LDC Conference 2021
Motions for debate

SESSION ONE

Regulation

1.Bromley Bexley & Greenwich LDC, Nick Patsias

The CQC should regulate compliance companies as well as the profession.

England

Supporting statement:

At present compliance companies vary hugely in their advice. Some advise other sectors as well as dentistry so the recommendations tend to be generic and others have unnecessarily long winded procedures yet miss out vital information. All this leads to a massive amount of time wasting which knocks on to less chairside time and patient care.

I should like to see the CQC inspectors sit down themselves to complete each individual companies' paperwork to their standard to see how much time it takes and actually realise and modify the workload so that the profession does exactly what is needed in the most efficient manner.

Regulation/Recruitment

2. West Pennine LDC, Martin Longbottom

This conference calls for long term clarity on the admission of new EEA graduates onto the GDC list of registrants.

UK

Supporting statement:

The GDC announced in December 2020 that it would continue to recognise newly EEA qualified dentists for up to 2 years from 1st January 2021. As there is no prospect of UK dentists qualifying in sufficient numbers to maintain the service it is essential that this alternative source is maintained.

3.West Pennine LDC, Martin Longbottom

This conference calls for an increase in the number of places to sit the ORE and an improved application process.

UK

Supporting statement:

Since the pandemic both parts of the ORE have been cancelled, this could add to the crisis in dental recruitment.

Recruitment and retention in rural areas

4.Northampton LDC, Geraint Evans

This conference demands government and commissioning bodies take urgent action to address the serious problem recruiting and retaining dentists faced by rural communities and those distant from dental schools.

UK, Policy

Supporting statement:

Proactive efforts to recruit young dentists into Northamptonshire were very successful historically, however the importance and value to patient care has been overlooked with changes in foundation training boundaries. Practices face punitive and irreversible contract changes for underperformance despite best efforts to recruit. Inadequate, fragmented workforce planning initiatives have failed our profession and patients.

We call for recruitment, return to work and retention incentives to be fully explored and implemented combined with the support of commissioners by providing flexibility with contract targets where practices have suffered recruitment challenges.

4a.Lincolnshire LDC, Amelia Coulby

This conference calls for a definitive strategy by NHSE&I and HEE to address recruitment and retention issues in rural areas such as Lincolnshire.

England

Supporting statement:

We are witnessing a growing crisis in recruitment and retention of not only dentists but, latterly, the whole of the dental team.

Even prior to the current crisis there were an unacceptable number of patients unable to access dental care. This situation is now becoming far worse.

In 2019, BDA analysis estimated that over one million patients could not secure a NHS dental appointment. It was shown that access was an issue across every English region but that this was significantly more pronounced in rural areas with for example, over 60% of patients in Lincolnshire wishing to access NHS dental care unable to secure an appointment. In rural areas there is very clearly a shortage of dentists with NHS vacancies in particular not being filled. The reasons are

multifactorial including the combination of large practice lists and the current UDA system, combined with lower UDA values, typically found in rural areas.

This issue needs to be at the forefront of the NHSE&I and HEE strategy to ensure there is not a collapse of NHS dental care in rural areas, and any reforms should address this deepening crisis.

Working conditions - PPE

5.Nottinghamshire LDC, Simon Thackery

This conference calls for an urgent review into the need for enhanced PPE in the dental setting with a particular focus on comfort, staff fatigue/burnout and the devastating environmental impact of such measures, clearly weighed against the risk of contamination.

UK

Supporting statement:

The current level of enhanced PPE requirements is causing a tremendous strain on the mental health of the profession within the context of a target driven NHS system demanding back-to-back AGPs. We have also noted anecdotal evidence locally to suggest that it may be having a noticeable effect on staff morale and ultimately workforce retention. The additional environmental impact of this PPE regime is also a growing concern with the huge amounts of plastic waste being generated in order simply interact with our patients, let alone use a turbine.

With the reducing infection rates due to the effective vaccination programme and the questionable evidence base regarding the lack of transmission through dental aerosol, it is essential that these requirements be urgently reviewed, rather than use the precautionary principle as a convenient back stop.

One of the positive aspects that could emerge from this unprecedented period could be to steer the profession to a more sustainable footing. All future IPC measures, including PPE, should be weighed up against this metric and the contamination risk be considered in the context more seriously.

Working conditions / career development /contract reform

6.West Sussex LDC, Agi Tarnowski

Contract reform must reflect and sustain a changing workforce and allow for a future with a real chance of career progression while staying in NHS primary dental care.

UK, Policy

Supporting statement:

The current contract arrangements mean that having completed your vocational year a set UDA value will be available to you with few ways of gaining skills and progressing within primary care.

Level 2 contracts are award based on commissioning needs of an area at a particular time. Consequently, investing in up-skilling yourself in your chosen field doesn't necessarily mean that your career can progress and that your newfound skills will be valued or welcomed by the NHS.

While it important to focus on the viability of practices when contract negotiations are taking place though should be given to how to attract, develop and retain a workforce that is no longer predominately practice owners.

I call on the LDC Conference to support a motion to address the issue of career progression for the work force during contract reform negotiations.

Contract reform

7.Wakefield LDC, Tejaswi Mellachervu

Conference asks that following the recent commitment by NHS England and the government minister to contract reform, it is essential that the UDA treadmill is not replaced by another one in disguise.

England, Policy

Supporting statement:

The pandemic has highlighted now more than ever the inadequacies of the current NHS dental contract, which was never fit for purpose. Any new contract must have prevention as a central feature along with patient outcomes to monitor and improve oral health, and not just measure activity targets.

8. Gwent LDC, Russell Gidney

This conference calls for Welsh Assembly Government to guarantee that where untested metrics are applied to NHS contracts through reform there is no risk of financial penalties for practices making reasonable efforts to meet their responsibilities.

Wales

Supporting statement:

Welsh practices are lucky to see revolutionary changes in the NHS contract with the possibility of the total removal of the UDA as a measure for treatment. These are (almost!) universally welcomed.

However, the restrictions through C19 have interfered with the staged development of the contract reform and now in recovery these changes are being introduced without the opportunity to test or validate the measures that are being rolled out.

This conference calls on Welsh Assembly Government to make explicitly clear that untested measures will not be used to financially penalise practices until they can be validated.

9.Northumberland LDC, Duncan Thomas

Conference asks that the BDA adopts a position in negotiating a reformed NHS contract which allows use of the full range of DCP competencies.

To sustain any form of NHS dental contract with an adequate workforce it must be able to utilise the full scope of practice of our DCP team. Under current contract terms a DCP is unable to open an NHS course of treatment in England. The prototype arrangements made a tweak to the regulations allowing DCPs to complete interim care appointments without the need for the dentist to see the patient. A logical move in an increasingly complex multi- disciplinary profession.

This however does not go far enough. The current DCP workforce is vastly underutilised in delivering care for patients with deskilling of many expensively trained dental therapists. Only a contract that allows contract holders the freedom to utilise the skill mix of their teams to their full potential will stand a chance of reinvigorating NHS dentistry.

Contract / Patient care

10.Northumberland LDC, Duncan Thomas

Conference demands that for the profession to flourish and for a high standard of care to be delivered, any future NHS contract must recognise that more time needs to be spent with each patient encounter.

England, Policy

Supporting statement:

Historically, the NHS dental contract based on fee per item and generations of dentists trying to work faster and faster for the same remuneration, has resulted in a high volume of dentistry being provided by dentists within the NHS. This high volume has been translated into UDA targets since 2006.

Communicating with patients about their options, the risks and benefits of those options, before we even counsel our patients about their oral health habits, takes longer than ever. Could this be the reason that the prototypes have been deemed to be a failure as many have failed to see the same number of patients?

Millennials and Generation Z dentists appear to have more sense than my generation. They want to be able to provide high quality care they can be proud of, using techniques that take time to deliver well – What's the remuneration under the NHS for molar endodontics?

The current NHS contract is failing for many reasons, but one of the biggest is that the current workforce of dentists do not want to work in a system that doesn't allow them the time to deliver care to the standard they aspire to.

SESSION TWO

NHS Dentistry - Funding

11. Birmingham LDC, Ranjit Singh-Chohan

This conference calls for an increase in funding to NHS Dentistry (similar to the support offered across other NHS sectors), to allow practices to reduce waiting lists, treating more patients safely by increasing NHS care provision hours over and above those contracted for.

UK, Policy

Supporting statement:

Dental waiting lists have escalated due to Covid 19, as practices are severely restricted on the number of patients that can be treated safely, during contracted hours. This has been further compounded by patients presenting with greater treatment needs, due to delayed routine examinations, restrictions in service delivery and issues surrounding access. Health and Social Care Secretary Matt Hancock stated that the 'government has backed the NHS at every point in this pandemic, so they can treat patients.' The Government also recently announced a £7 billion package for health and care services to support the next phase of the NHS response to COVID-19, including additional funding for secondary care, to manage procedures delayed due to COVID-19. Yet, dentists have suffered years of pay restraints prior to Covid 19, and are currently struggling with a spike in waiting lists and treatment needs, which will only deteriorate further without action. This conference calls for additional funding so that practices can extend opening hours beyond those contracted, allowing more patients to be treated safely, and prevent further deterioration in the health of our patients.

NHS Contractual Arrangements

12. Hants and IoW LDC, Keith Percival

This conference deplores the 11th hour announcements for Q4 2020/21 and yet again more recently Q1 and Q2 for the current contract year. We demand that all future contract arrangements notices are shared with the profession in a timely manner so that practices can remain a sustainable and viable resource for NHS patients.

England, Wales, Policy

Supporting statement:

Throughout the Covid-19 pandemic NHS dental practices have worked incredibly hard to provide a safe and responsive service for NHS dental patients. Many practices have also provided UDC based care for those in urgent need when the risk was greatest. Surely, NHS England must realise the perverse impact of their severely delayed contract performance notices on the wellbeing of practice teams who cannot realistically plan for their future.

13. Coventry LDC, William Sidhu

Since there is a high demand from the public for dental consultations; Dental Practices should be remunerated for Triaging patients.

England, Policy

Supporting statement:

During recent months, NHS England has imposed 60% targets on Dentists during the next 6 months without taking into account the time taken by Dental Practices to Triage patients and issuing Prescriptions where necessary.

NHS Contractual Arrangements – abatement clawbacks

14.West Sussex LDC, Agi Tarnowski

Abatement clawbacks must be urgently reviewed and removed to reflect the fact that 'variable costs' have actually increased not decreased despite a 'reduced' level of NHS service.

England, Wales, Policy

Supporting statement:

With the announcement of a minimum 60% activity target until September comes the news that practices will suffer a 16.75% abatement on the 40% (or less) not physically provided. This abatement is to allegedly reflect the variable and reduced costs of providing. NHS service at this level. However practices are observing the opposite reality with vastly increased running costs as a result of new ways of working or increased charges including provision of remote / virtual appointments, clinical waste collections more frequently and larger quantities due to the increased size and amount of PPE, staffing costs including increases in market rates due to increased living wage, cost of materials and consumables as well as the cost to communicate with patients for recalls and appointments. Many have had to Invest heavily in their practices to operate at the requested levels and make them Covid secure (including ventilation). Practices are not currently able to operate at 100% with current social distancing restrictions despite inflating costs due to Covid and Brexit. Abatement threatens the current viability of providing a vital NHS service and will push more of the workforce to go private.

I call on the LDC Conference to support a motion to address the issue of abatement and support struggling NHS practices big and small!

14a. Birmingham LDC, Ahmad El-Toudmeri

This conference calls for an immediate removal of the abatement of contracts enforced on practices.

England, Wales

Supporting statement

This conference notes that the abatement of contracts that has been enforced on practices has no place in the current climate and must be withdrawn with immediate effect.

This conference recognises that during the first quarter of 2020-2021, whilst face to face dentistry was limited owing to the coronavirus pandemic that certain expenses may have been reduced in practice ownership. However, as the country has slowly moved to recovery and practices are now open for routine care including face to face provision. With ever increasing costs being borne by dental practices each day, as well as targets that have to be met - this abatement simply cannot be justified. Whilst the PPE portal has been welcomed, this is very much a case of rearranging the deck chairs on the Titanic. Limiting NHS resources at this vital time is both counterproductive and damaging to the oral health care of the population and could prove to be costly for years to come.

This conference, therefore, calls for the immediate removal of the abatement of contracts enforced on dental practices, such abatements are not applied elsewhere in the NHS.

15. Birmingham LDC, Abid Hussain

This conference believes a legal challenge should be funded by LDCs on the non-evidenced abatement being applied to NHS Contracts.

England, Wales

Supporting statement:

At the beginning of the pandemic a blanket closure was imposed on all dental practices in line with government guidelines. As practices started to re-open and financial constraints started to lift, an abatement was introduced on all NHS dental contracts. The abatement was only dental specific and not applied to any other NHS service, it was also not evidenced based.

Although practice overheads such lab fees were reduced (to begin with at least), together with the cost of materials, no consideration was given to of thousands of pounds of out-of-date unused materials and stock which was disposed of, having not been used during the closure.
PPE is provided via the portal (which does not reflect the amount of abatement), but no considerations are made of the increased clinical waste costs associated with the increased use and disposal of PPE.

A legal opinion is needed, to seek evidence for the level of abatement applied to NHS dental contracts, as we believe the amount of abatement does not truly reflect the reduced service costs associated with reduced activity and opinion given by the profession was not considered.

Equalisation of UDA values

16.Liverpool LDC, Bill Powell

This conference calls for the equalisation of UDA rates.

England

Supporting statement:

We have been providing General Dental Services for 15 years since the introduction of UDAs. The widely differing UDA values bear no reflection of the cost of delivery or incidence of need. In our STP area there are examples of evidence to the contrary, the higher the need, the lower the UDA value. The perverse consequences are practices and colleagues being driven into financial hardship, stress, clawback, distorted pensions contributions, declining morale, and increasingly tragically, significant mental health issues.

Patients/carers and taxpayers have no awareness of these huge disparities. We believe they would be shocked if they knew the truth.

This exact motion was proposed by Jason Wong (now Deputy Chief Dental Officer) On behalf of Lincolnshire LDC in 2019

<u>17.Liverpool LDC, Bill Powell</u>

This conference considers it unacceptable that all providers are expected to provide the same service despite huge disparities in remuneration.

England, Policy

Supporting statement:

Liverpool LDC reserves the right to immediately withdraw this motion, should the previous motion Equalisation of UDA values, be carried.

If the delegates do not accept that UDA values should be equalised, then conference will, by reason, reject this motion.

SESSION THREE

<u>18. Bro Taf LDC, Adam Porter</u>

This conference calls on Wales Government to reduce the target for application of fluoride varnish to a more manageable level, to allow dentists to use their clinical judgement regarding the appropriateness of application for any given patient.

Wales

Supporting statement:

One of the primary contractual targets in Wales is the requirement to apply fluoride varnish on 80% of all children, and 80% of adults with a moderate or high caries risk as determined by a standardised assessment of clinical risk or need (ACORN). Failure to achieve this target will result in a reduction in contract value.

There are a number of reasons why patients may not have fluoride applied, including allergies, personal beliefs and preferences, and failure to attend the application appointment. The target of 80% is very high and doesn't leave much scope for dentists to make choices regarding patients' best interests. Practitioners are uncomfortable coercing patients into receiving fluoride varnish in order to achieve a target.

Patients - Unacceptable waiting times for General Anaesthetic provision

<u>**19. Northampton LDC, Jessica Wyatt**</u>

Conference calls on government to address the unacceptable waiting times for General Anaesthetic provisions, especially for the CDS services, from referral to treatment in secondary care settings following the recovery from the Covid-19 pandemic.

UK, Policy

Supporting statement:

The current RTT (referral to treatment) stands at 36 weeks, it is essential to ensure there is adequate provision for dental teams to access appropriate specialist treatment for our patients, especially with the recognition that oral health is essential to health and wellbeing.

With GA lists running at 50% capacity, without a set time for review of working practices, the impact will be felt throughput our communities, disproportionately affecting areas of highest need and deprivation. These lengthy waiting times leave dental teams with distraught patients, contribute to work based stress in an already unmanageable situation and increase health inequalities.

We call for the provision of clear and transparent information to advise patients on the current situation and the bodies with responsibility for it together with an urgent review of care provision.

Commissioning - flexible commissioning

<u>**20.Hull and East Riding of Yorkshire LDC, Simon Hearnshaw**</u>

This conference supports flexibility within commissioning frameworks enabling services to be delivered outside the constraints of UDAs within sustainable and effective frameworks.

England, Policy

Supporting statement:

During Covid there was a lot of progressive discussion around building back better outside of UDAs. The success of the shift away from UDAs to care volume freeing up practices to deliver the priorities of providing more urgent care and facilitating access for irregular patients provided an opportunity to move forward with greater flexibility. As the Minister says – we need change in how we approach dentistry and transformation of the commissioning of dentistry is necessary. We now need to move forward with designing and implementing sustainable systems of care that are more outcomes focused, that use a whole team approach, that prioritise prevention outside of the UDA system.

The pandemic has exposed fault lines in lots of frameworks as systems were strained by the challenges presented. Certainly, where systems were poor before Covid 19 these systems struggled to

cope. A system where contracts are handed back or where practices become insolvent points to a broken system. A system that pays lip service to prevention and does not target inequality needs to change.

The guidance published in March around developing a revised reform process focused on designing implementable proposals that address the key challenges facing the delivery of NHS dentistry is a starting point for work that that needs urgent acceleration.

Vulnerable groups/ Commissioning of oral care in a domiciliary setting

21. Norfolk LDC, Jason Stokes

This Conference acknowledges the importance of Oral Care in a domiciliary setting. The important role of domiciliary dental care is often viewed as an afterthought and is not well commissioned by NHSE.

This Conference recognises the importance of an intelligently commissioned and effective domiciliary service.

This Conference, therefore, calls for the GDPC to ensure that: NHSE conducts specific & transparent needs assessments for domiciliary care to gain accurate local intelligence to support the commissioning and delivery of domiciliary dental care.

England

22. Norfolk LDC, Jason Stokes

This Conference acknowledges the importance of Oral Care in a domiciliary setting. The important role of domiciliary dental care is growing as the population ages and their needs change.

This Conference recognises the importance of a flexibly commissioned and adaptable domiciliary service.

This Conference, therefore, calls for the GDPC to ensure that:
NHSE commissions adequate care for the changing demography of the population and reflects local variation.

England

23. Norfolk LDC, Jason Stokes

This Conference acknowledges the importance of Oral Care in a domiciliary setting. The important role of domiciliary dental care is not reflected in a commissioning model that supports efficient delivery of this care.

This Conference recognises the importance of a contracting mechanism that acknowledges the differences between domiciliary and surgery based primary care.

This Conference, therefore, calls for the GDPC to ensure that:

NHSE contracts for domiciliary services with a mechanism and KPIs that reflect the particular challenges of domiciliary dental care.

England

Supporting statement for motions 21-23:

The CQC has made it clear that care home residents do not receive the quality of care they require.

What we found among the homes visited:

most had no policy to promote and protect people's oral health (52%)
nearly half were not training staff to support daily oral healthcare (47%)
73% of care plans reviewed only partly covered or did not cover oral health
it could be difficult for residents to access dental care
10% of homes had no way to access emergency dental treatment for residents

We recommend a cross-sector approach including:

sharing best practice
repeating and reinforcing the guidance
mandatory staff training
oral health check-ups for all residents moving into a care home
a multi-agency group to raise awareness

Addressing oral health inequalities

24. Leeds LDC, Ian Wilson

This Conference supports the development of robust and effective programmes on a sound financial footing to support oral health services for the homeless and socially marginalised groups in society. We urge policy makers to develop programme frameworks that enable sustainable care for these groups to be delivered hence removing obstacles to access.

UK

Supporting statement:

In the UK, over 300,000 people are estimated to be homeless including around 4,500 sleeping rough and over 70,000 households in temporary accommodation. Research by the Charity Groundswell has shown that the prevalence of oral health problems among the homeless is much higher than in the general population.

Evidence suggests that people experiencing homelessness have significant difficulties in accessing dental care services. These patients are often presenting with high levels of treatment need and many of them require additional complex levels of support.

Targeted services tailored to the needs of these communities are fragmented but mostly absent. The contribution of Dentaid is hugely welcome but if the NHS is serious about reducing inequalities - we need commissioned services to meet the needs of these groups and not reliance on charities.

We ask that you support this motion.

<u>25. Gwent LDC, Russell Gidney</u>

This conference calls for Design to Smile to be restarted and expanded to build on the previous successes in addressing oral health inequalities.

Wales

Supporting statement:

Wales previously ran a hugely successful Design to Smile programme that looked to catch children in early years and pre-school to introduce fluoride application and oral health education. This has been refocused and now paused as a result of Covid-19.

This conference calls on Welsh Assembly Government to reinstate the program with additional funding to build on the current successful programme rather than amending to allow the refocus to new untested interventions.

NHS Offer

<u>26.Hants and IoW LDC, Claudia Peace</u>

This conference demands that the Department of Health and Social Care define and make public the NHS Offer so that patients and the profession alike are clear as to the availability of treatments.

UK, Policy

Supporting statement:

Covid has highlighted the inequalities in accessing NHS dental care with many practices only offering private provision despite holding an NHS contract.

To define the NHS offer would be to make transparent the treatments available to patients and assist in reducing inequalities.

<u>26a.North Yorkshire LDC, Ian Gordon</u>

This conference calls for the NHS dental offer to be clearly defined.

UK

Supporting statement:

For far too long NHS dental services have pretended that it provides everything for everyone. Now is the time to address this issue and admit that it can't and as such it needs to be clearly defined as to what is available and what is not.

27.Bromley Bexley & Greenwich LDC, Nick Patsias

It should become our industry standard that deposits should be taken to secure NHS appointments for all fee-paying patients.

England

Supporting statement:

Never before has appointment time been more precious yet this is at a time when targets are harder to reach than ever. In 2006 our ability to charge NHS patients was taken away and yet in the latest letter from our CDO we are being asked to address urgent cases and those with most needs. How many times does reception field calls from patients looking for NHS treatment who book appointments who then don't show up either because they have been offered another one sooner at another practice or can't be bothered?

Why on earth does the NHS allow band 2 and 3 charge to be taken yet not Band 1or 4?

DHSC White Paper Integration and Innovation

28.Hull and East Riding of Yorkshire LDC, Simon Hearnshaw

This conference fully supports the proposals in the Health & Social Care White Paper to remove funding barriers to the implementation of Water Fluoridation schemes.

UK

Supporting statement:

For the last four years this Conference has supported motions on Community Water Fluoridation (CWF). In 2017 Conference supported the inclusion of fluoridation within the Starting Well programme emphasising a targeted approach to prevention.

In 2018 we called for support for the grassroots LDC campaign advocating for CWF within local oral health strategies and in 2019 we called for the costs of programmes to be paid centrally removing financial barriers to implementation. Last year the Motion asked for, and received, overwhelming support for Councils in the North East of England moving towards public consultation.

This year's motion is in support of the proposals within in the Health & Social Care white paper page 57) to remove the barriers to implementation giving the Secretary of State for Health and Social Care the power to directly introduce water fluoridation schemes and shifting the costs burden for

feasibility studies, public consultation and both capital and revenue costs away from Local Authorities to central Government. In many respects these planned changes respond to all of the motions over previous years and in a stroke remove obstacles to the implementation of new schemes with the evidence-based potential to make real differences to health inequalities and lives. In many respects these changes completely vindicate the efforts of this Conference to raise the profile of CWF and to drive positive change. Please support this motion.

29. Leicestershire LDC, Sarah May

With Local Dental Networks likely to be heavily involved in the establishment of Integrated care systems this conference demands that LDN chairs have an understanding of the needs of primary dental care, be promptly appointed to any vacancies and that they are properly remunerated.

England

Supporting statement:

Representation from both primary and secondary care within the LDN leadership structure is essential for the needs of Primary Dental Care to be considered within the new Integrated Care Systems.

Local Dental Committees

30.Bro Taf LDC, Ruwa Kadenhe

Conference calls for all local dental committees to actively engage with Dental Care Professionals and to ensure that their voices are heard.

UK

Supporting statement:

Significant advances have been made in the delivery of dentistry. Many opportunities have opened up for the wider dental team over recent years, and their professional role has been recognised by the GDC, as well as the many practices who utilise their skills. Effective use of skill mix is a central topic in discussions around contract reform. It follows that in the interests of patients and improving the profession, local dental committees should actively engage with all members of the team and give a voice to all.

Dental Care Professionals are generally unable to join NHS performer lists and are hence generally prevented from sitting on Local Dental Committees as full members.

<u>31. Gwent LDC, Russell Gidney</u>

This conference calls for a review of the funding sources for LDCs to allow them and the committees they support to be more representative of the GDP practices as a whole.

UK

Supporting statement:

The response to Covid-19 restrictions and imposed measures demonstrated the imbalance in representation of private practices compared to mixed/NHS practices. This led to frustration within the practices and indirectly lead to the inception of organisations trying to fill that void.
The funding for LDCs that then trickles up the BDA committees dictates this situation. This conference calls for an immediate review of the funding for LDCs to allow their work and those of the other committees to be more representative of the full spread of GDP dental work.

<u>32. Oxfordshire LDC, Laurie Powell</u>

This conference condemns the continuing competitive procurement of Special Care and Paediatric Dentistry services in the South East and demands that those procurements currently being pursued be abandoned until NHS England's new provider selection regime is in place.

England, Policy

Supporting statement:

'NHSE/I is pursuing a dogmatic policy of competition for Special Care and Paediatric dentistry across the South East despite the development of a national policy for services to collaborate. Their justification for the competitive tender is:

1. *Significant variation in service provision, funding, contract form and different types of provider as many services were commissioned by legacy organisations.*
2. *To create a common core offer for all patients across the South East region through fewer contracts*

Since the first mention of the procurement, national policy has changed. The recent White Paper (DHSC, 2021) emphasises collaboration and integration in place of competition. The former competition and procurement rules are not well suited to the way healthcare is arranged; they create barriers to integrating care, disrupt the development of stable collaborations, and cause protracted processes with wasteful legal and administration costs. The procurement for orthodontic services across the same region led to disruption in services and ended in a legal challenge.

Oxfordshire LDC feels that the tender process will lead to a race to the bottom, compromised service provision and poorer quality care for patients.