LDC Conference 2023 Motions

for debate

Contractual and commissioning

1. **Birmingham LDC, TBC**

Re GDC v Lucy Williams, this Conference demands that NHSE pay all legal fees incurred in pursuing and losing the two appeals including the Court of Appeal at the High Courts of Justice. Registrants must not be expected to pay for the errors and ambiguities within the GDS 2006 contract, responsibility lies purely at the door of the Department of Health and Social Care (DHSC) and NHS England (NHSE).

UK

Supporting statement

Whatever the wrongs and rights of this case, or any other pursued by the regulators, the fact remains that, in this case at least, three Appeal Court judges have declared that the Judge Ritchie was correct in his interpretation of the contract. This is a DHSC/NHSE contract, if they want to challenge rulings, they should pay for it, not the profession that try to make sense of the ambiguities of a wholly discredited contract.

2. **Birmingham LDC, TBC**

The findings of the Court of Appeal in GDC v Williams highlight once again many of the ambiguities in the 2006 GDS contract. Conference states that this is yet another reason for immediate and wholesale reform of a defunct contract, one not fit for purpose.

England and Wales, Policy

Supporting statement:

It is clear that the 2006 GDS contract has failed the profession and the public we serve. The findings of this ruling may have significant ramifications for others that may have been affected by rulings guided by misinterpretation of the regulations. The cost of retrospective challenges may be huge. Just in case another reason were needed …. this contract has to go – now!

3. **Wakefield LDC, Tejaswi Mellachervu**

This Conference asks for sessional payments to be offered in a new national contract in order to increase access.

England

4. **West Sussex LDC, Agi Tarnowski (TBC)**

This Conference calls for NHS England to recognise that vulnerable groups in primary care (outside current Community Dental Services acceptance criteria) require different funding arrangements than the current UDA model in primary care.

England

Supporting statement

CDS acceptance criteria are meant to ensure that the most vulnerable groups have access to care. CDS are a very limited resource however so other vulnerable groups may not be caught under the umbrella. These patients could be served in primary care with different funding arrangements outside the current UDA contracting model.

5. **Liverpool LDC, Steve Croston**

This Conference calls for future contractual negotiations with the Department of Health (DHSC) to aim to define a core service that General Dental Service contract providers would be obliged to provide.

UK

Supporting statement:

There is a defined budget for General Dental services which, regardless of the political complexion of the government, is unlikely to change significantly.

That budget is spread too thinly to maintain the pretence of a comprehensive dental service.

If a defined core service was established, the government, the profession and patients (and their carers) would know where they stand.

Ideally more effective prevention and treatment for children would be at the core of the core service. Geographical areas of high need could be targeted appropriately. Irregularly attending adults would not have unrealistic expectations of the "NHS" offer, and those prepared to invest in a more comprehensive service on a regular basis would (if they haven't already done so) access an affordable non-NHS alternative, provided by a motivated, appropriately remunerated, and reskilled profession.

6. Norfolk LDC, Andy Bell

This Conference believes that Continuing Professional Development, for all dental team members, should be a core part of contract reform including funded, protected time for practices to undertake relevant training.

UK

Supporting statement:

Many of us have encountered problems recruiting new team members. Part of this is based on the treadmill nature of NHS dental care, and the lack of professional development pathways. Any significant future changes to the NHS contract should value the workforce that provide this care and support their skills and development. A more highly developed and less stressed professional team will benefit patients and enhance the attractiveness of a dental career.

7. North Yorkshire LDC, Ian Gordon

This Conference calls on the Government to rapidly expand the recent marginal gains. Whole scale contract reform is still needed but after 14 years of pilots the crisis in dentistry cannot wait any longer. A minimum UDA rate of £30 and a roll over of 10% of contract could be set today. That would help stabilise many practices and reduce contracts being handed back.

England

8. West Sussex LDC, Toby Hancock

This Conference calls for all contracts of low UDA values in each region to be raised to the regional average.

England and Wales

Supporting statement

The purpose of this motion is to move beyond the current £23 per UDA minimum, to level up practices with lower funding, reduce disparity without de-stabilising other practices.

9. Coventry LDC, Jagroop Virk

This Conference believes that Government is removing access to NHS dentistry by increasing patient charges and clawbacks instead of improving access to NHS dentistry.

UK

Supporting statement:

From what is happening at the moment, one can only draw the conclusion as highlighted in the motion.

10. <u>Bro Taf LDC, Ruwa Kadenhe</u>

This Conference calls for all current and future Chief Dental Officers (CDOs) to take a leadership role in contractual arrangements and to be required to act in the best interests of patients (as required by the GDC) and not in the interests of politicians.

UK

Supporting statement:

After a very trying year, where the majority of dental professionals where at odds with Welsh Government policy on contractual arrangements, largely because we believe contract reform in its present state does not represent patient interests nor does it consider the wellbeing of professionals. It was our hope that the CDO would take a leadership role in addressing this pressing matter. However, in March 2023, we were dismayed to learn that our chief dental officer had decided not to be directly involved with negotiations on a new contract with the Welsh Government. The primary role and responsibilities of the CDO taken from the public health Wales website include:

providing leadership to all dental practitioners and dental care professionals
professional input into workforce planning and contractual arrangements to support their professional role
providing advice, guidance, and support to ministers on all matters relating to dental services and oral health
monitoring and promoting quality of:
dental healthcare services
patient-related outcomes
strategies to address oral health inequalities
oral health regulation
education
training
performance
implementation of evidence-based standards to achieve, and maintain, high quality dental services
developing policies and strategies to promote and improve the health of the population ensuring timely access to dental services

It is for this reason we ask conference to vote to ensure all future CDOs must take a leadership role in contractual arrangements and to act as the GDC requires in the best interests of patients and not politicians that are often not well versed in these matters.

11. <u>West Sussex LDC, Agi Tarnowski (TBC)</u>

This Conference calls for NHS England not to use referral pathways as a means of rationing more complex dental care.

England

Supporting statement:

The GDC recognises that dentists have a duty to provide safe and effective care to their patients, and they must only undertake procedures within their competence and training. If a dentist encounters a case that is beyond their scope of practice or expertise, they should refer the patient to an appropriately qualified colleague or specialist.

NHS England also have a duty of care to ensure that the healthcare services they commission, including dental services, are safe, effective, and provide high-quality care to patients knowingly limiting care seems to be at odds with this.

*As a result of acceptance criteria and tiering, dentists regardless of level of experience are expected to provide care which **they** may not consider they have.*

The effects of commissioning decisions, lack of services and enforcement of tiering rations referrals for the delivery of more complex care.

Primary care dentists over time cease to believe there is an effective NHS referral option for the patient that they feel they cannot treat and have little other choice but to find a simpler private pathway.

12. <u>West Sussex LDC, Agi Tarnowski (TBC)</u>

This Conference calls for pragmatism in the face of ever reducing NHS commitments that allow child only contracts.

UK

Supporting statement:

There are an increasing number of NHS Dental practices handing back contracts. In the past they may have been inclined to see children, but this is no longer possible.

Children from families of modest income may have more difficulty in access to dental care. Private dental care can be expensive and may be out of reach for many families. By providing child-only NHS dental contracts, the government can ensure that all children, regardless of their family's income, have access to dental care.

Early intervention and treatment of dental issues in children can prevent them from developing into more severe problems that require more extensive and costly treatment in adulthood.

Allowing child only NHS dental contracts can be seen as a proactive measure to promote children's oral health, prevent more significant dental problems in the future and help keep practices in the NHS that would otherwise leave. This motion is not about targeting at risk groups but more about promoting universal access to all children through the NHS via any willing provider.

13. North Wales LDC, Jeremy Williams

This Conference calls for the complete removal of NHS dental targets for the contract year 2023-24 in Wales and for that to remain until a new and negotiated contract is provided by Welsh Government that demonstrates robust and well thought out metrics that are specific, measurable, achievable, relevant and time-based (SMART).

Wales

Supporting statement:

It has become clear to all that the current reform system has a limited basis in evidence and is responsible in part for the exodus of practitioners and practices from the NHS. It has demonstrated that the time previously used for treatment is now being eroded by more and more data collection and with the lack of clarity from Government, software companies continue to provide quick fixes to changes rather than being given time to develop more effective and longer-term solutions. This motion directly calls on Welsh Government to stop developing a contract on the hoof and to sit down with the profession over the next few months to create something that is fit for the post-covid era. Whilst this process is being undertaken, there should be no hard targets to achieve, and Health Boards should be allowed to work with providers to support their recovery from the pandemic in a positive and transparent way.

14. Gwent LDC, Ben Payne

This Conference calls for Welsh Government to underwrite the metrics where practices are being asked to reserve time to manage access/emergency patients.

Wales

Supporting statement:

Welsh Government has amended patient number metrics to hugely increase Emergency Dental Service (EDS) access at blanket levels across Wales beyond the demand in some areas. Practices have allocated time reserved for the Local Health Board (LHB) to book patients with practices reporting 30% underutilisation giving no activity against performance metrics. Welsh Government and Health Boards must underwrite the patient metrics for the EDS slots.

15. Hertfordshire LDC, Alison Chastell

This Conference demands that Units of Dental Activity or Units of Activity (UDA/UOA) are awarded to practitioners to compensate for loss of practice time due to patients failing to attend appointments or cancelling with insufficient time to reallocate the time booked.

England and Wales, Policy

Supporting statement:

Each working day practices across the country have appointment time wasted to no-shows or late cancellations. This means we cannot earn UDAs/UOAs. The NHS policy is not to charge for missed appointments; why must practitioners carry this cost?

Workforce

16. Norfolk LDC, Andy Bell

This Conference calls on GDPC and the BDA to insist that Whole Time Equivalent (WTE) number of dentists working within the NHS is accurately calculated by the various national governments. These should be the only figures used in debate and comparisons between the profession and the relevant government.

UK, Policy

Supporting statement:

We have encountered a recent trend for central government to favour the "number" of dentists working on the NHS. Recent BDA research has indicated the amount of NHS work being provided by dentists has reduced and is likely to continue to reduce. Without an accurate measure of the level of dental activity - the WTE NHS dentist - the government will continue to use a metric that disguises the current flight from dental provision.

17. Calderdale & Kirklees LDC, Matthew Collins

This Conference calls on the Government to train enough UK dentists to meet the needs of the population.

UK

Supporting statement:

While there are obvious issues with the existing contract and funding levels currently, the fundamental underlying problem is the lack of dental workforce to meet the needs of the population. We seem overly focused on contract reform but regardless of how this progresses we are desperately in need of more dentists. There is no shortage of demand for places, it is the lack of places available at UK dental schools that is the bottleneck.

18. Leeds LDC, Munaf Qayyum (TBC)

This Conference calls on the Government to ensure that newly qualified UK dental graduates commit to at least 5 years' service in the NHS dental service. As an incentive for the graduate there should be a corresponding tuition fee reduction or grant.

UK

Supporting statement

It costs approx. £250,000 to train each dental graduate. Many are leaving NHS dentistry very early in their career and some not even entering it after their FD year. This loss to the workforce cannot be sustained. It is time to tie in new graduates to the NHS or they should agree to pay back some of the money that has gone in to train them.

(**Motions 18 and 19 will be discussed together)**

19. Birmingham LDC, Vijay Sudra

In the absence of meaningful Dental Contract Reform (DCR), this Conference calls for a voluntary protected arrangement for dentists to remain working in the NHS for a minimum period after completion of the FD year to help develop their skills in general dentistry.

UK

Many of our younger colleagues are looking to get out of the NHS as soon as is practicable, some not even embarking on their FD training year. The 2006 GDS contract is seen by many as a massive barrier to wanting to work in the NHS, a service where most senior colleagues 'cut their teeth.' Having a period (limited to, say, three years maximum post FD) where the colleague is paid a salary which has been substituted for UDAs would mean that the practice employing this colleague has their UDA target reduced from the contract by a nationally agreed amount for each year the salaried dentist works at the practice, delivering NHS activity. The salaried dentist cannot deliver more than (say) 20% private care in any one year whilst on this programme. In addition, the protected arrangement must allow time for postgraduate development including protected time for peer review, audits and pursuing special clinical interests. A practitioner can leave the programme at any time following the completion of each full 12-month block, subject to 3 months' notice. This must be a voluntary arrangement and anyone going into it must be made aware of the loss of self-employed status that associates presently enjoy, it may not suit all. The benefit of this will be that these colleagues are not working for UDAs, not having the significantly higher risks that come with private service provision, still in a protected environment where they can get support from senior colleagues, and fundamentally, it aids the recruitment crisis in NHS practice. By employing one of these dentists, the practice has their UDA target reduced. The salary package would be nationally agreed.

20. Wirral LDC, Phillip Brown

This Conference calls for government, NHS bodies and Higher Education institutions to revisit the model of undergraduate training for dental professionals by providing a UK wide approach to providing a dental education system that prepares young dentists for a career in NHS dental primary care.

UK

Supporting statement:

Most of the Dental Undergraduate training in the UK takes place in secondary care Dental Hospitals. This traditional model for undergraduate training may not be suitable for our workforce requirements. Training undergraduates to deliver primary care dentistry to patients in a secondary care environment is becoming increasingly difficult, with undergraduates being provided with limited NHS primary care experience throughout their training. We need to carefully consider how we want our future colleagues trained, otherwise we may be failing in preparing young dentists for a career in NHS general dental practice. Training undergraduates in secondary care can be expensive and some may feel it restricts an undergraduate student's understanding of the patient journey and how to holistically care for a patient in a primary care system. Educational Supervisors continually reference in their anecdotal feedback that they lack confidence in the undergraduate training system they once trained in themselves. NHS Dental Primary Care must be an important training environment for our workforce, which requires appropriate funding mechanisms to allow Higher Education institutes and NHSE to invest in a model that works for primary care providers.

21. <u>Wirral LDC, Phillip Brown</u>

This Conference calls for Government, NHS England, and Postgraduate Deaneries to work closely together to develop skill enhancing training pathways and to provide a system that would allow the delivery of enhanced services in a primary care setting for all general dental practitioners.

England, Policy

Supporting statement:

All UK trained dentists have limited training options within NHS dental primary care once they have completed Dental Foundation Training. There is a mass exodus of NHS dentists who are leaving NHS primary care services because it is no longer an attractive career option, a worrying situation NHS practices across the country are experiencing. General dental practitioners are turning to the private sector and funding their own training to be able to offer patients treatment options that may be too complex and or costly to deliver in NHS primary care, but not complex enough to be delivered in a secondary care specialist setting. This is a situation that deters dental practitioners from planning a career in NHS primary care, but it also disadvantages patients who are unable to afford more expensive treatment in the private sector. A system is required that provides long term training opportunities in a primary care environment post completion of foundation training, which also recognises the need for a primary care service delivered by dentists with enhanced skills. Dentists are voting with their feet and leaving NHS primary care positions because it is no longer an attractive place to work, as it restricts skill enhancement and career satisfaction within the NHS.

22. Leicestershire LDC, Philip Martin

This Conference calls upon NHS England and COPDEND to carry out an urgent review into the remuneration and responsibilities of foundation trainers.

England and Wales, Policy

Supporting statement:

The escalating costs and requirements for practices hosting foundation dentists are causing experienced trainers to re-evaluate their commitment to foundation training whilst potential new trainers are increasingly reluctant to become involved with schemes.

23. Derbyshire County LDC, Rami Khatib

This Conference calls for dental hygienists and therapists to have access to an NHS England performer number.

England

Supporting statement:

We believe that this would empower therapists and give them a degree of autonomy that currently isn't possible.

(Motions 23 and 24 will be discussed together)

24. Birmingham LDC, TBC

This Conference calls on provision of NHS pensions for all those working in dental practice that carry out NHS care.

UK, Policy

Auxiliary dental staff including dental nurses and receptionists, alongside hygienists and therapists operate as the backbone of a dental practice. Morale within NHS primary dental care is at an all-time low which is reflected in the nationwide retention and recruitment crisis. NHS dental contract reform is protracted with only marginal changes that have limited bearing on staff spirits. Inclusion of auxiliary dental staff in the NHS pension scheme would not only provide a future financial benefit, but an immediate sense of value to these members of the dental team.

Regulation and legislation

25. Gwent LDC, Russell Gidney

This Conference calls for practices not to be penalised by confidentiality rules when a patient posts public comments on social media relating to care at a practice.

UK

Supporting statement:

Patients are free to in social forums messages that can be very damaging to the reputation of the dentists. Often these can misrepresent the facts or be plain malicious but unlike other sectors dentists cannot respond without breaching confidentiality. Legislation needs to evolve to keep pace with the social media scene - Patients posting on social media by implication should be deemed to have given consent for directly relevant details from the patient record to be disclosed.

26. Gwent LDC, Dan Cook

This Conference believes that practitioners should not be expected to put their professional standing at risk when their patients go abroad as dental tourists and expect their UK dentist to put right the damage.

UK, Policy

Supporting statement:

Dental tourism has grown hugely in the past few years, with patients seeking to quickly get their 'teeth fixed' with the promise of low costs and high-quality treatment. Sadly, the reality is often patients paying thousands of pounds for poor quality, invasive dentistry which is destroying their dentitions. It is unreasonable to expect UK dentists, particularly those with NHS patients, to try and mitigate the damage that is often done, but this creates a dilemma in terms of GDC standards. There needs to be clear guidance from both the GDC and NHS bodies across the UK regarding where dentists stand when a patient presents with such inappropriate treatment.

27. Birmingham LDC, TBC

This Conference calls for the GDC to reform their policy on immediately removing dental professionals from the register for missing payment deadlines.

UK

Supporting statement:

So many colleagues are caught out by this every year. If you do disagree with this motion, please explain why to Conference?

28. Wakefield LDC, Zoe Connelly

This Conference believes that the Chair of any Fitness to Practise Panel must be a person with experience of healthcare.

UK

29. Wakefield LDC, Zoe Connelly

The GDC is showing itself to be not fit for purpose. This Conference calls for regulatory responsibilities for dentistry to be returned to The General Medical Council.

UK

Supporting statement

The GDC was formed in 1956. Previous to this, dental regulatory activities had been the responsibility of the Dental Board of the General Medical Council. In recent years we have seen large increases in the ARF compared to our medical colleagues yet the service they provide has diminished. Delays in processing registrations due staffing issues as well as an apparent reduction in oversight of the training of undergraduates. It has become acceptable that new graduates only require minimal clinical experience before leaving dental school, putting more pressure on Foundation Training and requiring more supervision in the early years of dental practice under a dental contracting mechanism also deemed unfit for purpose. Our medical colleagues have not had to suffer this dumbing down of training.

30. **West Sussex LDC, Mary Green**

This Conference calls for HTM01-05 guidance to be scrutinised by BDJ Evidence-Based Dentistry (EBD) on scientific evidence for cross infection and environmental sustainability.

England and Wales

Supporting statement:

The world is drowning under disposable plastic, pouches and our poor environmental practices. Do we feel confident that the guidance and rational behind standard practices is correct? What is the evidence base for the dogma we adhere to?

The EBD is a trusted unbiassed no governmental publication. We must keep patients safe and consider our impacts on the planet.

Conference requests the EBD to examine the current guidance and offer a impartial view on both its scientific basis and the environmental impact.

Integrated Care Systems

Birmingham LDC

31. **This Conference calls to provide a formalised, protected place for LDC members with their local ICBs.**

England, Policy

Supporting statement:

The spirit of the ICSs is, by definition, the integration of health, social care, local government policy and the work of the voluntary and enterprise sectors by working collaboratively. Only wet fingered dentists understand the problems that the profession are faced with on a daily basis. The (previous) 'AT commissioners' buy the service (and should plan it in collaboration with LDCs - but never did), they are not the delivers of care. It is essential therefore that the profession has an active voice on the ICBs. Having an NHS dental employee there (e.g. LDN chair) or someone from outside of GDS (e.g. community salaried service), or a team from the dental public health service fails the ICS and the public we serve.

32. Oxfordshire LDC, Laurie Powell

This Conference demands that funding for research and innovation (R&I) is available for dentistry on exactly the same basis and to the same extent as it is for medicine.

UK

Supporting statement

Current evidence suggests that there is an association between engagement in research and improvements in healthcare performance. The Health and Care Act 2022 specifies that Integrated Care Boards must promote innovation and research in the provision of health services.

Research and innovation funding for medical practices has been delivered through primary care networks so clearly a similar and equitable mechanism is needed for dentistry.

33. Leicestershire LDC, Hanif Moti

This Conference calls on BDA to assist with the creation of local business plans for dental services.

England

Supporting statement:

With the advent of ICS, Medicine, Pharmacy and Optometry are submitting business plans which will enable them to target and secure funding for those areas they identify as priorities. We need to ensure the dental profession is able to compete on a level basis with the other three primary care professions for discretionary ICS spending.

LDC Support

34. North Yorkshire LDC, Ian Gordon

This Conference calls for all LDCs to financially support their representatives' travel to Regional Liaison Group meetings, GDPC meetings and LDC Officials' day to enable more of the infinitely more valuable face to face meetings to take place.

UK

Collective day of CPD

35. Birmingham LDC, TBC

This Conference calls on a collective day of CPD to demonstrate what a total lack of NHS dental provision looks like.

UK

Supporting statement:

A version of this motion has been presented to conference before. Over the past year, we have seen industrial action not seen for decades. There are growing anxieties across the public, health and social care sectors about erosion of pay and living standards over the past 15 years. For dentists, it has become practically impossible to maintain a practice with NHS income alone. Many are demonstrating their anger and frustration by ceasing NHS service provision or even retiring from the profession altogether. By taking action like this, along with the current groundswell of media interest in NHS dentistry, we will send yet another message to the DHSC and NHSE about the precarious nature of the service. What will happen when the bare bones service that presently exists stops, even for a day?