

LDC Conference 2026 Motions

Funding and NHS Contracts

Prevention programmes

Motion 1

Norfolk LDC, Andy Bell

This conference calls on all UK Governments to urgently implement and fully fund comprehensive, evidence-based national oral health prevention programmes.

UK, Policy

Supporting statement:

Oral disease remains one of the most common yet preventable health conditions in the UK, disproportionately affecting children and vulnerable populations. The current model—largely reactive and treatment-focused—places an unsustainable financial and operational burden on the NHS while failing to address the root causes of disease.

There is overwhelming evidence that prevention is both clinically effective and cost-efficient. For every £1 invested in preventative measures, several pounds are saved in avoided restorative and emergency care. Proven programmes such as Childsmile in Scotland, alongside successful national prevention strategies in countries including Sweden and Denmark, demonstrate measurable improvements in oral health outcomes and reductions in inequality.

At a time when the existing dental contract is widely acknowledged to be unfit for purpose, with no meaningful reform or sufficient investment in primary care dentistry, a national prevention programme is not optional—it is essential. Without decisive action, oral health inequalities will widen, access will continue to deteriorate, and costs to the NHS will escalate further.

A coordinated, adequately funded national prevention strategy offers the most realistic and effective means to stabilise and improve the nation's oral health, reduce long-term costs, and relieve pressure on frontline dental services.

Inequitable targets

Motion 2

Lancashire and South Cumbria LDC, Stuart Johnson

This Conference calls upon GDPC to reject NHSE and DHSC initiatives that impose retrospective, interdependent targets, forcing practices to gamble on the financial viability of providing essential patient care.

England

Supporting statement

We have been subjected to a string of short-term reactive initiatives to meet politically driven targets; access for new patients over regular patients and provision of urgent appointments with an arbitrary target.

The implementation of these initiatives has been fraught with errors, unintended consequences, and unnecessary complexity; for example, due to NHS BSA's continued inability to provide accurate data such as tracking new patients seen.

The schemes are loaded with inherent inequities; unfairly penalising practices for unavoidable fluctuations in activity caused by illness, disability, maternity & paternity, and recruitment issues. This year's Urgent Care is a prime example; a target based retrospectively on an arbitrary baseline period of the first third of the financial year, without due consideration whether this is a reasonable baseline period for any particular practice.

Crucially, this convoluted approach forces clinicians into unpredictable strategic manoeuvring just to keep their practices sustainable. Because targets are retrospective and interdependent, a clinician does not know whether seeing a new patient or a new-patient emergency will ultimately be loss-making until much later in the year. There's no way of knowing the remuneration for a particular appointment at the time, as you can't predict, for example, how many more new patients you'll be able to see or the future demand for urgent care; it depends on other clinicians and factors you can't influence. Providing necessary dental care cannot be a game of fee-roulette.

Furthermore, this complex, unpredictable approach has a significant administrative burden; both for practices and shrinking commissioning teams; particularly in the absence of robust relevant information through COMPASS.

Conference calls upon the GDPC to reject any initiatives by NHS England and the DHSC that leverage this approach of using inequitable, volatile performance metrics in favour of

transparent, stable, and fair contractual frameworks - which support the necessary investment in practices, staff and equipment to provide a sustainable service.

Unscheduled care

Motion 3

Birmingham LDC, Ranjit Singh-Chohan

This conference believes that unscheduled care must not be used as a substitute for continuing care within NHS dentistry, nor as a mechanism by which access is improved on paper while continuity deteriorates in practice.

England

Supporting statement

The 2026/27 contractual changes introduce a defined minimum requirement for unscheduled care within NHS dental contracts. While providing care for patients with urgent needs has always been part of NHS dentistry, this change formalises a specific level of activity that practices are expected to deliver.

The current requirement of 8.2% of contract value being directed towards unscheduled care appears to have limited transparency in how it has been derived, and there is concern that this figure may be subject to future increase without clear evidence base or assessment of system capacity.

There is therefore a risk that, without appropriate safeguards, this requirement may be delivered at the expense of continuing care for patients already under treatment or with ongoing clinical need. In many practices, demand for unscheduled care already exceeds available capacity.

Prioritising this activity risks displacing routine and stabilisation care, particularly for high needs patients who require continuity and phased treatment. This may result in a system where access appears to improve in headline terms, while continuity of care deteriorates in practice.

Compass

Motion 4

Tees LDC, Charlie Daniels

Conference calls on the BSA to be able to deliver change so Compass clearly shows relevant information at the appropriate time.

England and Wales

Supporting statement

Presently Compass does not show unscheduled care and regular UDAs separately, causing confusion among the profession of where the goal posts are.

This issue needs addressing as a matter of urgency.

We need assurances that any further changes to the pathways and new contracts are fully tested by the BSA before implementation.

Contract Reform

Consultation and negotiation with the profession

Motion 5

Enfield and Haringey LDC, Roger Levy

Conference demands that government dental teams and negotiators involved in contractual changes make all relevant data and data sources available to BDA.

England and Wales

Supporting statement

The BDA is hamstrung in discussions and negotiations by the lack of access to data and reports which it knows to exist, and which are used or misused by government. The cost-of service report which informed the government's strategy on recent contractual reform is only one example of data that is being kept from the BDA.

It is impossible and unacceptable to expect the BDA to consider any contractual negotiations without all the data to hand. There must be openness and transparency.

Funding

Motion 6

Birmingham LDC, Abid Hussain

Conference believes that the continued claim that there is "no more money" for NHS dentistry is unacceptable and calls on the government to prioritise and increase investment to restore access and ensure NHS dental services are funded to a level that reflects the real cost of delivering care.

England and Wales

Supporting statement

The idea that there is “no more money” for NHS dentistry is becoming harder to accept. If the political will is there, the money could be found? We’ve seen in other areas that when pressure builds, funding decisions can and do change. Dentistry shouldn’t be any different.

What we’re seeing now just isn’t sustainable — access is falling, the workforce is shrinking, and patients are struggling to get care. This isn’t just about money being unavailable, it’s about where priorities sit. Without proper investment, the gap between what patients need and what the system can deliver will only keep getting worse.

Motion 7

Enfield and Haringey LDC, Roger Levy

Conference asks the BDA to present government with our plan for NHS contract reform without new money, and notify them that, with or without government partnership, it will publish that plan.

England

Supporting statement

This is an issue that must, finally, be publicly debated.

Dentists are withdrawing from the NHS. They will not return. NHS dentistry is at a crossroads. The only viable NHS model is the mixed practice. Contractual tinkering is short-term distractions and delays. They will further reduce NHS access. This is camouflaged rationing. When access falls, there will be more tweaks, but it looks like we have to accept that there will be no more money.

The government has to come clean about their rationale and the true consequences for patients. They have to start the conversation. Call it perhaps an essential or a focused service but call it something. If they don't, the nation's dental deserts will become a wasteland.

NHSE/DHSC Clinical Guidance

Motion 8

Enfield and Haringey LDC, Roger Levy

Conference demands that OCDO appoints an advisory member, a wet fingered dentist working in a primary care dental practice which provides a full range of treatments on the NHS.

England

Supporting statement

Senior OCDO officers have no significant current experience of working in NHS primary care. They therefore have little understanding of the consequences of their recommendations on the working lives of practitioners. Furthermore, if they don't understand the problems, they can't pass them upwards to their political masters. When OCDO fails to convey the reality of primary care practice to politicians, it's no surprise that politicians distrust the profession, nor that practitioners have no faith in OCDO.

An illustration of this failure to comprehend primary care reality was a February OCDO webinar on clinical aspects of the recent contract adjustments. Presentations by secondary care specialists were inappropriate and unachievable for an overburdened NHS primary care model.

It is unacceptable that executives of a body with power over those who work in the service have neither direct understanding of the demands of the service, nor of the pressures on those who work in it.

A BDA-approved practitioner with current primary care experience should be embedded within OCDO, to give them a view of the real world, to review GDP-impacting policies from OCDO, and to ensure at the very least that primary care realities are passed back to government.

Lessons from Wales contract reform

Motion 9

North Yorkshire LDC, Ian Gordon

This conference asks the government to carefully review the reformed dental contract in Wales and learn from its failings. Whilst a move away from UDAs has always been welcomed, overcomplicating the system and trying to gain some degree of central control will inevitably cause the collapse of NHS dental services in England.

A (non) working example of this interference is the abject failure of the overcomplication to deliver any increase in urgent care courses in 25-26.

England

Supporting statement

The trial of complex care pathways in the current marginal tweaks to the current system worries many in the profession. The worry is that these pathways will become part of the new contract.

The typical NHS dental practice is the most efficient delivery of primary care services within the NHS, and the administration of these pathways is overburdensome taking time away from frontline delivery. Complex care is complex enough!

Motion 10

Gwent LDC, Lauren Harry

This Conference calls upon the governments of the UK to learn from the errors made in the Welsh contract reform fiasco to ensure that nothing like this happens in Britain again.

UK

Supporting statement:

Any new contract implemented must be piloted. The newly imposed Welsh contract has created a raft of issues including software discrepancies, rejection of multiple NHS claims, multiple ambiguities in claiming rules and a lack of support for dental laboratories. Many of these issues could have been ironed out with six months to a year of piloting but instead the Welsh Government decided to impose the contract on practices with no such piloting and at the full commercial risk of the practice owners and associates.

Negotiation

Motion 11

Leeds LDC, Munaf Qayyum

The BDA/GDPC has tried the collaborative approach, but the Government is not listening. Conference asks for the BDA/GDPC to consider a different approach to show the Government that dentists cannot continue with the current situation of contract negotiation.

Supporting statement:

We call on the BDA/GDPC to:

- 1. Commit to robust escalation measures should the government continue to disregard DDRB recommendations, including—but not limited to—balloting members on collective action where appropriate.*
- 2. Define explicit red lines beyond which continued negotiation without progress will cease.*

3. Actively challenge government narratives that normalise underfunding and workforce loss in NHS dentistry.

4. Reassert the BDA's role as a strong, assertive, and unapologetic trade union, willing to apply pressure to protect NHS dentists and the future of NHS dentistry.

Pay, conditions and benefits

CPD day of action

Motion 12

Birmingham LDC, Ranjit Singh-Chohan

This Conference believes it is now time to revisit plans for a national CPD day of action to pressurise the Department of Health and Social Care to apply an appropriate expenses uplift to NHS dental contracts, rather than relying on the GDP deflator, which does not reflect the true cost of delivering care in general dental practice.

England

Supporting statement:

When the DDRB recommends an uplift to NHS dental contract values, the final figure applied by the Department of Health and Social Care is often reduced through the use of a Gross Domestic Product (GDP) deflator. This mechanism is complex, lacks transparency, and is poorly understood within the profession.

More importantly, the GDP deflator does not reflect the real and increasing costs faced by general dental practices. Expenses such as staffing, laboratory fees, waste disposal, materials, compliance and energy have risen significantly, and these pressures are not captured by a broad macroeconomic measure. As a result, contract uplifts frequently fall short of what is required to maintain the viability of NHS dental services, placing increasing financial strain on practices.

This motion calls for a renewed and collective response, including consideration of a CPD day of action, to highlight the need for a more appropriate and transparent method of calculating expenses uplift that properly reflects the cost of delivering NHS dentistry.

Allocation of uplift

Motion 13

Norfolk LDC, Andy Bell

This conference calls on the Government to implement a clear, enforceable mechanism to ensure that any uplift to NHS dental contract values arising from the DDRB process is fairly and transparently allocated to NHS associates.

England

Supporting statement

Recommendations from the DDRB may result in uplifts to NHS dental contract values. However, associate dentists, who make up most of the clinical workforce delivering NHS dental care, have no guaranteed mechanism to ensure they benefit from these increases. This lack of transparency and consistency risks undermining morale, worsening NHS recruitment and retention, and destabilising the dental workforce at a time of significant pressure on NHS services.

A fair and equitable approach to remuneration is essential to maintain workforce confidence and ensure the continued delivery of high-quality patient care. Clear guidance, alongside an appropriate accountability framework, should be developed to support consistent and fair implementation across all contract types.

UDAs delivered by Foundation dentists

Motion 14

Leicestershire LDC, Hanish Chotai

This conference proposes that UDAs delivered by Foundation Dentists (FDs) should be fully counted towards the host practice's NHS contractual UDA target.

England and Wales

Supporting statement

This conference recognises the vital role that Foundation Dentists (FDs) play in delivering frontline NHS dental care. As newly qualified professionals transitioning into independent practice, FDs contribute significantly to patient access, service delivery, and the sustainability of NHS dentistry.

However, under current arrangements, the units of dental activity (UDAs) completed by FDs are often not fully recognised or counted towards the host practice's contractual UDA targets. This creates a structural disincentive for practices to take on and support FDs, as it can negatively impact their ability to meet contractual obligations and maintain financial viability.

The conference believes that all clinical work carried out by FDs is valid, supervised, and contributes meaningfully to patient care. Therefore, it should be treated equivalently to that of more experienced associates in contractual accounting.

Failing to fully count FD-delivered UDAs risks:

*Discouraging practices from hosting and mentoring newly qualified dentists
Reducing training and employment opportunities for early-career professionals
Exacerbating workforce shortages within NHS dentistry
Limiting patient access to essential dental services*

By ensuring that UDAs delivered by FDs are fully counted towards the host practice's NHS contractual target, this policy would:

*Incentivise practices to invest in training and mentorship
Support smoother transition from education to independent practice
Strengthen workforce retention and morale
Improve overall access to NHS dental care*

This conference therefore calls for policy reform to ensure equitable recognition of FD contributions within the NHS dental contract framework.

Maternity pay

Motion 15

Wakefield LDC, Rebekah Hadley

Conference supports the payment of maternity pay directly to the performer and calls on NHS to explore how this could be achieved.

England and Wales

Supporting statement

If a practice loses their NHS contract whilst an associate is on maternity leave that associate will not get any maternity pay. For example, in a situation where a practice quite fairly wants

to undergo a private conversion. If they have an NHS associate on maternity pay that associate will lose their maternity pay. Why not just pay the maternity directly to the performer? It can be done. Why is it not the standard?

Seniority payments

Motion 16

Leicestershire LDC, Hanish Chotai

This conference calls for the reintroduction of seniority payments for dentists providing NHS care, based on years of committed service within the NHS.

England and Wales

Supporting statement

This conference strongly supports the reintroduction of seniority payments for dentists providing NHS care, recognising the value of long-term commitment, experience, and continuity within the service.

For many years, seniority payments served as an important mechanism to reward dentists who dedicated substantial portions of their careers to the NHS. These payments acknowledged not only clinical experience, but also the stability, mentorship, and institutional knowledge that more experienced practitioners bring to the profession. Their removal has contributed to a growing sense that loyalty to NHS dentistry is neither recognised nor rewarded.

In the current climate, NHS dentistry faces significant workforce challenges, including recruitment difficulties, low morale, and an increasing shift towards private practice. The absence of meaningful financial progression for experienced dentists has further exacerbated these issues, creating a system where long-term service offers little incentive compared to alternative career pathways.

Reintroducing seniority payments would send a clear and positive message: that sustained commitment to NHS care matters. It would:

Improve retention of experienced dentists within the NHS

Encourage career longevity in public service

Support mentorship and leadership within practices

Help maintain high standards of patient care through accumulated expertise

Importantly, such payments would not simply reward time served but recognise the ongoing contribution of skilled professionals who continue to deliver high-quality care under increasing pressures.

This conference believes that a fair and sustainable NHS dental system must value experience as well as activity. Reinstating seniority payments is a practical and symbolic step towards rebuilding morale, strengthening the workforce, and ensuring the long-term stability of NHS dental services.

Abuse of dental staff

Motion 17

Birmingham LDC, Ahmad Tadmory

Conference calls on DHSC to establish a national zero-tolerance framework for abuse towards dental teams, including standardised reporting, contractual support for removing abusive patients, staff support mechanisms, and a public campaign reinforcing that abuse will not be tolerated.

England

Supporting statement

Dental practices are increasingly becoming easy targets for abuse and aggression, often as a result of wider system pressures and patient frustration. While most patients are respectful, the impact of even isolated incidents on staff morale is significant, with many team members feeling exposed and unsupported. There is a growing sense that dental teams are not afforded the same protection as others within the NHS family. A clear, nationally backed framework would help ensure consistency, support staff, and reinforce that this behaviour is not acceptable.

Recognition of Leadership Activity Within NHS Dental Contracts

Motion 18

Dorset LDC, John Cobley

This Conference recognises that NHS dental contracts increasingly rely upon clinicians undertaking leadership, pathway development and service improvement activity, whilst simultaneously requiring full UDA delivery and potentially treating any resulting underperformance as contractual breach.

Conference welcomes the Dorset pilot model, which provides contractual recognition for approved leadership activity through notional credited UDA allocation, supporting clinicians who contribute to the development and sustainability of NHS dental services.

Conference therefore calls for the development of a national framework through which recognised leadership activity may be appropriately credited within NHS dental contracts.

England

Supporting statement

Primary care dentists are contractually required to meet UDA targets, which leaves limited flexibility to undertake system leadership roles without risk of underperformance or clawback.

In contrast, leadership activity in secondary care is recognised and supported through structured job planning.

As NHS dental services evolve, effective clinical leadership within primary care is increasingly essential — including participation in Managed Clinical Networks, peer review, pathway development, and system improvement.

The current contractual framework therefore creates a structural disincentive for primary care clinicians to engage in leadership activity.

This motion seeks to address that imbalance by enabling appropriate recognition of approved clinical leadership activity through UDA credit, supported by a nationally consistent framework for definition, approval, and quality assurance.

NHS Contracts and commissioning

Local Dental Networks

Motion 19

Hertfordshire LDC /Leicestershire LDC, Peter Tatton

Conference believes that all ICBs must have their own Local Dental Network (LDN), led by an LDN Chair and with specific Managed Clinical Networks (MCN), to facilitate ICBs in planning, commissioning, and delivery of dental services.

England

Supporting statement

Effective commissioning of dental services is essential to ensure equitable access to high quality oral healthcare across the country. All ICBs must have their own Local Dental Networks (LDNs) to provide professional leadership and valuable clinical expertise, along with local insight that can guide Commissioners in making informed decisions tailored to their communities' needs.

Currently, access to LDN advice is inconsistent or absent, leading to variation in service provision and ultimately patient outcomes.

Ensuring that all regions benefit from LDN advice will promote a more consistent, evidence-based approach to dental commissioning. This will help improve overall oral health outcomes and support the development of sustainable, prevention-focused care models.

Conference therefore urges action to ensure that all Commissioners are supported by appropriate LDN expertise, so that dental services can be planned and delivered in the best interests of the population.

Motion 20

North Yorkshire LDC, Ian Gordon

This conference calls for the ambiguity around what it describes as underspend to be removed and clarity as to how much is clawback and how much is genuine non-commissioned underspend be separated out.

England

Supporting statement

When the health minister stands up in the house and say figures that are at best confusing and at worst misleading it creates misinformation as to the direction NHS dentistry is heading.

Clarity is all we are asking for rather than the smoke and mirrors that often accompany these figures when they are released.

Clinical management

Motion 21

Liverpool LDC, Stuart Garton

This conference calls on the NHS (cardiologists/GPs) to implement a standardised process ensuring that patients at high or moderate risk of infective endocarditis—including those with prosthetic heart valves or previous infective endocarditis—are clearly informed of their risk status. This should include written or digital information on the need for antibiotic prophylaxis for relevant dental procedures, in line with the current guidance, and communication to primary care providers. This would provide clarity to patient and dentist.

UK

Conference further supports exploration of a coded risk indicator accessible via the NHS App, in keeping with the NHS Long Term Plan.

England

Supporting statement

Patient safety gap: Many high-risk patients are unaware they need antibiotic prophylaxis before invasive dental procedures.

Communication failure: Information often isn't consistently passed from cardiology → GP → dentist → patient. Patients often don't know the type of prosthetic heart valves they have or the materials used. With the change to GP processes adding more pressure on consultant admin the likelihood of consultants replying to dentist requests for clarification is going to be very low.

Preventable harm: Infective endocarditis carries high morbidity and mortality but is partly preventable.

Digital opportunity: The NHS App could act as a "single source of truth" for risk status.

IE risk status becomes a coded clinical flag (like allergies or medications) This flag is:

Visible in the NHS App

Shareable with dentists

Automatically updated from hospital

Dental Tourism

Motion 22

Birmingham LDC, Ahmad Tadmory

Given the massive rise in dental tourism, Conference calls on NHS England to establish a nationally consistent clinical and contractual referral pathway, with appropriate remuneration, for the assessment of patients presenting with complications arising from dental treatment undertaken abroad.

England

Supporting statement

Practices are seeing more patients with complications following overseas treatment, often requiring complex assessment and stabilisation. This work is time-consuming and currently lacks consistent recognition within NHS systems. Many of our colleagues are rightfully worried of how much they are able to do for fear of “owning” a problem as soon as they intervene and being held liable. A clear national pathway with appropriate remuneration would support safer and more consistent care - already overstretched primary care practices should not be left to pick up the pieces from poor choices and decisions made abroad.

Education and Regulation

Motion 23

Dental Tourism

Birmingham LDC, Ahmad Tadmory

As patients may be unaware of the risks of having treatment abroad, this Conference calls on the GDC and DHSC to introduce and enforce clear rules governing the UK promotion of overseas dental treatment, including mandatory disclosure of regulatory status, indemnity and complaints routes, and a clear prohibition on any clinical assessment or advice in the UK by individuals not lawfully entitled to practise dentistry here.

England

Supporting statement

There has been a clear rise in overseas providers actively marketing to UK patients within the UK, including events where treatment is promoted and, in some cases, assessments appear to be taking place. The current regulatory response feels insufficient, with the GDC seemingly unable to effectively challenge this activity. At the same time, NHS practices are increasingly managing the complications that arise from complex treatment carried out abroad, often where patients were not fully informed of the risks.

Workforce support for expansion of ORE and LDS places

Motion 24

Andy Bell, Norfolk LDC

This conference calls on the Government to undertake an urgent review of the workforce support implications arising from the expansion of places for the Overseas Registration Exam (ORE) and Licence in Dental Surgery (LDS), specifically in relation to mentorship capacity and the processes required for NHS performer list validation.

England

Supporting statement

Recent system changes, including the abolition of NHS England and significant restructuring within Integrated Care Boards (ICBs), have resulted in substantial workforce disruption, including the loss and uncertainty of key roles such as Dental Practice Advisors (DPAs) and Case Managers. These roles are essential in supporting non-UK qualified dentists through supervised practice, mentorship, and the completion of requirements necessary to obtain an NHS performer number.

While increasing ORE and LDS capacity aims to strengthen the NHS dental workforce, this ambition is not currently matched by investment in the infrastructure required to support it. Without sufficient numbers of trained mentors, DPAs and Case Managers, there is a significant risk of bottlenecks, delays, and system failure within this critical pathway. Moves to dilute support for new non-UK workforce to ease bottlenecks will create future problems that will erode this workforce resource.

This conference therefore calls on Government to ensure that any expansion in international entry routes is aligned with appropriate workforce planning and investment in supervision, mentorship, and administrative capacity, to safeguard the effectiveness and sustainability of this important route into NHS dental practice.

Expansion of ORE and LDS places

Motion 25

North Yorkshire LDC, Jeremy Boyles

This conference believes that the significant numbers of overseas-trained dentists who are predicted to join the UK register through expanded LDS and ORE places are unlikely to address NHS dental workforce shortages as suggested by government. GDC registration will permit working on a private basis, while working in the NHS requires inclusion on the performers list through application, assessment and likely educational requirements and support in practice. The current NHS contract does not provide an attractive career outlook or earning potential, which is why dentists are leaving the system.

England and Wales

Supporting statement

There is no obligation on anybody joining the register to work in the NHS and given the failed contract it is unlikely that the majority of overseas-trained dentists will be any keener to work in the NHS than their UK counterparts. What is a concern is that we may go from an undersupply of dentists to an oversupply of dentists in the next few years across the board, which will affect both UK and overseas dentists' earnings whether in NHS or private practice.

ARF

Motion 26

Norfolk LDC, Jason Stokes

This conference insists that the remainder of a GDC ARF must be refunded to a registrant in exceptional circumstances.

UK

Supporting statement

A dentist in Norfolk paid their ARF in good faith to remain on the register for the coming year. Unfortunately, the dentist was subsequently diagnosed with a terminal illness. Before the December 31st deadline the dentist contacted the GDC to request a refund of the remainder of the ARF but was refused.

This refusal is unjust and lacks humanity. Financial burdens at the end of life should be minimised where possible, particularly where they could be used at a time where income will reduce significantly and it is an important time for creating memories with loved ones.

This also has the undesirable effect of artificially increasing the number of registrants, rendering this statistic less useful for workforce planning.

Over-regulation

Motion 27

Coventry LDC, William Sidhu

The role of organisations relating to dentistry should be urgently reviewed.

UK

Supporting statement

Organisations such as NHS, CQC, GDC are increasingly placing more burden on dental practices in terms of time, financial resources and manpower.

Subsequently practice expenses are increasing, taking resources away from patient care. It appears that they are just trying to justify their roles by micromanaging dentistry. In some instances, they are becoming a hindrance to patient care.

Indemnity

Motion 28

Devon LDC, Timothy Hodges

This Conference believes that the current indemnity arrangements for NHS dental performers are inequitable compared with those provided to NHS doctors.

This Conference calls on the Government and NHS England to extend state-backed Crown Indemnity to all NHS dental performers delivering NHS care, ensuring parity with other NHS clinicians and removing the requirement for dentists to personally fund clinical negligence cover for NHS work.

England

Supporting statement

NHS dentists are required by law to maintain appropriate clinical negligence indemnity arrangements to compensate patients in the event of harm. However, unlike most NHS doctors and many hospital clinicians who benefit from state-backed Crown Indemnity through NHS Resolution, NHS dental performers must personally purchase professional indemnity cover even when delivering NHS-commissioned care.

This creates a clear inequity between dentists and other NHS professionals delivering publicly funded healthcare. The cost of indemnity has increased significantly over recent years and represents a substantial financial burden for NHS dentists, particularly associates and early career clinicians.

These costs contribute to the declining attractiveness of NHS dentistry and exacerbate workforce pressures within the service. Dentists providing NHS care should not face greater personal financial risk than other NHS clinicians working within the same publicly funded system.

Extending Crown Indemnity to NHS dental performers would provide parity across the NHS workforce, reduce professional risk for clinicians delivering NHS care, and help support recruitment and retention within NHS dentistry.

Conference therefore urges the Government and NHS England to implement Crown Indemnity arrangements for NHS dental performers.

Engagement with LDCs

Motion 29

West Sussex LDC, Mary Green

This conference recognises the need to establish a fellowship status which would stand as a pre-membership for an LDC when a committee is full.

UK

Supporting statement

Some LDCs have vacancies and are able to co-opt members when interest is expressed from prospective dentists. However, some LDCs run with full committees and lack any ability to retain interest prior to their next elections. Having a sub membership or fellowship would allow dentists to be invited as guests, receive newsletters and have their contact details retained by the LDC for personal communications.

Attracting young and enthusiastic dentists, especially associates has long been a challenge for LDCs. A means by which dentists can feel included without breaking the constitution of the LDC membership would allow engagement and introduction to NHS politics for those who are keen.

Motion 30

Wakefield LDC, Zoe Connelly

This Conference believes that the viability of LDCs is at risk due to declining engagement and changes in workforce and asks that NHSE's Workforce, Training and Education (WT&E) directorate includes mandatory attendance at a number of LDC meetings into their DFT programme.

England

Supporting Statement:

It is essential that LDCs are able to showcase their knowledge and provide a community spirit to newer dentists. This will not only help support those new dentists during the early years of their careers but hopefully future proof the LDC. If attendance at a number of LDC meetings or Conference was included in the DFT programme this would help to build engagement.

Motions which re-affirm current policy

These motions will not be discussed unless this is specifically requested ahead.

Motion 31

West Sussex LDC, Toby Hancock

This Conference believes that future NHS dental contract reform must reflect the evolving needs, values, and working patterns of both the current and next generation of dentists and calls for these principles to be explicitly embedded within negotiations and policy development.

UK, Policy

Supporting statement

The dental workforce is undergoing significant change, with increasing numbers of clinicians seeking flexible working patterns, portfolio careers, and a better balance between professional and personal commitments.

The current NHS dental contract does not adequately reflect these shifts and risks becoming increasingly misaligned with the expectations of both existing practitioners and those entering the profession.

If contract reform fails to recognise these changes, it will struggle to recruit, retain, and motivate the workforce required to sustain NHS dental services.

This Conference calls for a clear articulation of workforce values and ongoing opportunities for GPs in primary care within contract negotiations, ensuring that future models of care support flexibility, professional development, and long-term career sustainability.

Motion 32

Gateshead and South Tyneside LDC, Nick Marshall

This conference calls on the profession and other stakeholders to take action to significantly reduce the inappropriate use of antibiotics, which is compromising patient care and contributing to antimicrobial resistance.

UK, Policy

Supporting statement

Dentists are responsible for approximately 10% of antibiotics prescribed in primary care in the UK. Research suggests that up to 80% of these prescriptions are inappropriate or could have been avoided. Too many of us have got into the habit of reaching for the prescribing pad as the primary management of acute dental conditions, either delaying definitive treatment to another time, or in the case of non-routine patients, considering antibiotics the definitive treatment.

The recent changes in payment for unscheduled care in England provides an excellent opportunity for most of us to reconsider our attitude towards the use of antibiotics. It has been convenient to attribute suboptimal use of antibiotics to a poor dental contract, but we must all acknowledge our professional and ethical responsibility to making antimicrobial stewardship a foundational aspect of our day-to-day practice.

Motion 33

North Yorkshire LDC, Ian Gordon

This conference asks that dental therapists and other dental care professionals (DCPs) performing on the NHS should be entitled to claim pension contributions on that work done.

England, Policy (with the caveat that it is funded appropriately by the NHS)

Supporting statement

Allowing pension for our colleagues is a no cost option as it is within the NPE ceiling and not doing so is inequitable.