir: We need to be realistic. Covid put us in a situation that the world had not seen in recent years, and the question is how we come out of that. What steps do we need to take? We do not want to ask you to take a step that you cannot take. We need to take small steps, if we have a limited budget. I do not know what budget you or the Government has, but if we have only that amount of budget, we must find a better way of spending it. It is public money, so we have to speak up. As providers at the front line, we have to tell you, the people who are running the country: "This is not good enough. It is not serving the people of Scotland well enough."

If that is our only budget, let us use it better. Better means trimming down the items of service that we have on the NHS, but without going below the level of securing people's oral health. That is our line—our marker. Any funds that are left after that should be put into prevention. That is a way forward—a step forward. It should be much more than that, but that is the first step. That is the narrative behind the statement.

The Convener: Stuart, do you mind if I come in for a second, because something has popped into my head that I would really like to ask? I will come back to you.

Stuart McMillan: Okay.

The Convener: Dr Bashir, are you saying that there is too much choice of treatment on the NHS, given the funding that is available?

Dr Bashir: On whether there is too much choice, I will let David McColl answer.

David McColl: Under our SDR, we have 600 items of treatment that have been there since before 1990, and none of them makes any sense any more. Even we do not understand half of those items, and we have been working in the NHS for about 100 years between us. It needed to be reformed a long time ago, so an attempt is being made to whittle those down to a few items that are workable under an SDR. However, as I think we have all agreed, none of us wants to go back to an SDR. We need to have a funding model that allows us to deliver what we can to our patients.

The Convener: Thank you for that clarification. I will hand back to you, Stuart. I apologise for that.

Stuart McMillan: Dr Bashir, is the narrative that you just gave the committee the same narrative that has been put forward to the Scottish Government and its officials? It certainly sounded very clear and it sounded like a logical step forward, but that is not what has come across in some of the paperwork.

Dr Bashir: The Scottish Dental Practice Owners group is desperate to sit down with the policy makers who are reviewing the NHS delivery model, but we are being excluded. We have been told that the policy makers are already aware of the opinions of the Scottish Dental Practice Owners, but I am here to tell you that they are not, because no one has asked us. One of the last statements in our submission is simply this: "listen to the profession."

10:30

David McColl might be able to give you more of an insight, because the BDA has been in negotiations or talks with the Government. David, do you want to give your feedback on that to the committee?

David McColl: Obviously, I cannot say anything specific about our negotiations, because those are currently private and confidential, but our preferred model is not to go back to the SDR; we cannot repeat that often enough.

We need to move to a weighted capitation model. We are happy to talk to the Scottish Government about that, but I think that it has stated that its preferred method of delivery is a blended model of capitation, continuing care allowances and item of service. Government will say, "We hear you," but we need it to listen.

Dr Bashir: We also need it to engage with the three organisations.

Stuart McMillan: Why did 30 per cent of dentists, according to your survey, and 31 per cent of the respondents to the committee's survey not apply for the additional funding throughout the Covid pandemic?

Douglas Thain: I can answer that on my behalf. We applied for funding to install ventilation in our practice and our health board refused because the standard of ventilation that was proposed by one of the contractors—which has installed ventilation in a lot of practices—did not meet the standards that it thought were appropriate for our building. Several other contractors put forward proposals,

but nothing was done. Seemingly, a ventilation action group was formed in Lanarkshire to look at how ventilation could be installed, but nothing happened with it, and it has now disappeared in the rear view mirror.

We lost patient access, relative to other practices, from the time that we first applied until ventilation was not an issue. I assume that other practices might be in similar situations, although some practices might have had ventilation installed in the first place, but there are questions over the science of how appropriate the ventilation that was recommended and installed in a lot of places actually was. Certainly, NHS Lanarkshire questioned the Government's science on that front.

David McColl: Ventilation is a complicated issue. It is not just a matter of putting a fan in one bit and sticking a fan out the other bit. The funding equated to £5,000 per practice. My practice is in a health centre that is owned by NHS Greater Glasgow and Clyde. At that time, we had three surgeries there; we now have five. I got the estates department and the board to give me a quote for the ventilation system. For the three surgeries, the system was going to cost £50,000, so £5,000 did not even touch it.

The funding process needed to be more specific about the requirements because, as I said, you cannot just draw air in from one place and put it out somewhere else. High-efficiency particulate absorbing filters need to be involved. I ended up just buying two HEPA filters per surgery, which got me up to the requirement of 10 air changes per hour. The issue of ventilation is going to be an on-going problem, not just in dental surgeries but in the whole of the NHS.

Stuart McMillan: Throughout recent times, the oral health improvement group has suggested bringing in directors of dentistry in each health board area, which has since happened. Has that been beneficial?

David McColl: It has been beneficial, because I have a working relationship with the director of dentistry in Greater Glasgow and Clyde. However, I sometimes feel that he is hamstrung by the board, because the board is heavily secondary-care-centric. I have said for many years that what we actually need is a primary care board to integrate with that. That goes back to the fact that the funding for everything goes into secondary care, so primary care is just left behind.

Douglas Thain: Personally, I cannot see any significant benefit, although, given that it has been such an unusual time, that might be an unfair comment.

Stuart McMillan: How are graduates incentivised to work in the NHS?

Dr Bashir: I think that David McColl has already said that there is not much of an incentive for graduates to go into NHS dentistry. It is becoming more and more unattractive for them. Again, that relates to the delivery model, so we need a shift to happen. It needs to be a prevention-based model as opposed to a disease-centred model. There is no real incentive for graduates to work in the NHS.

David McColl: The Government has incentives in the form of golden handcuff and golden handshake bursaries, but they do not work. Those are very short-term fixes, which do not work. We need to make the NHS an attractive place to work in the long term—a place where people can have a career. Currently, if a graduate goes to work in a practice where there are two dentists working, the most qualified person there might have two years' experience, so there is no managed clinical network, no training and no support. That is why graduates do not want to work in the NHS. We need a practice model that means that we have that managed clinical network and support.

Douglas Thain: As a vocational trainer for 10 years, I had new graduates in my practice, and it was quite a soul-destroying experience to have to un-teach them the best practice that they had spent their university years learning in order to teach them a way that things could be made to work in the NHS. Even that initial exposure makes a lot of people realise that their next career move will be very briefly in the NHS, if at all.

Associates used to stay with us for a good few years after they had done their vocational training—that was how we developed our business—but that just does not happen to the same extent now. They know that there is a better life out there and a better way to do the right thing for their patients, and they are not willing to sacrifice themselves for the NHS in the way that we all did, without considering it to be a sacrifice at the time.

Stuart McMillan: What funding or other measures would have increased capacity and recovery for practices?

David McColl: I come back to the fact that any recovery hinges on reform. I do not know how many times we have said that in today's evidence session. We really need radical reform, because tinkering about rearranging the deck chairs on the Titanic is not going to work this time. We need a radical rethink of how we deliver NHS dentistry. We all want NHS dentistry to work. We have the good will between us in NHS dentistry. We want to ensure that the NHS survives and that patients get the treatment that they need. We do not want to go back to people queueing in the street to register—that is not what we want to see. We need it to work.

The Convener: We are getting very close to finishing.

Stuart McMillan: Can Mr Thain answer that question briefly?

The Convener: Yes.

Douglas Thain: On how things could have improved, in early 2021, we organised an online conference at which the chief dental officer spoke, and there was a commitment to the SDR not returning and a commitment to engaging with the profession in order to get reform. At that stage, there was actually enthusiasm among the profession to engage in creating something better. The fact that everything ground to a halt because of Covid gave us literally a once-in-a-career chance to start again doing something different. There was definitely good will to make that work.

As time has gone by and people have seen that not happen, a lot of practices and individual dentists have started to move away from providing NHS dentistry to operating privately. The train has left the station now. So many people have just lost faith. The gesture that it is going to take to get things back on track will have to be bigger now than it would have been a year or two years ago.

Dr Bashir: The final thing that I would add is to ask you to use dentists on the NHS better, because, really, you are using them as tooth mechanics.

The Convener: We are already 10 minutes over our time, but I have one final thing to ask you, because there is an anomaly in some of what I am hearing, in the sense that you are saying that we need a system of prevention rather than cure and yet we have a backlog of people with diseased teeth. What will it take to bring those two things together? David McColl, I know that you are going to say that it will take reform, but what does that look like?

David McColl: If we have reform, we can attract more people into our practice and our practice team to deliver it. Without reform, we cannot attract anyone. That is the situation at the moment.

The Convener: However, if we have a fixed budget right now—I promise you that this is not a "Gotcha!" question; I am merely trying to get my head around this—and we have a backlog of people with diseased teeth that need to be sorted, but we also require to create a system of prevention, how do you do that? Can you physically do that?

David McColl: We need to be realistic about what we are delivering at the minute, and the SDR is the reason why we are delivering the type of care that we are. That is why we need to get rid of the SDR.

Douglas Thain: That is the impossible conundrum. The truth is that the only way to move forward is to have two separate trains of thought: the preventive side needs to be brought forward so that children growing up do not have significant dental disease—

The Convener: Is that not what childsmile was all about?

Douglas Thain: Yes, it was. More of that work needs to be done and it needs to be taken through to adulthood. Childsmile worked, but as long as we focus too heavily on catching up with the backlog, the preventive end will never become big enough to take over. That is the problem. In an ideal world, we would need twice as many dentists for a couple of years, all being paid enough to make them want to do the job, and then we could get rid of the half that we did not need, but that is pie in the sky.

The Convener: Atif Bashir, I will give you the last word.

Dr Bashir: What we need to do next is reduce the SDR—the 600 items that David McColl has mentioned already—to only those items that will secure oral health. That is our first base; we have got to get to that. We also need to remunerate the providers better for what they are doing within the same budget and start to promote our preventative model. If we do that, we will make the NHS more attractive for dentists to work in, and that is what we want.

The Convener: Okay. Gentlemen, thank you very much for your time this morning, especially given that we have gone quite a bit over time. If you would like to raise any other evidence with the committee, you can do that in writing, and the clerks will be happy to liaise with you on that.

We will hear from the Scottish Government at our next meeting on 29 June, which will conclude our evidence taking for the inquiry.

That concludes the public part of our meeting.

10:42

Meeting continued in private until 11:06.

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