General Dental Council

Consultation Response

The DHSC consultation on NHS dentistry contract: quality and payment reforms

19 August 2025

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GDC response to the DHSC consultation on NHS dentistry contract: quality and payment reforms

1. About the GDC

The General Dental Council (GDC) is the UK-wide statutory professional regulator of over 128,000 members of the dental team, including over 47,000 dentists and around 81,000 Dental Care Professionals (DCPs). As at 15 August 2025, there were 37,604 dentists and 75,718 DCPs on the register in England.

An individual must be registered with the GDC to practise dentistry in the UK. Unlike other health professional regulators, we register the whole professional team, across the four nations of the UK, including dental nurses, clinical dental technicians, dental hygienists, dental technicians, dental therapists, orthodontic therapists and dentists.

Our primary objective is to protect the public, and in doing so to:

- Protect, promote and maintain the health, safety, and well-being of the public.
- Promote and maintain public confidence in the professions regulated.
- Promote and maintain proper professional standards and conduct for members of those professions.

All patients should be confident that the treatment they receive is provided by a dental professional who is properly trained, qualified, and meets our standards. To achieve this, we register qualified dental professionals, set standards for the dental team, investigate complaints about dental professionals' fitness to practise, and work to ensure the quality of dental education.

2. How we have responded to this consultation

We welcome the opportunity to respond to this consultation.

It is important for patients and the public that the NHS dental contract works in a way that facilitates access to safe, high-quality care, and aligns with wider efforts to address health inequalities. It is also important for registrants that the system in which they work is supportive and enables them to practise at their best.

While the factors above are relevant to public protection and public confidence in the dental profession, the GDC has no role in relation to the commissioning or provision of NHS services, nor the design of the NHS dental contract. We have therefore restricted our comments to highlight the relevant issues from a regulatory standpoint, for the DHSC to consider as work progresses.

We have not responded directly to the consultation questions. Instead, we have set out our comments under the following subheadings:

- Fluoride varnish application by dental nurses: regulatory considerations.
- Linking annual appraisals to Continuing Professional Development (CPD).

- Promoting professionalism through support for the NHS workforce.
- Equality, Diversity and Inclusion (EDI) considerations.

3. Consultation response

a) Fluoride varnish application by dental nurses: regulatory considerations

We support the intention to increase access to fluoride varnish through improved use of skill mix. However, we highlight that any new arrangements for courses of NHS treatment, or changes to the sequencing of appointment types, must take into account that:

- Fluoride varnish licensed for the prevention of tooth decay is a prescription-only medicine.
- Dental nurses can only administer fluoride varnish under the prescription (or patient specific direction) of a dentist. Medicines legislation does not enable dental nurses to administer medicines under Patient Group Directions, nor under exemptions.
- Dentists must prescribe responsibly in all circumstances, in line with GDC guidance and in the patient's best interests.
- Dental nurses do not diagnose disease or treatment plan. They provide care under supervision.
- Dental nurses should only administer fluoride varnish when they are trained, competent and indemnified/insured to do so. They should not be expected to act outside of their individual scope of practice.

We note that the GDC does not use the term "Extended Duties Dental Nurse". This term is not defined within our regulatory framework. Instead, we use the term "dental nurse" and recognise that dental nurses may increase their individual scope of practice to carry out additional duties (e.g. fluoride varnish application) where they are trained, competent and indemnified/insured.

b) Linking annual appraisals to CPD

All dental professionals must meet the requirements of the GDC's CPD scheme to maintain their registration. Annual appraisals would provide a useful opportunity for registrants to reflect on their practice, identify personal training needs, and update their personal development plans in line with GDC requirements.

The DHSC has explained that one of the current barriers to undertaking annual appraisals is that contract holders are concerned about the loss of revenue when the time being used for appraisals takes away from the time being used for clinical practice. Whilst proposals to fund appraisals may alleviate that concern, it is just as important to ensure that dental professionals are supported to secure and undertake development activities based on the outcomes of their appraisals - which may also require time away from their usual clinics.

We note that proposals cover funding for appraisals for associate dentists, dental therapists and dental hygienists only. However, we would recommend that NHS appraisal systems are designed to benefit all dental professions involved in providing care under NHS contracts (e.g. dental nurses, orthodontic therapists), so that CPD is encouraged across the whole dental team and the associated benefits are felt by patients in all aspects of their NHS dental care.

c) Promoting professionalism through support for the NHS workforce

We are pleased that the government recognises the importance of support, job satisfaction and incentives for the dental workforce as part of efforts to improve NHS recruitment and retention.

Features of the NHS working environment should support dental professionals' morale and wellbeing. This is not only for their welfare and to encourage them to keep choosing to work in the NHS, but also because high levels of morale and wellbeing will positively influence professional behaviours, and in turn, patient care.

Changes to the NHS dental contract, dentists' financial entitlement, minimum terms of engagement for associates, and the NHS handbook, are helpful opportunities to make improvements to the NHS working environment. However, we note that the proposed changes would largely benefit dentists, with less impact on other members of the dental team whose contribution is also critical to NHS services.

Regarding the proposals for minimum terms of engagement and an NHS model contract for dental associates, we have heard anecdotal reports from stakeholders that some associates – especially those whose circumstances may make them more vulnerable (e.g. overseas qualified dentists who have recently relocated to the UK without support networks and with limited knowledge of working norms and practices) – may be at higher risk of being exploited in the workplace. We hope that a model contract would reduce this risk, and be helpful in limiting the potential for unfair or unprofessional behaviour from contract holders or business owners (including when this type of behaviour is unintentional).

We understand that the proposed measures for supporting the dental workforce in this consultation are "first steps", and await further information on wider plans to be developed under the 10 Year Health Plan.

d) EDI considerations

Our comments on several separate matters are set out below:

- Under proposals, it is envisaged that NHS contract holders would deliver a set amount of unscheduled care each year for which there would be additional financial incentives. Dental teams would address patients' immediate care needs through unscheduled care appointments and then offer them further care as a banded course of treatment or on the new complex care pathways as required. It is important that NHS service capacity to deliver unscheduled care aligns appropriately with the capacity to deliver continued care, to ensure that even if access to urgent care improves, inequalities in accessing non-urgent care do not persist.

- We highlight that there will be patients who do not meet the eligibility criteria for the proposed complex care pathways, but may still have complex needs or other vulnerabilities (e.g. severe tooth wear, medical complexities, learning disabilities) which are not adequately allowed for in the NHS system. Measures should also be considered to better enable these patients to access dental services.

- The DHSC has asked for views on including children and young people within complex care pathways. We would support appropriate care pathways or other targeted measures for children with complex treatment needs or other vulnerabilities, to advance equality of dental access opportunity for underserved groups.

- The DHSC has flagged that after the consultation, patient charges may need to be reviewed as part of implementation considerations. We note that cost continues to be a significant barrier to dental access, often amongst people with high care needs. This issue should be allowed for during that review, so that barriers associated with cost are reduced as far as possible.

- It is unclear whether decisions around if and how to implement certain proposals (e.g. implementation of the quality improvement initiatives, allocation of unscheduled care appointments) would sit locally with Integrated Care Boards, and if so, how variation in local approaches could affect patient and dental team outcomes differently in different geographies. Whilst different approaches may be required to meet different population needs, it is important that activity does not introduce any inappropriate geographical variation in outcomes.

- Please see our comments at section 3(c) in relation to the minimum terms of engagement and NHS model contract for dental associates. This should be used as part of efforts to address inequalities in working conditions experienced by certain groups of NHS dentists.

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