NORTH WALES
LOCAL DENTAL COMMITTEE

Sent via email on Tuesday 14th May 2024

Dr C Stockport
Betsi Cadwaladr University Health Board

Re: Concerns Across GDS and CDS

Dear Dr Stockport

I hope this letter finds you well. I am writing to you on behalf of the North Wales Local Dental Committee (LDC) as you are the executive member at BCUHB with the responsibility for Dentistry. We would usually direct our questions or concerns to Pete Greensmith, as Assistant Director for North Wales Dental Service, but our understanding is that Pete is currently off with ill-health and so we thought best not include him at this time to allow him time to focus on recovering. I have copied in Karen Higgins, Pete's immediate line manager, but our understanding is that she is soon to be leaving her post. As one of our questions was to ask about on-going responsibility for dentistry, it seemed most sensible to write to you.

We have concerns across a broad range of areas in dentistry and would like to raise the following issues:

1. The Loss of GDS Funding used to Deliver Clinical Dentistry:

You will be aware that there have been a significant number of contract handbacks over the last few years. In an effort to address this, a procurement process to replace lost GDS provision was started in March 2023 which has still not concluded. We are led to believe that circa £6.4 million has been recommissioned following that process but no contracts have yet been awarded more than a year later. This money represents hand back and clawback from existing GDS contracts and its loss is being keenly felt as existing practices struggle to meet demand. Many of the patients who lost their NHS dentists when the contracts were handed back are seeking emergency and non-emergency care from already stretched NHS practices. The situation is unsustainable and will likely result in further contract hand backs.

It would appear that money is being lost to dentistry or is being spent on the "non-productive" areas of dentistry, rather than on front-line staff and commissioning/delivery of care.

We would like to know what has happened to the lost dental budget and what has happened with the GDS procurement process.

a) Where has the money gone to date? Syphoned off into the black hole of the BCU overspend? Returned to Welsh Government?
b) Why are practices not being offered this money to provide additional care even on a non-recurrent basis? It appears the money is simply being lost to dentistry and patients year on year.

c) We seem unable to find any additional resource for clinical dentistry, yet the contracts management team appears to be expanding. Is clinical money being lost to fund this expansion and promote staff to higher bands because the management element does not appear to be facing the squeeze that clinical services are?

2. The CDS Service is on its Knees:

Management is taking the service in a direction that is seemingly at odds with WAG guidance and are refocussing the service on special care. However, in reality this is not happening as specialists are not being replaced when they retire or leave the service. Concern over this comes up time and time again at our LDC meetings.

WAG guidance can be found at the following link: https://www.gov.wales/role-community-dental-service-whc2022022
In summary:
1. The CDS should be developed to provide a wider range of routine and specialist services (level 2 and 3) and not limited to special care and paediatric dentistry;
2. Expansion of salaried GDP roles;
3. Ensuring satisfactory infrastructure/equipment;
4. Robust IT infrastructure;
5. An example of best practice in dental skill mixing;
6. Expansion of Dental Therapists;
7. Maximise use of dental nurses;
8. Public Health function;
9. Expansion of training and development role;
10. Maximum chair space utilised.

At our last meeting with the dental contracts team at the LHB in April, it was suggested that over 1/3rd of CDS clinicians had left their posts in the last two years and are not being replaced. Pete Greensmith's response to this was that he felt the numbers were even higher but that this was not his responsibility. This is extremely worrying for many reasons but perhaps the most important is that the CDS is the safety net for the children of North Wales unable to access care in the GDS.

When you add to this the refocusing of the CDS role and the recent management directive to "cleanse" the CDS patient list that will result in 7000 individuals [mostly children] being excluded from NHS care, we are quite simply failing in our duty of care to the children of North Wales. Anecdotally, providers of Emergency Dental Service (EDS) sessions agreed at our last LDC meeting that we are seeing evidence of this weekly with more and more children attending EDS sessions. This is further exacerbating the burden on this already stretched service and also means that the children seen are not having any continuity of care.

We would like some clarification on the following:
a) Will the "cleansing" of CDS waiting lists continue, in contradiction to WAG guidance?
b) Will the already "cleansed" patients be reinstated with the CDS?
c) Why are there so many lost clinicians and why is there not a recruitment drive to replace these employees? For example, we are seeing Foundation Dentists coming to the end of their year-

long training across North Wales looking for CDS positions, but none are being advertised? We will lose these clinicians if we do not address the shortcomings in recruitment.

3. The Orthodontic Service:

Orthodontics is a challenged service; it has been specifically identified as such as part of special measures. There are longstanding issues in secondary care over a lack of consultants and this was the case even before Sarah Gale taking her maternity leave and the unfortunate accident which has left Ben Lewis unable to work currently.
In primary care, all but one DwSI (DES) contracts have unfortunately been returned with just one remaining in the CDS. Waiting times remain far too long.
We would encourage the management in BCU to support the Orthodontic clinicians and the MCN in their efforts to address these issues.

4. Restorative Service:

We simply do not have a restorative service with significant implications for both primary and secondary care. Operating without a restorative service has been described by one of the orthodontic consultants as working in an "unsafe environment". This is especially the case for head and neck cancer patients and young orthognathic patients as these services simply cannot function effectively without high-level restorative input.
It is a long-term issue and due to overly restrictive acceptance criteria when the post was last occupied, there is no meaningful data on need in North Wales.
It appears to the LDC that nothing is being done to address this either to identify the level of need or extrapolate from the data in other areas of Wales.
We have a number of ideas around this but are simply unclear as to who has responsibility for this service. No-one seems to be is our view.
We would like clarification as to who has responsibility, and what contingency measures, interim and longer-term, are being considered to support patients and prevent clinicians continuing to work in an unsafe environment? We cannot accept that no contingency is admissible or sustainable for our dentists and patients of North Wales.

5. Oral Surgery Tier 2 Contracts:

We have made enormous strides up-skilling existing practitioners to tier 2 level, at a significant cost to the LHB, but we have not then provided the tier 2 contracts for the unskilled practitioners. We have therefore lost the services of the first two to achieve this status to posts in England and run the risk of the same with the practitioners in training currently. This is ludicrous and was entirely foreseeable.
We would like clarification regarding what measures are in the pipeline to ensure that tier 2 contracts are made available. It is our understanding that Pete Greensmith has been trying to progress this but our assumption is that the process is mired in bureaucracy.

6. Collaboratives and Clusters:

As dentists we are unable to make any progress with collaboratives and clusters as there is no mechanism for recognising the time commitment required with the existing contracts.
We would like clarification regarding what is being considered to address this inequality and allow clusters to function as they were intended.

7. Clinical Lead:

We are unclear who our clinical lead in dentistry currently is. Our understanding is that it is no longer Sandra Sandham and there is no longer any dental-specific expertise?
With Pete off with ill-health and Karen leaving, it would appear there is no clear management structure in place. This is as unacceptable as it is worrying, particularly given the problems we are facing.

8. Clinical Governance:

The primary care clinical governance (CG) team have been reduced in numbers from 3 to 2, and the officer that left was the individual primarily responsible for, and with the greatest knowledge of dentistry.
Management is delegating work down from the contracting team to CG into a vacuum that is not capable of dealing with the workload. These concerns have been raised to management but not yet been addressed. This is a patient safety risk, and we would like clarification regarding interim and longer-term support for the CG team.

Thank you for taking time to consider the above concerns. We would very much support the idea of a face-to-face meeting with you and any other relevant parties in order that we may expedite the process of solving the above problems. This collaborative problem-solving, together with patient safety, are our primary concerns.

Kind regards,

Committee, North Wales LDC