General Dental Practice Committee

Responses to motions carried at LDC Conference 2023

This paper outlines responses to the motions from LDC Conference from the GDPC. Progress flags have been placed to illustrate which motions have been accepted by GDPC and where progress has been made.

Green = positive change achieved by GDPC
Amber = GDPC consistently and actively representing this view to the relevant bodies
Red = no longer GDPC policy

Motion 1.

Carried with 95% of the votes	**Supported by GDPC**	

Birmingham LDC, Ranjit Singh Chohan

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

The GDPC agrees with this statement. As the GDS 2006 contract is the responsibility of DHSC/NHSE, any ambiguity that requires testing in court should be funded by the Government, not individual dentists or the profession more widely. This has been repeatedly raised with the GDC in our regular engagement with it.

Motion 2.

Carried with 93% of the votes	**Supported by GDPC**	

Birmingham LDC, Abid Hussain

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!

This is existing GDPC policy. The GDPC is actively engaged in all four nations of the UK in seeking contract reform that addresses the long-term, systemic issues that have driven NHS dentistry into crisis.

Motion 3.

Carried with 84% of the votes	**Supported by GDPC**	

Wakefield LDC, Tejaswi Mellachervu

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

England

The GDPC has proposed sessional payment as the basis for the delivery of urgent care in discussions with NHS England, but this has not been agreed nationally. Many local areas make use of sessional payments for the delivery of urgent care and other schemes. This is supported by the GDPC and LDCs are encouraged to work with their ICB to implement such sessional payment-based schemes.

Regarding fundamental contract reform, the GDPC supports a capitation-based contract.

Motion 4.

Carried with 58% of the votes	**Supported by GDPC**	

West Sussex LDC, Agi Tarnowski

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 mode.

The GDPC agrees that the development of robust and effective programmes to support oral health services for vulnerable groups who do not fall under current CDS acceptance criteria is stymied by the UDA system The GDPC has been working with NHS England on measures to ensure that there are appropriate funding arrangements to support the treatment of high needs patients, many of whom will be in vulnerable groups. This was what lay behind the sub-division of band 2 to provide more UDAs for more complex treatments. The GDPC has been working to ensure that NHS England addresses access to care for all patients, including the most vulnerable groups. For example, we have highlighted the lack of access to domiciliary care and called for commissioning schemes to resolve this.

In the longer term, The GDPC's policy is to move away from the UDA system to a capitation-based contract model that we believe more appropriately funds patient care.

Motion 6.

Carried with 81% of the votes	**Supported by GDPC**	

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.

The GDPC agrees with this motion. It has made proposals to NHS England for funded training. In particular, it has made proposals for the reintroduction of clinical audit and peer review, with funded, protected time.

Motion 7.

Carried with 64% of the votes	**Supported by GDPC**	

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

The GDPC agrees that a higher minimum UDA value would offer meaningful support to practices that are struggling to remain financially sustainable given the long-term underfunding of NHS activity, and continues to seek to

negotiate a higher minimum UDA value with NHS England. It has proposed a £35 per UDA minimum value. This was also submitted to the Minister as a proposal for the Dental Recovery Plan.

As a result of the GDPC's engagement with NHS England, there is now guidance for ICBs on negotiating increased UDA values on a contract-level, where there is evidence, this is necessary to support the viability of the contract. The guidance also sets out how flexible commissioning can be implemented.

The marginal changes negotiated by the GDPC allow for commissioners to agree with contractors that they can overdeliver by 10%.

Motion 9.

Carried with 76% of the votes	**Supported by GDPC**	

Coventry LDC, William Sidhu

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

England

Supporting statement:

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

The GDPC agrees that there has been long-term underfunding of NHS dentistry, with significant real-terms cuts throughout the 2010s. The impact of this has been compounded by increasing levels of clawback. In addition to this, patient charges have been increased so that patients pay more and the Government contributes less. The GDPC's policy is that patient charges should not exist, and so long as they do increases should not exceed inflation and dentists should not collect this tax on patients. These combined pressures now fundamentally threaten the financial viability of NHS dentistry.

Motion 10.

Carried with 64% of the votes		

Bro Taf LDC, Ruwa Kadenhe

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.

The role of the CDO varies significantly across the UK.

In England, the role of the CDO and their Office is to provide clinical advice to NHS England. The OCDO has done this with respect to contractual discussions. The GDPC does not believe it would be appropriate for the CDO to play a greater role in this, given that the post has no direct remit for contractual matters.

Motion 11.

Carried with 65% of the votes	**Supported by GDPC**	

West Sussex LDC, Agi Tarnowski

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.

The GDPC agrees that commissioning structures should enable the delivery of high-quality dentistry delivered by professionals operating within their scope of competence, and further that all dentists should be able to refer as clinically appropriately, and with confidence that the patient will receive the treatment they need whether within the NHS or privately.

Motion 12.

Carried with 78% of the votes	**Supported by GDPC**	

West Sussex LDC, Agi Tarnowski

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.

The GDPC supports the option of child-only and exempt-only contracts remaining available and believes that they are a pragmatic means of securing some NHS services where practices are looking to hand back contracts. However, commissioners are responsible for securing services for the entire population, and this is what the NHS pledges to deliver, and so cannot rely solely on these contracts. Ultimately, reform and investment is needed so that there is an NHS dental service in which dentists are happy to work and patients can receive access to NHS dentistry.

Motion 13.

Carried with 83% of the votes		

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.

The WGDPC feels that this motion has been overtaken by subsequent events. Instead, its emphasis is on dealing with clawback.

Motion 14.

Carried with 93% of the votes	**Supported by GDPC**	

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

The WGDPC believes that, fundamentally, practices should not be financially penalised for not holding access sessions. The blanket imposition of increased Emergency Dental Service (EDS) access has meant that in some areas, supply of emergency sessions outstrips demand, with obvious consequences for the finances of practices.

Motion 15.

Carried with 88% of the votes	**Supported by GDPC**	

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?

The GDPC's existing policy is that practices should be able to fine patients who fail to attend and that practices should be reimbursed UDAs when patients fail to attend.

Motion 16.

Carried with 98% of the votes	**Supported by GDPC**	

Norfolk LDC, Jason Stokes

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.

This is existing policy. Data collection exercises have taken place in the NHS in England and Wales recently. The GDPC has worked to ensure that identified issues with these data collection processes are raised with the NHS. The GDC will also collect workforce data as part of the registration renewal process. These combined exercises should deliver far better data on the real workforce capacity, rather than using headcount figures.

Motion 17.

Carried with 96% of the votes		

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.

Given the lack of appropriate and accurate workforce data, we are not convinced that we or the government know whether there are enough dentists in the UK or not. It is clear that there are not currently enough dentists willing to work in the NHS system, and this is due to the contractual issues which we therefore believe are the main and correct focus of current discussion. There is no point in training more dentists if the system stays the same, as these additional numbers of dentists will also not wish to work in the system. Therefore, it is important to work on the evidence for a WTE number of dentists and base workforce planning on that evidence.

In any case, the NHS long-term workforce plan for England has since announced an increase in dental school places, but it has done so without information on funding or a promise of an equivalent rise in dental foundation places. This causes us great concern. The plan also sets out an aspiration for dentists to spend a greater portion of their time working on the NHS, which does not appear to be feasible given the government's failure to deliver contract reform or increased funding.

Motion 21.

Carried with 87% of the votes	**Supported by GDPC**	

Wirral LDC, Phillip Brown

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 10 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.

We support this motion in principle although the lack of career pathways is just one aspect of issues with the current system; whole system reform to ensure dental practices can continue providing NHS services is needed to ensure dentists will actually wish to work in it. In negotiations with NHS England, we have consistently raised the need for greater career and professional development support.

Motion 22.

Carried with 100% of the votes	**Supported by GDPC**	

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.

This is existing policy. The GDPC continues to raise the failure to uplift DFT service cost payments with NHS and DHSC.

Motion 23.

Carried with 99% of the votes	**Supported by GDPC**	

Derbyshire County LDC, Rami Khatib

All members of the dental team who are involved in delivering NHS services should have access to occupational health services funded by the NHS.

England, Policy

Supporting statement:

This motion aims to give greater recognition and value to all members of the dental team.

The GDPC agrees with this motion and continues to raise this with NHS as a means to improve recruitment and retention.

Motion 24.

Carried with 89% of the votes	**Supported by GDPC**	

Birmingham LDC, Ranjit Singh Chohan

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.

This is existing policy. The GDPC is supportive of the principle of providing access to the NHS Pension Scheme for those members of the dental and practice team who are involved with NHS work. However, it is important that funding for such arrangements comes via the NHS, and is not simply a financial burden on employers. It might also be a challenge to ascertain how much work of each individual staff member is apportioned to NHS work in the context of this motion.

Motion 25.

Carried with 88% of the votes		

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.

While we have great sympathy with the reasons and background of this motion and the difficulty of handling negative, especially vexatious, social media comments, we are not supportive of this motion. Enabling dental practices to respond in detail online to patient complaints and negative comments is more likely to exacerbate a given situation that is then less likely to be resolved positively. Inviting the individual to contact the practice, explaining the complaints policy, and offering a discussion if necessary is the professional approach.

The GDPC has carried out meetings with other relevant national stakeholders to discuss tackling vexatious complaints and will continue to seek opportunities to address this challenge. There are also regular meetings with NHS.uk in relation to its ratings and reviews function to ensure that the patient comments left on practice profiles are appropriately moderated.

Motion 26.

Carried with 95% of the votes	**Supported by GDPC**	

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

This is existing policy. The GDPC view is that it is reasonable for NHS dentists to decline to replace treatments that would not normally be provided on the NHS and that patients should not have an expectation that treatment should be replaced like-for-like. However, dentists have an obligation to treat patients, particularly where there is an immediate risk to a patient's oral health, subject to practice capacity. Imposing restrictions as suggested by the motion would be very difficult to enforce in practice, as it would not always be clear whether treatment had been conducted privately or abroad.

When patients present with issues resulting from treatment abroad, the likelihood is that the necessary care will be quite complex and may often be beyond a general dental practitioner's usual competence. As no registrant should work out with their competence, it is appropriate to deal with issues of acute or spreading infection and immediate risk to the patient's oral health, but to refer them on or advise them to return to the initial clinician for more extensive remedial work.

The Office of the Chief Dental Officer in England is currently looking at this issue and is expected to issue guidance on the responsibilities of NHS practices in this context. The GDPC is represented in relation to this work.

Motion 27.

Carried with 94% of the votes	**Supported by GDPC**	

Birmingham LDC, Ahmad El-Toudmeri

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?

The GDPC agrees with this motion. This has been the focus of a lot of work in the past year especially for the BDA due to the long delays caused by recruitment issues in the GDC's registration team, although we have also made representations on this in previous years. The GDC continues to require registrants who have unintentionally lost their registration due to a missed payment to go through the full restoration process without any prioritisation; there is seemingly no interest within the GDC's leadership to mitigate the significant issues that arise for registrants and patients from this. The GDC made small changes in summer 2023 so that registrants whose records show that they had complied with the CPD requirements until that time could sign a self-declaration of compliance rather than provide their full CPD record. While this is helpful as it takes out one administrative burden, the GDC has not taken on board any other suggestions for improvements to the process for this very specific cohort. The BDA will continue to raise the need for improvements, both in written communications and in meetings with the GDC.

Motion 28.

Carried with 91% of the votes		

Wakefield LDC, James Sanders

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

UK

The GDPC does not agree with this motion. We have taken advice from BDA Indemnity on the content of this motion as they work regularly on cases and therefore have considerable experience of observing the work and behaviour of FTP panels and chairs. It does not share the concern about lay members chairing FTP panels and indeed believe that a degree of independence can be beneficial. It is more important to have clinical expertise in the process and in particular registrants on the panel that are of the same registrant group and have experience in the actual area of the complaint (eg if there is a link to the NHS contract, there should be a dentist who has current experience of NHS general dental practice on the panel). Having a lay chair can be helpful in ensuring that the process remains impartial, especially as many of them have a legal background. It was therefore not supported to require dentists/DCPs as chairs of FTP panels in each case.

Motion 30.

Carried with 95% of the votes	**Supported by GDPC**	

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.

Sustainability in dentistry is clearly a theme that is ever-increasing in importance, and the review of HTM01-05 is necessary to ensure steps are taken to support sustainability policies in general dental practices. EBD as a journal publishes research rather than conducting it, but a researcher or research team should be commissioned to undertake this work. As HTM01-05 is not a BDA document, we believe that it is for the Department of Health and Social Care to initiate this review, and the Health and Science Committee will write to them on this matter.

Motion 31.

Carried with 100% of the votes	**Supported by GDPC**	

Birmingham LDC, Ahmad El-Toudmeri

This Conference calls for 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.

During the passage of the Health and Care Bill, the BDA lobbied hard for dentistry to be included in the governance structures and programmes of work of both Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs). We joined with other primary care associations to highlight the risks of under-representation of wider primary care sectors on the ICBs, and encouraged parliamentarians to ask for provisions to be made to ensure the whole of the primary care sector was represented in local systems. Our call was for dentistry to be represented and involved in decision-making at all levels of the Integrated Care Systems, including strategic decision-making forums, with a specific ask for LDC nominations for these roles. Though the Government did not accept our amendments for Integrated Care Boards to be required to work with primary care services, in his response the Minister said he was "open to further conversations in this area'.

Whilst it is frustrating that the Board structures in many ICS areas continue to reflect the in-minimus model set out in the legislation we continue to engage in any conversations which will make this goal a reality.

This was a key part of our submission to the Health and Social Care Committee's Inquiry into NHS dentistry and resulted in the following recommendation: 'The dental profession should be represented on Integrated Care Boards to ensure they have the necessary expertise to inform decision-making around contracting and flexible commissioning. This should include wider engagement with the profession locally, for example through Local Dental Committees'.

We will continue to take every opportunity both to encourage engagement and press for an LDC place on ICBs. We have recently written to all ICB leads to encourage engagement with LDCs in the development of local commissioning schemes.

Motion 32.

Carried with 93% of the votes	**Supported by GDPC**	

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.

Research and innovation (R&I) can lead to new advances in dentistry, such as providing evidence for improved treatments and techniques enabling changes to future working practices. We have been able to confirm that in England dental practices are eligible for the same research payments for undertaking research as medical practices, but that medical practices have contractually facilitated payments to cover service costs related to research, which dental practices do not. We are aware of NIHR Clinical Research Networks' efforts to facilitate and promote research in dentistry. A national direction has been set for ICBs to integrate primary care. There should be continued engagement with the NIHR to create a clear pathway to support oral and dental care within primary care research policy and practice.

Motion 33.

Carried with 86% of the votes	**Supported by GDPC**	

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.

The BDA is working to provide a toolkit of resources (data, templates, examples of good practice) to assist Local Dental Committee officers in making the case for change at local level.

Motion 34.

Carried with 99% of the votes	**Supported by GDPC**	

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

The decision to support representatives' travel to meetings is a matter for Local Dental Committees. A guidance document is being produced for LDC treasurers for discussion at Officials' Day.

Motion 35.

Carried with 50% of the votes		

Birmingham LDC, Ranjit Singh Chohan

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?

The GDPC continues to carefully consider all options on the table in terms of our approach to future campaigning. We are not currently actively pursuing industrial or collective action within general dental practice. Our focus has been on political and wider public relations, which we think offers the best opportunity to deliver change. The profile of NHS dentistry has never been higher as a consequence of our activity, supported by engagement from across the profession with politicians and the media. Many colleagues are voting with their feet and handing back their NHS contracts or more often reducing their NHS commitment. That sustained action is doing more than any single one-off event could do" to demonstrate what a total lack of dental provision looks like". Our current focus remains on leveraging that NHS exodus via our work with the media and our political partners.