LDC Conference 2025

Motions passed at Conference

MOTION 1

West Sussex LDC, Toby Hancock

The Government has protected patients from increases in prescription charges. This Conference believes dental patients who experience deprivation – and have higher disease levels – deserve equal protection.

England

Supporting statement:

Prescription charges have been frozen, but not patient charges. Wes Streeting said: "our moves... to freeze prescription charges will put money back into the pockets of millions of patients."

With a static budget, patient charges are just a substitute for state investment. Patients pay more, so ministers pay less.
We call for an end to double standards. The Government has intimated it will not rollout real time exemption checking to dentistry for reasons of cost. In a climate where reductions are being made to the welfare state and incorrect claiming can lead to huge fines this is unacceptable.
Ministers must be reminded that deprivation and disease are linked. If we believe a national health service should protect the most vulnerable and redress imbalances in risk, then protection from cost to the most deprived cannot be lost.
With the Spending Review ongoing, and NHS 10 Year plan coming, the message from dentists is that this service requires sustainable funding.

GDPC Response:

The GDPC strongly supports the principle that patients should not be deterred from accessing dental care due to cost pressures. As set out in existing GDPC policy, patient charges should ideally not exist, and where they do, increases should be limited and not used as a substitute for government investment.

We will continue to press government to adopt a consistent approach across NHS services and to ensure protection for vulnerable and high-needs groups. We also support the introduction of real-time exemption checking to protect patients and practices.

MOTION 2

Hampshire and Isle of Wight LDC, Phil Gowers

We urge conference – and dental teams - to sign up to the BDA's campaign : Make Sugar the new Tobacco | 38 Degrees and call on the government to spearhead this change with urgency – and ringfence the tax collected to dentistry.

UK

We praise the work the BDA has done in revealing the shocking levels of 'hidden sugars' in more than 200 baby food pouches. The Association's research inspired Panorama's recent investigation into this (if you haven't seen it, it's still on iPlayer): these products are disingenuously promoted to parents as 'healthy', when they're loaded with sugar, causing tooth decay.

It's time for Government to make the food industry do the right thing and cut sugar in applying tried and tested policies from home and abroad. We have seen how effective the soft drinks levy has been on making manufacturers reformulate their products with less sugar to avoid tax.

We therefore urge conference – and dental teams - to sign up to the BDA's campaign : Make Sugar the new Tobacco | 38 Degrees and call on the government to spearhead this change with urgency – and ringfence the tax collected to dentistry.

GDPC Response:

The GDPC supports public health measures to reduce sugar consumption and improve oral health. While taxation policy sits beyond GDPC's remit, we recognise the importance of funding prevention and support the BDA's wider campaign work on this issue. We will continue to emphasise the importance of public health policy and appropriate reinvestment into dentistry.

Health and Science response:

Following the work of the BDA and partner organisations, including those featured on BBC's Panorama programme, the Government announced the publication of voluntary industry guidelines for commercial baby food and drink aimed at children aged up to 36 months. These guidelines, published in August of this year, set out targets for businesses to reduce levels of sugar and salt in product categories and the actions businesses should take to improve the labelling and marketing of these products to help make it easier for parents and carers to make a healthier choice. Businesses will have 18 months to implement both the salt and sugar targets and the actions on labelling and marketing, and the Government will consider additional or alternative measures if they fail to implement these guidelines.

Alongside these guidelines, the NHS have also published updated advice on their Best Start in Life website, recommending that shop-bought food pouches, jars, trays and pots should only be used occasionally and not as an everyday food.

The BDA continue to campaign for mandatory guidelines to reduce the sugar content in commercial baby foods and drinks, alongside regulations on the marketing and labelling of these products.

MOTION 3

Norfolk LDC, Andrew Bell

Conference calls on the DHSC to recognise the role of "minority providers" (such as domiciliary care providers etc) when designing any new NHS contract.

England

Supporting statement:

All of the NHS dental workforce is crying out for a new contract. Without a radical change to the dental contract NHS dentistry will cease to exist. However, if we are fortunate to see a significant change in how NHS dental care is contracted, we must be aware of the law of unintended consequences. It is easier to see the impact of a contract on large providers, and their lobby groups will ensure this focus will exist. However, there are smaller niche providers of NHS care for whom any new contract must also function. Any negotiation must recognise the nuances of and give proper consideration to the viability of a new NHS contract in all practicing situations, or we risk creating a new set of dental deserts for those who cannot access NHS dental care in the standard way.

GDPC Response:

The GDPC recognises the crucial role of smaller providers including those delivering only domiciliary and specialist services. GDPC policy is clear that a reformed contract must support different patient groups and delivery models, and we continue to call for flexible models and commissioning standards, particularly for vulnerable and high-needs populations.

MOTION 4

Northamptonshire LDC, Judith Husband

This conference believes that the interests of Private Equity providers are rarely aligned with this profession, and there is an urgent need for an assessment of the risks associated with their growing dominance of both private and NHS care.

UK

Supporting statement:

- *Palamon Capital Partners have put MyDentist – the UK's single largest dental group – up for auction to other Private Equity companies, just four years after they completed their takeover from Carlyle in 2021.*
- *Some of the companies lining up for control have been accused of loading their acquisitions with debt (TDR Capital) or fined for price fixing on NHS drugs (Cinven).*
- *The 'efficiency savings' these private equity groups typically seek are a clear and present danger to the delivery of ongoing care, as is the pattern of repeat resales.*
- *The General Dental Council has not taken forward action to regulate corporate entities when they relaxed regulations for incorporation. The Government has yet to undertake any form of risk assessment on the exposure of dental provision to Private Equity providers.*

GDPC & REC response:

It is current BDA policy that there is a need to seek stronger regulation of the dental corporates, and the BDA has had discussions with the GDC about this and will continue to do so. One of the issues is to ensure that there are no unintended consequences from introducing more regulation for any smaller incorporated dental practices, as there is a risk that they could be covered by the

existing legislation as it is currently worded. So, it is not just a question of enacting existing legislation but ensuring that only actual corporate bodies defined through private equity investment factors are included in such a regulatory framework.

More broadly, NHSE needs to be alive to the risks of local market dominance by large corporate groups, the impact this can have on the local dental economy and the creation of single points of failure. Ultimately, it may also be an issue for the Competition and Markets Authority, who have already conducted some limited interventions into the dental market.

MOTION 5

Coastal LDC - Lancashire & South Cumbria, Zoe Mack

LDC Conference calls on NHSE/The Government to urgently overhaul commissioning guidance to ICBs to ensure that small independent practices are not disadvantaged by commissioning processes.

England

Supporting statement:

Without clear guidance commissioners have supported a race to the bottom in dental provision, which has resulted in undeliverable contracts, closures and deepening of access problems.

We are calling on NHSE/The Government to urgently overhaul commissioning guidance to ensure Equity in commissioning. This is required to ensure small independent practices are not set at a disadvantage compared to large corporate bodies when bidding for contracts and in particular recruitment initiatives.

The new arrangements for flexible commissioning, which include recruitment pilots such as financial support to attract international graduates and financially support their training, are leading to large corporate bodies being given an advantage. Schemes are currently being run across England (and potentially extended) through what effectively is a closed bidding process under the "pilot" designation.

ICB Commissioning Teams often run at low staffing levels, and this inevitably means that one large contract is easier and less time consuming to arrange, and thus more attractive than obtaining the same access levels across a number of smaller providers. The situation could be made worse by recent government restructuring announcements.

This unchecked, and inequitable, commissioning not only disadvantages smaller independent providers (in this case the ability to recruit); it can lead to an imbalance of power between commissioning teams and large corporate bodies, where the behaviour or business decisions of a single provider can all but collapse the service within an area. This risk may result in an ingrained two-tier system where ICBs can be pressured into greater comparative leniency when dealing with these organisations; such dependency makes it hard for any ICB to ever say 'no'.

GDPC Response:

The GDPC supports equitable commissioning and continues to advocate for commissioning

approaches that do not disadvantage independent practices. We have consistently opposed competitive procurement mechanisms and support the Provider Selection Regime to avoid "race to the bottom" procurement.

We will engage with NHSE to call for transparent and fair commissioning rules that safeguard smaller providers and protect local access.

MOTION 7

Norfolk LDC, Andrew Bell

Conference calls on the GDC to have a better understanding of non-UK Dental School curriculums and communicate this with the wider dental community working to support these new entrants to the NHS workforce.

UK

Supporting statement:

The GDC is able to register dentists who have graduated from Dental Schools within the European Economic Area with "unilateral automatic recognition".

There is no appraisal of the quality and content of the curriculum or spectrum and quantity of clinical work undertaken as an undergraduate.

For example, in some non-UK programs it is commonplace for dental nurses to take radiographs and for the dental student to never have experience of this.

In the current climate when both NHS and Private practices are suffering from the recruitment and retention crisis within dentistry, they are employing inexperienced clinicians from these dental schools under a Terms of Agreement or Equivalence arrangement. This then puts pressure on the supervising dentists to teach a newly qualified dentist with an essentially unknown competence how to be a dentist which is wholly inappropriate. This also has a huge impact for patient safety and vicarious liability/non-delegable duty of care.

REC response:

It is correct that the GDC does not currently quality-assure degrees from the EU/EEA while automatic recognition processes are in place. It is agreed that it might be helpful for the GDC to issue advice on differences to support practices taking on new dentists if it has specific information on such differences.

It is likely to be a temporary issue from now on (although it has existed for some time) as the unilateral automatic recognition of EEA dental degrees is currently expected to end in the summer of 2028, unless the government decides to continue with the policy and the legislation underpinning it. The (draft) GDC's strategy for the next few years includes an intention at GDC level to look at international registration routes and to streamline and improve them, so we expect a piece of work around this to start in the near future (details are not known at this point in time).

Beyond that, it should be noted that the Council of European Dentists (CED) has also identified issues with the direct clinical experience of some graduates and is working to have the relevant EU legislation updated as well as to make the European Commission aware of discrepancies and the need to address them. The BDA has input into the CED's work on this theme.

MOTION 8

North Yorkshire LDC, Isobel Greenstreet

This conference calls for equal and appropriate funding of Foundation Training schemes that is the same in all UK countries.

UK

Supporting statement:
This conference calls for all four nations to have a properly funded Foundation training scheme that is equal across all the nations. Currently this is not the case.

GDPC and REC response:

The BDA is sympathetic to this motion. Dental foundation training is extremely valuable and needs to have sufficient funding to deliver high-quality training. However, the funding of dental foundation training is based on national government decisions in England, Wales, Northern Ireland and Scotland, not on central UK government funding. Therefore, budgets will be set by the four governments in accordance with their own financial assessments, and parity will be difficult to achieve. BDA lobbying and negotiating will have to continue to take place at the national level, rather than the central level.

Where there is national recruitment for England, Wales and Northern Ireland there should be parity of salary for the foundation dentist and where this is not the case this should be clearly signposted to applicants.

In England and Wales, service cost payments have not been uplifted appropriately for a decade. We continue to call for a revaluation of the payments to bring them in line with the costs, and for annual uplifts to apply.

MOTION 9

Leicestershire LDC Hanish Chotai

This conference notes that the grants provided to training practices for supporting Foundation Dentists have remained stagnant for several years. We propose that these grants be increased to an amount agreed upon by the General Dental Practice Committee (GDPC) that ensures practices do not need to subsidise the cost of training a Foundation Dentist. Furthermore, we call for these grants to be reviewed annually and adjusted in line with inflation to maintain financial sustainability for training practices.

England and Wales

Supporting statement:

The practice grant for DFT has been stagnant for more than 10 years with a less-than-optimal increase proposed for the year 2025-26. The practice running cost, staffing cost, laboratory cost and the cost of dental materials have increased exponentially over the last 11 years, which has led to practices indirectly subsidising the training.

GDPC and REC response:

This is existing policy and supported. The BDA's evidence to DDRB and its submissions to the DHSC call for a revaluation of the service cost payments to account for the real-terms cut, and then for annual uplifts to be applied.

MOTION 10

Bedfordshire LDC, Gurpram Lidder

This conference believes government must cover costs of dental care, by undertaking a robust cost of service exercise, that ensures future contracts can operate sustainably.

UK

Supporting statement:

A typical practice is losing over £40 delivering a set of NHS dentures. No part of our health service can operate sustainably on this basis, but the Treasury expects it of us.

The Public Accounts Committee has already called for an accurate assessment of these costs.

If NHS dentistry is going to have a future it is not enough to gather this data. Conference believes the Treasury must commit to meeting these costs.

GDPC Response:

The GDPC secured a cost-of-service review conducted by the DHSC in summer 2025, as recommended by the Public Accounts Committee following the BDA's engagement with that Committee. Fair remuneration is essential for sustainability and recruitment, and having a full assessment of the costs of dental care is a critical component of developing a reformed contract.

MOTION 11

Cornwall and IoS LDC, Mark Card

This conference calls for reassessment of the division of NHS funds for priority groups that are inadvertently detracting away from other in-need groups such as older people and children.

England

Supporting statement:

The advent of more use of the flexible commissioning model of the UDA contract has been welcomed for some aspects of the NHS dental contract. Whilst these initiatives already appear to detract from progressing contract reform, worse than this, many patients are being isolated out of 'priority' groups and there is a risk that access will only be targeted at certain groups. This could cause dental teams to discriminate against many groups of patients who are permitted and eligible to be seen under the current headline contract. For a vast number of patients, especially those on a low income but not in a 'priority group' or able to claim NHS payment exemption, access is being denied. These tax-payers will understandably feel aggrieved at not getting value for their money and this will just add to the frustrations felt by the public about how NHS dental services are managed.

GDPC Response:

The GDPC supports equitable and comprehensive access, advocating for adequate funding across all patient groups rather than reallocation within a fixed envelope. Any local decisions on prioritisation through flexible commissioning schemes should consider the impact on wider access, and this should include consultation with the LDC on the design of these schemes.

MOTION 12

Tees LDC, Kamini Shaw

This conference calls for continuing care payments for children (in addition to payments for activity).

England

Supporting statement:
The rates of children accessing dental care have not recovered to pre-COVID levels. Only 47% of children in England as of June 2022 had attended for a check-up compared to 58% in March 2020. If the NHS are committed to improving oral health in children, the dental reforms could provide the opportunity to incentivise practices to accept new child patients, providing access to care for all children.

GDPC Response:

The GDPC supports contract mechanisms that incentivise access and preventive care for children. We continue to push for weighted capitation, including for paediatric patients, to support prevention and improved access.

MOTION 13

Tees LDC, Ian Gordon

This conference calls for a 3-year rolling UDA contract.

England

Supporting statement:

When a colleague is off on long term sickness or is on maternity/paternity/adoption leave getting a replacement on a temporary basis is challenging and puts a practice at risk of not meeting contractual targets and a breach notice. If NHS dental contracts were averaged over a three-year period, it would provide these practices some headroom to catch up the required UDAs without penalty.

GDPC Response:

GDPC recognises the operational pressures created by rigid annual delivery requirements. We are pressing for flexible approaches during contract reform, including mechanisms to support practices experiencing temporary workforce disruption. We are mindful that a three-year contract may simply store up a very large clawback that bankrupts a business and that there may be other means to achieve these ends.

MOTION 14

Birmingham LDC, Ranjit Chohan

This Conference calls for the BDA to lobby for the development of NHS dental contract adjustments that allow practices more flexibility in the event of maternity leave, including adjusted UDA targets and the return of any potential clawback monies resulting from reduced activity during that period, to ensure practices are financially protected and can support returning dentists.

England and Wales

Supporting statement

Maternity leave can create significant challenges for both dentists and practices. When a dentist takes maternity leave, the practice often experiences reduced activity, which can trigger clawback of funding due to unmet UDA targets. This can financially penalise the practice, despite making provisions for a temporary absence.

This motion calls for adjustments to the NHS contract to provide more flexibility during maternity leave, including adjusting UDA targets and returning any potential clawback due to reduced activity during that period, ensuring that practices can continue to function smoothly and support returning dentists without financial penalties

GDPC Response:

The GDPC supports mechanisms to better support practices and dentists during maternity leave. In line with our advocacy around practice sustainability and workforce support, we will continue to seek contractual protections and flexible models during periods of extended leave.

MOTION 15

Cornwall and IoS LDC, Mark Card

This conference calls for availability of a minimal PASS provision across all LDCs and BDA support to set up a quality assurance framework to include training.

UK

Supporting statement:

LDC's need to be able to prioritise PASS support for practitioners, particularly at this time of increased challenges and pressures of providing dental care. There is no standardised training package or advice on how to complete this effectively, and it would be useful to have support in place with training advice for PASS LDC members. PASS support has the potential to help effectively to keep dentists practising, but when done incorrectly could be devastating. By supporting the practitioners who are offering this service, confidence could be built and maintained for both the confidant and the recipients.

GDPC and REC response:

There is currently work in progress to ascertain the activity of existing PASS schemes, and the level of training and support they have. The BDA will look further at the support it can provide in training and quality assurance once this information has been gathered.

MOTION 16

Birmingham LDC, Ahmad Tadmory

This conference calls for DHSC to mandate that any individual involved in the commissioning or procurement of NHS dental services must undertake at least one day of observation in a primary care dental setting as part of their induction or ongoing professional development. England

Supporting statement

Far too many of the people making decisions about NHS dental services have never actually stepped inside a busy NHS dental practice. They have little real understanding of the day-to-day pressures we face—trying to deliver high-quality care under relentless time pressures, dealing with growing patient frustration and even aggression, and constantly navigating the impossible balance between demand and capacity. This motion calls for a simple, common-sense step: that anyone involved in commissioning or procuring NHS dental services must spend at least one day observing in a primary care dental setting. Whether as part of their induction or ongoing professional development, this experience will help ground their decisions in reality—and, hopefully, foster a little more empathy and a lot more informed thinking.

GDPC Response:

GDPC supports measures that improve commissioners' understanding of the realities of delivering NHS dentistry. We will raise this recommendation with NHSE as part of improving commissioning understanding of the practicalities of dental practices and strengthening clinical voice within ICBs, consistent with our policy on representation in ICS structures.

MOTION 17a

Birmingham LDC, Ranjit Chohan

This Conference believes that Integrated Care Boards have failed to accurately forecast clawback from under-delivered NHS dental contracts, despite real time access to activity data, and calls for a mechanism of accountability to ensure this funding is reinvested into dental services within the same financial year.

Supporting statement

NHS dental contract activity data is available to ICBs on a near real-Ime basis. Despite this, significant underspends are routinely identified only at year-end, too late for meaningful reinvestment. As a result, clawed-back dental funds are often lost to the wider NHS or returned to central government — representing a missed opportunity to improve access, pilot new models, or offer targeted commissioning. This motion calls for greater financial planning accountability within ICBs and a ring-fenced commitment to reinvest reclaimed funds into dentistry within the same financial year.

GDPC Response:

GDPC strongly supports ring-fencing dental funding and reinvesting clawback locally within the same financial year. This position aligns with our ongoing campaign for dental budget protection and accountability across ICBs.

MOTION 18

Tees LDC, Charles Daniels

This conference calls for clear, full and rapid mitigation of added costs from National Insurance and minimum wage increases in the last budget.

UK

Supporting statement:

For too many years the headline 'wage increase percentage' rate for general dental practice has been diluted by the 'dental deflator'.

The recent budget, with its significant increases to National Insurance contributions and the national minimum wage, will have a major impact on the sustainability of dental practices and may lead to a further exodus from providing NHS dental services.

Private practices may have some protection from the increases due to the ability to increase fees and from the increase in Employment Allowance.

NHS practices are not permitted to change their prices and are not entitled to claim the Employment Allowance relief. Once again General Dental Practice is treated less fairly than our General Medical Practice colleagues where approximately £900m has been made available to cover these costs.

GDPC Response:

GDPC continues to raise inflationary cost pressures, including NI and minimum wage increases, with DHSC and DDRB. We support full reimbursement for new statutory costs to ensure viability, consistent with the committee's long-standing position on expenses and uplift mechanisms.

MOTION 19

Wakefield LDC, Sneha Thakrar

In cases where Associates' retention fees are withheld for longer than three months, this conference calls for these sums to be protected in an Escrow account (or similar).

UK

Supporting statement:

Retention fees should not be drawn without consultation and discussion with the associate in order to reach an agreement that the funds are being properly used.

GDPC Response:

The GDPC acknowledges the concerns raised around associate retention monies, we encourage transparent and fair agreements and dealings in relation to them. This motion is a work in progress, and the BDA is considering the practicalities of retention payments being held in trust. The GDPC will consider whether any provision can be made to require the payments to be held in trust.

MOTION 20

Hertfordshire LDC, Alison Chastell

Conference calls for reforming the business rates rebate to reflect the exact percentage of NHS commitment undertaken.

England

Supporting statement:

The current method is based on a 10% band system for NHS work carried out. This means that many practices can only reclaim a smaller proportion of the business rates than the actual proportion of NHS work carried out. They are, therefore, disadvantaged.

GDPC Response:

While the GDPC recognises the issue raised, we feel that precise declarations risk generating greater administrative burdens and opening practices up to greater scrutiny.

MOTION 22

Tees LDC, Mike Barnett

This Conference calls on the GDC and the DHSC to ensure significant improvements to the timeliness of fitness-to-practise processes are made urgently.

UK

Supporting statement

The 2024 Performance Report by the Professional Standards Authority showed that the GDC once more had not met the standard for fitness-to-practise timeliness. As a result, the PSA has written to the Secretary of State for Health and Social Care and the Chair of the Health and Social Care Committee and is this year undertaking an in-depth review of FTP processes as part of the 2025 review. The fact that cases take months and years to move through the process is devastating to many registrants who are waiting to be 'judged' and find out what this will mean for their future working life. While there may be a variety of underlying reasons for the speed with which cases progress, it is important that there is no undue delay. In addition, there are significant delays to regulatory reform of all the regulators' legislation, a reform that could potentially help to make the FTP process less adversary. The GDC's turn for such reform does not even seem to be properly scheduled, while GMC and NMC are deemed to move forward over the next couple of years. We therefore call on the GDC to improve its timeliness of moving cases through the system, and on the DHSC to commit to and move forward regulatory reform of the GDC with speed.

Suggested REC response:

This is existing policy. The Association is extremely focused on the need to ensure improvements in the FTP area, regularly discusses raises FTP matters with the GDC leadership, and continues to highlight the urgent need for regulatory reform with the government wherever possible.

MOTION 23

North Yorkshire LDC, Mark Green

This conference calls for the disbandment of the CQC and for it to be replaced with a more clinically-led regulatory body.

England

Supporting statement:

The CQC have for years been criticised for their lack of proportionality and the increased importance given to paperwork and box ticking exercises.

Last year a damning report led by Dr Penny Dash highlighted significant failings including a lack of clinical expertise. The Secretary of State also concluded that the CQC is unfit for purpose and yet it continues to cause stress and unnecessary upheaval for many practices.
We propose a new regulatory structure based on the previous Dental Reference Officer role to replace the CQC

GDPC and REC response:

While the CQC is currently going through a wide-reaching process of review, some continuing place-based regulation was inevitable. While inspections are tough and time-consuming, they are rare and help demonstrate that dental practices are doing well in the area of compliance. The BDA does meet with the CQC regularly and highlights problems, and this includes the need for clinical input and oversight in the context of CQC regulation of dental practices.

MOTION 24

Tees LDC, Charles Daniels

This conference calls for a change in the indemnity model when clinicians are providing NHS dental treatment to a model where payouts are restricted to nationally agreed amounts that are solely used for corrective dental treatments.

UK

Supporting statement:

The current model of dental indemnity is broken. One dentally based solicitors company model provides for a 'heads they win, tails you lose' situation where their fees are always covered either by insurance or by the dentist/their indemnity company, encouraging patients to claim against dentists. Payments for failed simple treatments can be significant and in many cases the money is not used for corrective dental work. Payments to patients should be limited to nationally agreed amounts in a similar manner to other areas of the NHS.

Suggested REC response:

The costs relating to a successful claim come under two different headings. The first is quantum (damages paid to the claimant) and the second is the claimant's legal costs.

In relation to damages there are special damages and general damages.
General damages: compensation for pain and suffering and loss of amenity (PSLA). These are based on Judicial College Guidelines and are nationally accepted figures though subject to negotiation.

Special damages: This covers financial losses arising from the negligence, e.g. loss of earnings, remedial dental treatment costs, travel costs along with future financial losses associated with replacement of the dental treatment e.g. crowns, fillings etc.

There also the claimant's legal costs in bringing the case - a regime called Fixed Recoverable costs - this came in for all fast track civil claims up to about £25,000 in damages and intermediate track for simpler claims valued between £25,000 and £100,000. These will cover the majority of dental cases. This regime limits the amount of money a claimant's law firms can recover in a successful case.

We would support the idea of fixed recoverable costs for special damages. It could be argued that remedial treatment should be costed at NHS fee levels, but there may need to be consideration of treatment costs that are not available or accessible on the NHS.

MOTION 25

West Sussex LDC, Matt Botha

This Conference calls for the introduction of a no-fault compensation scheme within NHS indemnity for primary care dental practitioners, ensuring fair, timely, and transparent resolution of patient claims without the need to establish negligence.

UK

Supporting statement:

There are few incentives for working in the NHS and an increasing litigious landscape. A no fault compensation scheme would address both these problems. It would show the workforce they are valued, it could be cost effective and protect patients.

Joint GDPC and REC response:

In principle, we support this motion. In theory a no-fault system is attractive as it removes the adversarial nature of the process which makes it stressful for both parties and it might be quicker but the scheme would have to be paid for via general taxation or dentists' contributions.

There are some other risks:

***Increased costs**: Compensation payouts could increase dramatically. A New Zealand scheme saw claims rise significantly after its introduction, and it is estimated that compensating everyone who experiences avoidable harm would cost more than the current system, despite savings on legal fees.*

***Reduced accountability**: Some argue that removing the threat of litigation could lead to a lowering of clinical standards, as there would be less incentive to maintain high levels of care.*

***Risk of a two-tiered system**: Unless the scheme covers both NHS and private dentistry, it could create an inequitable system. Furthermore, people injured in other ways (e.g., in road traffic accidents) would continue to receive higher, full compensation through the existing tort system.*

***Integration with private indemnity**: Unlike NHS trusts that are centrally indemnified, dental practitioners are independent contractors with their professional indemnity cover. Integrating a no-fault scheme with these private arrangements would be challenging*

MOTION 26

Liverpool LDC, Bill Powell

This Conference calls for Indemnity protection to help retain newly qualified dentists within the NHS.

UK

Supporting statement

1 Newly qualified dentists face increasing costs and risks associated with indemnity, making NHS work less attractive compared to private practice.

2 The fear of litigation, especially in the early years of practice, discourages young dentists from committing to long term NHS careers.

3 Offering Crown indemnity or government-backed indemnity would provide essential protection, reduce financial burdens , and encourage retention within the NHS

4 Similar indemnity protections already exist for dentists in hospitals creating an unfair disparity.

GDPC and REC response

Most defence organisation have sliding scales of indemnity premiums /membership fees which can be very low in the first couple of years £150-£300 which rise incremental to Year 4 and 5 post qualification.
These are not prohibitive premiums.

Crown indemnity only works when clinicians are providing NHS services exclusively as they are in NHS trusts and the GPs are providing in NHS general practices. It becomes very difficult to unpick claims of negligence when both NHS and private treatment have been provided – sometimes on the same tooth.

Retention in the NHS will not rely on reducing already quite low premiums for young dentists. These low premiums are in fact cross subsidised by practitioners who have qualified for longer and it can be argued that the more inexperienced dentists are in fact a higher risk than the more experienced dentists making low premiums an anachronism.

MOTION 27

Hertfordshire LDC, Alison Chastell

Conference is disappointed that, unlike our medical colleagues, following foundation training, most dentists in the UK do not have a clear career pathway or access to formal mentoring, appraisal, or training.

UK

Supporting statement:

As a result, the standards of care for patients are more variable than they should be.

We must work towards a system in which all dentists are engaged in a professional career pathway framework such as that proposed by the College of General Dentistry.
This should apply to all GDPs, regardless of whether they work in the NHS, private practice, or mixed practice.

It must be funded appropriately, clinically, scientifically, and professionally rigorous, not the current tick-box exercise of CPD.

Agreed REC response:

The theme of career support and mentoring is a matter of current discussion. The BDA has included an exploration of provision of a mentoring scheme in its strategy for the next triennium.

MOTION 28

Norfolk LDC, Andrew Bell

Conference calls on government to focus on access to General Dental Services rather than Urgent Care.

England and Wales

Supporting statement:

The government is adopting a short-term strategy focusing on the delivery of urgent care. As all clinicians know, this is the start of a process of dental care, not the end. The focus on delivering urgent care without a viable system for these patients to move into for stabilisation and rehabilitation will convert our NHS dental population into those who can only access care when they have an emergency. A growing focus on "treat them and street them" will harm the long-term health of the nation and the morale of the remaining NHS dental teams.

GDPC Response:

The GDPC understands the Government's focus on urgent care and have attempted to support them to achieve their objective of delivering 700,000 additional urgent care appointments. However, we also recognise the point made in this motion that there needs to be an appropriate balance between urgent care and routine care. There are 14 million adults in England without access to an NHS dentist and the Government must address this point. The GDPC continues to press government for reforms and funding aimed at restoring full access to NHS dental services, consistent with our policy on comprehensive NHS care and prevention-focused contract reform where payments match the costs of treatments.

MOTION 29

West Sussex LDC, Mark O Hara

This Conference believes that NHS primary care dentistry must be recognised as providing far more than just urgent care and calls for a contract that recognises the need for delivering continuing care to patients.

England and Wales

Supporting statement:

During the pandemic lockdowns and restriction resulted in diminished capacity in a system already losing practices. It left patients in pain struggling to find care. It was right to prioritise getting access for urgent care. We are 5 years on now and activity has still not returned to pre pandemic levels, the situation has moved on. Many areas have established local urgent and stabilisation pathway's but failed to resolve long term and ongoing access to revalue dental care . If we don't work on a contract supporting routine care we may lose it forever.

GDPC Response:

The GDPC strongly supports this motion. NHS dentistry must supply long-term, prevention-focussed dental care, and not act solely as an emergency service. While we have attempted to support the Government's efforts to expand urgent care appointments, this cannot be the only focus or purpose for NHS dentistry. The GDPC continues to advocate for a reformed contract that replaces UDAs with a prevention-based system that supports continuing care.

MOTION 30

Cornwall and IoS LDC

This conference calls on the ICBs to learn from each other with what works in different ICB areas.

England

Supporting statement:

It is becoming increasingly known that Integrated Care Boards do not learn from each other to promote good practice and innovation that has worked in other areas. This has resulted in replication of work and errors, stalling progress, and has led to further disenchantment felt by NHS contractors. If ICB's could effectively communicate and learn from effective practice, this would in turn drive success and retention of NHS dental access for patients.

GDPC Response:

The GDPC agrees. There is significant variation in how ICBs operate, and a lack of shared learning has led to duplication, delay and missed opportunities to improve patient access. The GDPC continues to urge NHSE to provide national direction and mechanisms for sharing best practice and successful models, particularly regarding flexible commissioning.

MOTION 31

Liverpool LDC

This Conference calls for financial protection for NHS dental practices against missed appointments.

UK

Supporting statement:

1. NHS dental practices operate on tight margins, with funding based on UDA's leaving little room for lost revenue. Missed NHS appointments cost practices thousands annually, threatening their ability to provide NHS services. Without protection, more practices may reduce NHS commitments or close, exacerbating the access crisis. Fair compensation for DNAs would safeguard practice finances and NHS dental sustainability.

2. A significant number of NHS patients fail to attend (DNA) their appointments without notice, resulting in:
- Lost clinical time that cannot be reallocated.
- Unrecoverable costs (staff wages, overheads, and unused materials).
- Reduced capacity to deliver NHS care, as practices absorb losses.
3. Many independent dental practices—already struggling with rising costs and UDA underfunding—face financial instability due to DNAs, risking practice closures and reduced NHS dental access.

This conference believes
1. The current NHS dental contract fails to account for the financial impact of missed appointments, unfairly penalising practices.
2. Compensating practices for lost UDAs due to DNAs would:
- Improve practice viability.
- Sustain NHS dental provision.
- Reduce pressure to prioritise private care to offset losses.

This Conference call on
1. NHS England and the Department of Health
- Introduce a failed appointment UDA mechanism, awarding UDAs for booked NHS slots where patients DNA.
2. Local Dental Committees (LDCs) and the BDA to lobby urgently for this reform.

GDPC Response:

The GDPC supports this motion. Practices should not bear the financial burden of patient FTAs. As per GDPC policy, the contract must recognise and mitigate the loss of surgery time and resource resulting from failed appointments. GDPC will continue to press for contractual protections and a fair system for practices. For urgent care, we have advocated for sessional payment models that underwrite the risks of FTAs.

MOTION 32

Northamptonshire LDC

Conference is appalled by the continued approach of penalising dentists and dental practices for patients failed appointments. We call on NHSE to urgently address this perverse situation.

England

Supporting statement:

With the introduction of the Health and Social Care Act dentistry became a part of the NHS family in one important way, the banning of imposing charges for missed appointments.
This approach is still undertaken in private practice and works well as a disincentive to patients to wasting surgery time.

Other parts of the NHS are also blighted by failed appointments with medical colleagues often flagging this. Dental practices accepting new patients or undertaking emergency sessions know the risk of failure increases significantly with irregular attending patients.
It is imperative the government underwrites this risk for practices if there is to be even a glimmer of success to the marginal changes.

Conference believes either the practice should have the discretion to charge in a manner of their choosing or NHSE provides compensation to contractors. It is not acceptable to expect clinicians to pay for patients' actions with reduced income or for practices to incur costs without recognition.

GDPC Response:

The GDPC supports this motion. Practices should not bear the financial burden of patient FTAs. As per GDPC policy, the contract must recognise and mitigate the loss of surgery time and resource resulting from failed appointments. GDPC will continue to press for contractual protections and a fair system for practices. For urgent care, we have advocated for sessional payment models that underwrite the risks of FTAs.

MOTION 33

Leicestershire LDC

This conference calls for a statutory requirement that all monies collected by Integrated Care Boards (ICBs) from NHS dental practices for undelivered Units of Dental Activity (UDAs) be ring fenced exclusively for the provision of dental services. These funds should be transparently allocated to improving patient access, workforce support, and service sustainability within NHS dentistry.

England

Supporting statement:

Over the past many years, some money from the dental clawbacks have been used to fund projects outside of dentistry. In such times when access to NHS dentistry has been on the decline, a reduction in funds would only add to the ever-increasing access issues. Using clawback money for flexible commissioning or for recurrent funds for practices with resources will improve access.

GDPC Response:

GDPC supports the motion. Given current system pressures, timely local action through ICBs is essential. GDPC has consistently encouraged flexible commissioning, minimum UDA values and other local measures to stabilise NHS service delivery while national reform is awaited.

MOTION 34

Leicestershire LDC

This conference proposes that all Integrated Care Boards (ICBs) be required to include at least one representative from the Local Dental Committee (LDC). This will ensure that oral health needs are effectively highlighted and addressed within local healthcare planning, improving access to and provision of dental services for the community.

England

Supporting statement:

This is existing policy. Oral Health is often overlooked in wider healthcare planning. Including a LDC representation on ICBs would ensure that dentistry has a voice in local decision-making. LDCs understand the needs of both providers and patients and can help shape more integrated, effective strategies to tackle oral health inequalities.

GDPC Response:

GDPC supports this motion and has consistently advocated for there to be representation for LDCs on ICBs.

MOTION 35

Tees LDC

This conference calls for the NHS Pension scheme to be available to all members of the dental team providing NHS dental treatment including hygienists and therapists and other staff members.

UK

Supporting statement:

Currently any dentist who is delivering NHS dental care as a dental provider or performer can be admitted into the NHS Pension scheme (the exception being performers who operate through a limited company). As the model of delivery of NHS services changes to increase skill mix with DCPs holding Personal Numbers (as opposed to performer Numbers), more NHS dentistry will be provided by those unable to benefit from the NHS pension scheme. This is grossly unfair to all those dental staff involved and a change would match the offer made for any General Medical Practice staff to join the scheme.

GDPC Response:

GDPC supports widening pension access for members of the dental team where it is funded appropriately by the NHS. This is consistent with GDPC's existing position supporting access to NHS pensions for NHS dental staff.

MOTION 36

Birmingham LDC

This conference calls on DHSC to establish a streamlined national process for enabling the rapid adoption of successful flexible commissioning models across ICBs, removing unnecessary bureaucratic barriers and ensuring equitable access to innovation.

England

Supporting statement:

Too often in dentistry, when something works well in one part of the country, it hits a wall of red tape when we try to replicate it elsewhere. Local bureaucracies and inconsistent commissioning approaches mean proven models are left to gather dust instead of being scaled to benefit more

patients. Some long-standing commissioners seem to have no motivation—or outright refusal—to even entertain processes that could ultimately improve patient care. Instead, they cling to personal agendas or long-held vendettas against GDPs, ignoring reason and blocking progress. What's worse, ICBs, who should be providing oversight, often end up taking direction from these very individuals. This motion calls for a national, streamlined process to fast-track the rollout of successful flexible commissioning models—cutting through the noise, removing barriers, and making sure good ideas don't die in committee rooms.

GDPC Response:

The GDPC agrees. Flexible commissioning is a useful interim measure while full contract reform is awaited, but effective models should be capable of rapid, consistent spread across systems. GDPC will continue to press NHSE and DHSC for national frameworks to remove unnecessary local barriers and bureaucracy.

MOTION 37

Birmingham LDC

This conference calls for a formal mechanism to ensure that all unspent dental allocation within ICBs/Health Boards is ring fenced exclusively for reinvestment into local NHS primary care dental services. Furthermore, commissioners must be required to develop and publish a clear plan for how this funding will be utilised—whether through flexible commissioning or other mechanisms—no later than the end of the second financial quarter, to allow adequate time for effective implementation within the same financial year.

England and Wales

Supporting statement:

Year after year, we see millions in unspent dental allocation vanish at the end of the financial year—money that was meant for patients, lost to the system. This motion calls for two simple, fair actions: first, that all unspent dental funds are ringfenced exclusively for NHS primary care dentistry, not diverted to plug gaps in secondary care budgets or dental hospital deficits. Second, commissioners must be compelled to make clear, deliverable plans—such as through flexible commissioning—by the end of Q2. Waiting until the eleventh hour to deploy these funds is neither effective nor fair. It leaves providers scrambling, unable to mobilise workforce or plan services in time, and ultimately results in lost opportunities for patient care. By planning ahead, we can actually spend this money where it was intended and deliver meaningful impact for communities.

GDPC Response:

GDPC strongly supports this motion. Dental budget must remain within dentistry and be allocated in-year to support access. GDPC has consistently called for ring-fencing and will continue pressing DHSC and ICBs to ensure funding is deployed transparently and in time to benefit patients and practices.