Consultation Paper 162

PRIMARY HEALTHCARE

Liberal Democrats

Spring Conference

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Background

This consultation paper is presented as the first stage in the development of new Party policy in relation to primary healthcare. It does not represent agreed Party policy. It is designed to stimulate debate and discussion within the Party and outside; based on the response generated and on the deliberations of the working group a full policy paper will be drawn up and presented to Conference for debate.

The paper has been drawn up by a working group appointed by the Federal Policy Committee and chaired by Dr Kate O'Kelly. Members of the group are prepared to speak on the paper to outside bodies and to discussion meetings organised within the Party.

Comments on the paper, and requests for speakers, should be addressed to: Alexander Payne, Policy Unit, Liberal Democrats, First Floor, 66 Buckingham Gate, London, SW1E 6AU, United Kingdom. Email: policy.consultations@libdems.org.uk

Comments should reach us as soon as possible and no later than 27 March 2026. Further copies of this paper can be found online at https://www.libdems.org.uk/members/make-policy/policy-consultations

Contents

1 Our Starting Point and Recent Developments

1.1 Liberal Democrats last set out our approach in the 2024 General Election manifesto, *For a Fair Deal*, and Policy Paper 137, *Save the NHS and Social Care by Stopping Brexit* (2019). These policies proved popular in the 2024 General Election because they spoke to deep frustrations shared by everyone that has tried to use our broken primary healthcare system. The crisis in primary healthcare is one of the biggest challenges people face. It is bad for patients and bad for the NHS, putting more pressure on ambulances and A&E as more people end up in hospital who shouldn't have to be there, and bad in and of itself.

1.2 A rise in demand, pressures, and new technologies means it is the right time to re-evaluate our primary healthcare policies. Over the past five years, the foundations of the UK's primary healthcare system have been eroded by systemic pressures to the workforce, access, and funding. The disparity between patient demand for general practice, which was once the bedrock of the NHS's first-contact care model, and capacity continues to widen at an increased rate. Despite periodic recruitment drives, the ratio of fully qualified GPs to population remains lower than in prior years, with particularly pronounced shortages in deprived areas. The number of GPs per patient remains significantly below 2015 levels, which has led to longer waits and reduced continuity of care. This experience is reflected in the NHS's GP Patient Survey, which shows a 9.7 per cent decline in the proportion of patients who were satisfied with general practice between 2015 and 2025.

1.3 Primary dental care has also deteriorated sharply since 2019. NHS dental activity remains below pre-pandemic levels, with the total work done

last year still 8 per cent lower than in 2019. Access has not rebounded fully from Covid-related disruptions, and large geographic variation persists in treatment delivery. In real-terms, the Government is choosing to spend more than half a billion pounds per year less on dental care than it did before the pandemic, despite the proportion of adults seen by an NHS dentist remaining below historic figures, and four-in-ten adults having obvious decay, which is a return to 1990s levels. These challenges are especially pronounced in rural areas, many of which are now "dental deserts," where fewer than one in five adults can access routine care.

1.4 The community pharmacy sector, a vital gateway for medicines and basic clinical advice, is facing severe challenges. Hundreds of pharmacies are closing each year, amounting to well over a thousand closures since 2019 and leaving the number of community pharmacies at multi-year lows. Staffing pressures and constrained NHS funding have led to a rise in temporary closures and reductions in opening hours, which further undermines the consistency of care people are receiving, and damages faith in the pharmacy system. Despite policy shifts assigning more clinical roles and responsibilities to pharmacies, pharmacy workforce forecasts are warning of a potential future shortfall of thousands of community pharmacists, which threatens delivery of services and patient outcomes.

1.5 Despite the urgency of these challenges, this Labour Government is failing to address or even acknowledge them. This Government's choice to prioritise reducing secondary care waiting lists reflects a misreading of the public's most pressing concerns about the NHS. Voters are clear that they want timely access to GP appointments, confidence that an ambulance will arrive in an emergency, and the confidence that they won't be treated or diagnosed in corridors or unsafe overflow spaces. Long waiting lists for elective care do matter, critically for individuals themselves and because of

the additional economic impact it creates, but issues in secondary care cannot be resolved without accessible GPs, dentists and pharmacies.

1.6 Labour entered government better placed than the Conservatives to address these structural weaknesses, not least because it promised change after years of Conservative mismanagement and underinvestment. With its greater emphasis on prevention, neighbourhood health services and care closer to home, the NHS 10 Year Plan set out a broadly positive vision, but it failed to set out the workforce expansion, capital investment or revenue funding that will be needed to deliver it. This gap between ambition and delivery risks emulating past Conservative failures, leaving patients to continue navigating a broken and miserable system.

1.7 As liberals, we have an ideological interest in preventing ill health before it manifests, and in detecting diseases as early as possible. Living with ill health, and the painful, distressing, disabling, or expensive symptoms that accompany it, reduces an individual's opportunity to pursue a life of their choosing and impinges on their freedom to achieve well-being. From social prescribing and vaccinations to cancer screening and managing long-term conditions, the primary healthcare system is integral to prevention, and we believe that this relationship should be considered when designing health policy.

1.8 We believe that any plans to improve our primary healthcare system must have these values at their core:

- Universal.
- Evidence-led.
- Prioritises prevention.

- Accessible.
- Fairness and equality.
- Built around choice with patients at the centre.
- Driven by quality.
- Local and rooted in community.
- Able to take care of the people taking care of us.

1.9 The remainder of this paper sets out some of the challenges, and possible solutions and principles, that the primary healthcare policy working group is contending with, together with questions to which we would welcome input. These questions are not exhaustive; all comments are welcome.

Questions:

Q1 *Do these values encapsulate the Liberal Democrat approach to primary healthcare? Are there any values that you would add or remove?*

Q2 *Have we accurately identified the overarching problems impacting the primary healthcare system? In what order would you prioritise resolving workforce, access, and funding issues?*

Q3 *Have you had any notable, either negative or positive, experiences with primary healthcare?*

Q4 *Which countries are getting primary healthcare right? What should we look to emulate from those systems?*

Q5 *Which part of our primary healthcare system is the most broken? Which part would you prioritise fixing first?*

Q6 *Which ideas, concepts, organisations, and individuals should this working group be engaging with during the policy development process?*

Q7 *How should the Liberal Democrat approach to primary healthcare differ to a) the Labour Party's, b) the Conservatives', c) The Green Party's, and d) Reform UK's approaches?*

Q8 *To what extent does spending on primary healthcare need to increase? If it does, how would you fund this?*

Q9 *Should more money be spent on prevention in primary care? What are the most efficient ways to invest in prevention? What parts of primary care should we prioritise investing in to get the largest return on investment for prevention?*

Q10 *How does the primary healthcare experience differ for underrepresented groups?*

2 General Practice

2.1 For General Practice, our current policies would:

- Give everyone the right to see a GP or the most appropriate practice staff member within seven days, or within 24 hours if they urgently need to.
- Guarantee a same day phone or video appointment with a healthcare professional at your local GP practice, following morning triage (by phone or at the practice).
- Introduce a universal 24/7 GP booking system.
- Give everyone 70+ and everyone with long-term health conditions access to a named GP.
- Remove top-down bureaucracy to let practices hire the staff they need and invest in training.
- Establish a Strategic Small Surgeries Fund to sustain services in rural and remote areas.

2.2 GP access has consistently been the top concern raised with Healthwatch England since it was created in 2013. Their data shows that the choices that are most important to individuals seeking a GP appointment differ significantly depending on if they are young or old. As liberals, we recognise that quality means different things to different people, and our systems should reflect this by treating us as individuals.

2.3 Current data consistently shows that a large cohort of the population care more about having a choice over when they have their appointment and that they care about having the option to be seen online, whilst another cohort of the population prioritise being able to have a

face-to-face appointment and seeing the same professional each time. Given the current level of strain our primary care is under, meeting all of these needs with one service appears to be not feasible without a large increase in funding. One proposal is to have two different access points to general practice services. An uncomplicated access point would deliver quick, short, online appointments with a lot of availability, whilst the complex access point would deliver regular, in-person appointments with named professionals, but with the potential for longer waits to achieve the continuity and quality needed to match the complexity. There are reasons to be cautious, but the aim would be for these different pathways to reflect patient choice. However, there is strong evidence for both access points. GP practices, like GP Pathfinder Clinics, that offer a comparatively high level of virtual and remote services are delivering well-liked services to an extraordinarily high number of patients whilst employing a small number of GPs. Similarly, primary care providers like ChenMed in the United States, which is mainly for older people on Medicare, run clinics with smaller patient lists, longer appointments, and very proactive follow-up. This focus on preventing problems early with regular check-ins, monitoring of chronic conditions, and quick access when someone is getting worse results in 33 per cent fewer hospitalisations and ED visits.

2.4 The composition of the general practice workforce continues to evolve, including with the introduction of the Additional Roles Reimbursement Scheme (ARRS) in 2019, which enabled Primary Care Networks to employ a wider range of professionals within general practice, to expand capacity and broaden the skill mix available to patients. This has contributed to an 89.3 per cent increase in the number of direct patient care staff - that is pharmacists, physiotherapists, paramedics, physician associates, social prescribing link workers, and other non-GP and non-nurse professionals delivering patient care - working within general

practice over the past decade. However, the scheme has raised concerns about variation in how these roles are deployed and supervised, the complexity of employment arrangements, and the extent to which funding additional roles addresses longer-standing pressures on core general practice capacity. There is some evidence that unclear role boundaries and limited transparency for patients can contribute to fragmented care and repeated appointments, while uneven workforce availability has meant that the benefits of ARRS are not felt consistently across the country.

2.5 Since 2015, the amount of FTE nursing staff working in general practice has gradually increased to almost 17,000, which means there is roughly one nurse for every two GPs in today's general practice system. They play a highly valued role within general practice, and are central to many activities within surgeries. Similarly, the community-based care provided by District Durses is critical for keeping patients well and supported outside of hospital settings, and Advanced Nurse Practitioners play a significant role in managing long-term conditions. The Royal College of Nursing is currently campaigning for structures in England that would ensure that funding provided by the government for staff pay is actually used by employers to fund staff pay. There are also concerns that general practice nursing staff are delivering government funded NHS services, but as they are not directly employed by the NHS, some of these nurses only have access to basic statutory benefits including sick pay, maternity or parental leave. However, arguments are also made that the contracted, independent provider model has been deliberately designed since the inception of the NHS to allow general practice to innovate and respond to local need, and that national mandates and ringfencing mechanisms would undermine these advantages.

2.6 One way that we could consider to strengthen the general practice workforce lies in making better use of the existing healthcare professionals. There are limited senior, sustainable career pathways for paramedics later in their working lives, making frontline emergency response a less attractive long-term role for some. This presents an opportunity to retrain senior paramedics as GP assistants, embedding them within practice teams as a ready-made, highly skilled workforce. In this role, they would undertake home visits, urgent face-to-face assessments, post-discharge follow-ups, and the management of patients with complex or multiple conditions, working under the supervision of GPs. Their expertise in rapid clinical assessment, risk management and patient communication would enable earlier intervention, reduce avoidable hospital admissions, and improve continuity of care for patients who struggle to access surgery-based appointments. We are also considering how 111 services can be used to support GPs during out of hours.

2.7 We are concerned by reports of 'patient ping-pong', where individuals are passed between multiple healthcare professionals who lack the necessary authority or scope of practice to deliver the care ultimately required. This can result in repeated appointments, delayed diagnoses and frustration for patients, while also wasting scarce clinical capacity. There is strong evidence that these issues could be reduced by greater transparency at the point of booking, ensuring that patients know in advance which medical professional they will see and what that professional is able to do. Consideration could also be given to strengthening patient choice by allowing individuals to opt to wait longer to see a GP where they believe this would be more appropriate for their needs, and to establishing clear referral pathways to create stronger links between primary and secondary care.

2.8 One in five people who have been referred to a service by their GP have been sent to the wrong service, had their referral appointment cancelled, or simply did not hear anything further. This represents a significant waste of clinical time and a deeply frustrating experience for patients, especially given how difficult it was to secure that GP appointment in the first place. These failures point to systemic weaknesses in referral pathways, information sharing, and administrative capacity across the NHS. There may be scope to improve referral accuracy and follow-through via clearer national referral standards, better digital interoperability between primary and secondary care, and enhanced administrative support within GP practices. Greater use of advice-and-guidance systems, alongside improved feedback loops so practices can track referral outcomes, could also reduce inappropriate referrals and ensure patients are not lost in the system. Addressing these issues would improve patient experience, reduce duplication, and help ensure that scarce GP capacity is used as effectively as possible.

Questions:

Q11 Should there be two (or more) GP pathways that reflect the different needs of different patients?

Q12 What are your top priorities when trying to access a GP appointment?

Q13 Assuming robust evidence of safety and effectiveness, how comfortable would you be with having AI systems in the general practice system? What parts, if any, of the system (i.e. administration, triage, diagnosis) would you be comfortable with AI being in?

Q14 How can we enhance the credibility of our existing policies?

Q15 *What issues are patients/voters in your area most concerned with?*

Q16 *Would you support the introduction of measures, similar to the Armed Forces Covenant, that prevent long-term financial harm for cancer patients?*

Q17 *What skills should medical schools and medical royal colleges be teaching medical students to ensure they're ready to work in a modern general practice system?*

Q18 *What services do you want your GP practice to provide?*

Q19 *What professions do you think should be based within general practice surgeries?*

Q20 *Besides salary increases, how can we improve recruitment and retention of GPs and allied professionals?*

Q21 *What problems, big or small, do you experience when using GP services?*

Q22 *Besides AI, what technological improvements would most benefit GP services?*

Q23 *When you book a GP appointment on the phone, how important is it that you are speaking to someone based at that surgery? Would you be comfortable speaking with a team based elsewhere?*

Q24 *How important is continuity of care for you? Would you prioritise it*

over quick access? If so, why?

Q25 *How important is quick access to health care for you? Would you prioritise it over continuity of care? If so, why?*

Q26 *Are our existing GP policies still fit for purpose? What needs to be changed or added?*

Q27 *Should every primary care team have a district or community nurse on the team?*

3 Pharmacy

3.1 Our current policies related to pharmacies would see us:

- Work towards a fairer and more sustainable long-term funding model for pharmacies, and build on the Pharmacy First approach to give patients more accessible routine services and ease the pressure on GPs.
- Train independent community pharmacists as prescribers.
- Develop the range of services that pharmacists can perform, for instance trialling health checks by pharmacists, supported by pharmacist training as needed.

3.2 As a party, we are currently committed to building on the Pharmacy First approach. There are a number of reasons to believe that this is still the right approach. Firstly, community pharmacies are currently one of the most accessible forms of primary healthcare. 85 percent of the population live within a 20-minute walk of a community pharmacy, and this number is higher in areas with higher deprivation. Secondly, 97.1 per cent of the sector has signed up to Pharmacy First, so the service is already in place. Thirdly, it appears to be working, with Community Pharmacy England's data estimating that community pharmacies prevented 38 million GP appointments last year. Currently, pharmacies in England can prescribe for seven conditions under Pharmacy First, while in Scotland the figure is 29.

3.3 The Pharmacy First model has recently had some new developments, including the addition of emergency contraception and newly prescribed antidepressants to the new medicine service, and a new flu vaccination service for two-and three-year olds. There are a number of

other services that, with proper funding, the Pharmacy First approach could theoretically help deliver including:

- Smoking support.
- More vaccinations.
- Weight management.
- Women's health services.
- Deprescribing and amendment of prescriptions, which helps to safely stop, change or simplify medicines that are no longer needed or appropriate.
- Discharge medicine service, which supports patients to understand changes to their medicines after leaving hospital and reducing the risk of errors.
- New medicine service, which provides early follow-up and advice to patients starting a new long-term medication.
- Adherence support services, helping patients take their medicines correctly and consistently.
- Medicines optimisation services, ensuring patients are on the most effective and appropriate medicines for their condition.
- Management of long-term conditions.

3.4 Key industry stakeholders have raised serious concerns about the long-term viability of the community pharmacy network. Community pharmacy teams have experienced around five years of flat funding in real terms, alongside rising workload and operating costs, contributing to a sustained increase in both permanent and temporary pharmacy closures. Whilst public satisfaction with pharmacy remains high, patients are increasingly affected by unexpected closures, reduced opening hours, and difficulties getting prescriptions dispensed on time, particularly in rural and coastal areas. These pressures risk undermining the accessibility that

makes community pharmacy such a valuable part of the primary care system. Additionally, there is strong evidence that existing mitigation schemes, such as the Pharmacy Access Scheme, are too narrow and no longer reflect current patterns of need, including changing demographics, rurality, and workforce availability. We are interested in taking further evidence to review whether current funding mechanisms adequately support the pharmacies most relied upon by patients, and how we can deliver greater stability and predictability in funding to enable pharmacies to retain staff and reduce closures.

3.5 Recent policy initiatives have expanded the clinical role of community pharmacists, but the underlying contractual and funding framework has not kept pace with these expectations. Pharmacy funding remains heavily weighted towards medicines supply, and there is limited flexibility to address rising clinical workloads, complexity, or local population needs. This is driving a confused system in which pharmacies are incentivised to deliver more patient-facing services without the long-term financial certainty or staffing capacity required to do so sustainably. As Liberal Democrats, we are concerned that this “do more with less” mindset is contributing to recruitment and retention problems.

3.6 There are additional complexities to the workforce challenge that go beyond pharmacist numbers. Community pharmacies are reliant on a wider team of professionals including pharmacy technicians, dispensing assistants and trainee pharmacists, yet career progression, training pathways, and retention strategies for these roles remain underdeveloped. Many members of the pharmacy workforce delivering NHS services do not receive the same employment benefits or professional recognition associated with NHS roles elsewhere, despite being a first point of contact for millions of patients. If pharmacies' role in prevention is to continue to

grow, there is a strong case for reviewing how they are supported and integrated into the wider NHS.

3.7 Since we last reviewed our primary healthcare policies, there have been significant technological developments with potential implications for community pharmacy, including the expansion of automated dispensing systems beyond hospital settings and the emergence of pharmacogenomics. Automated dispensing offers opportunities to improve efficiency and accuracy in medicines supply, but also raises important questions about clinical oversight, workforce impact and patient safety that will need careful consideration as these systems are deployed more widely. Pharmacogenomics, which is the use of genetic and genomic information to predict an individual's response to different medicines, represents a particularly promising development. By enabling treatments to be better tailored to individual patients, it has the potential to improve therapeutic recommendations, reduce adverse drug reactions, and help ensure that patients receive the most effective medicines sooner. However, realising these benefits at scale would require investment in digital infrastructure, workforce training, and data systems. As liberals, we are particularly attuned to concerns around data privacy, consent and public trust. Any expansion in the use of genetic and medicines-related data would need to be underpinned by strong governance, transparency and safeguards, ensuring that sensitive information is generated, stored and shared responsibly.

Questions:

Q27 Are our existing pharmacy policies still fit for purpose? What needs to be changed or added?

Q28 *Which, if any, services should the Pharmacy First model also deliver?*

Q29 *How much should the state invest and support developing technologies in the pharmacy sector?*

Q30 *What should be a priority for investment in community pharmacy?*

Q31 *How can we best support rural pharmacies?*

Q32 *Should pharmacists be able to edit patient records?*

Q33 *What problems, big or small, do you experience when using pharmacy services?*

Q34 *Besides AI, what technological improvements would most benefit pharmacies?*

Q35 *Besides salary increases, how can we improve recruitment and retention of pharmacists?*

Q36 *Should Pharmacy First concentrate on delivering its current offer, or expanding to manage long term conditions?*

4 Dentists

4.1 For dentists we proposed to:

- Guarantee access to an NHS dentist for everyone needing urgent and emergency care, ending DIY dentistry and 'dental deserts'.
- Bring dentists back to the NHS from the private sector by fixing the broken NHS dental contract and using flexible commissioning to meet patient needs.
- Introduce an emergency scheme to guarantee access to free NHS dental check-ups for those already eligible: children, new mothers, those who are pregnant and those on low incomes.
- Guarantee appointments for all those who need a dental check before commencing surgery, chemotherapy or transplant.

4.2 The most pressing problem for the UK dentistry sector, and especially NHS dentistry, is a lack of funding. Since 2015, there has been a fall of over £525 million in real-terms spending on NHS dentistry and patient charges have risen each year by more than the rate of inflation. For most practices, delivering NHS services simply isn't profitable, which is one reason why only 15 per cent of practices are delivering solely NHS care. These problems are not limited to the NHS either, with a recent survey finding that 70 per cent of Denplan members are concerned about the future financial stability of their practice. These pressures have led to a substantial decline in our oral hygiene, as a quarter of children are not brushing their teeth twice a day, and one in ten patients are only accessing dental check-ups when in pain. This is having serious and expensive ramifications, with adult decay rates surging to 1990s levels, and oral cancers occurring more frequently and in younger age groups. The British

Dental Association (BDA) estimates that it would cost an additional £1.5 billion a year to give access to everyone who wants it.

4.3 One of the key drivers of problems in the dentistry sector is the dental contract. After significant Liberal Democrat and industry pressure, this government has begun to accept that the current dental contract is not working. The current contract is based on Units of Dental Activity (UDAs), which are tokens that measure and pay for dental work, with different treatments assigned different UDA values. This system is perversely incentivising quantity over quality, and rewards dentists for performing simple treatments, even when a complex treatment may have been more appropriate. Under this model, there is no motivation for prevention, nor any compensation or consideration for the fact that deprived areas with higher need will require more complex treatment. The BDA has proposed a sessional payment model, which has been used in Yorkshire. Under this model, practices receive a block fee for specific, additional urgent care sessions or courses of treatment, instead of being tied to UDAs. However, there are concerns that a block funding mechanism would not link remuneration to specific types of clinical work or outcomes in the same way as the UDA model, and the Government has rejected calls to expand this model nationally.

4.4 The pressure created by the current UDA-based dental contract results in high levels of dentist burnout and dissatisfaction, and is a leading contributor to the poor recruitment and retention rates, with 82 per cent of practices reporting the NHS contract as a major barrier to recruitment. The latest workforce data shows that there are 47,000 dentists on the General Dental Council (GDC) register but only 10,727 full-time equivalents currently working for the NHS in England. As of early 2024, over 21 per cent of NHS general dentist positions were unfilled, with more than 2,500 dentists

having stopped treating NHS patients in the preceding year. Under the Dental Recruitment Incentive Scheme (DRIS), there have been incentives - so-called Golden Hellos - that have been used to encourage relocation to areas with workforce challenges, to attract new workforce to the NHS, and to retain those who might have otherwise moved into private practice. Similarly, policy mechanisms that would tie new graduates to the NHS prove popular with the public, but have been criticised for leading to younger dentists having less goodwill towards the NHS and 'escaping' when the restrictions are removed, which could lead to an inexperienced workforce. Critics of these mechanisms have suggested that incentives alongside student loan relief may work better.

4.5 There are currently 7,300 overseas dentists who are waiting to take the Overseas Registration Examination (ORE), which they must pass in order to be allowed to practise in the UK. Data from the General Dental Council (GDC), which is the body responsible for the ORE, shows that around 30 per cent of all dentists on the register qualified outside the UK. Of these, around one third qualified for registration by passing the ORE, so the current blockage represents a significant barrier to increasing the number of dentists working in the United Kingdom. One solution to this would be to continue to automatically recognise EU dental qualifications, and to use public money to fund the GDC to perform rigorous and regular inspections of dental schools in parts of the world that are well represented on the ORE waiting list. For example, if a significant number of ORE applicants were trained at Melbourne Dental School (MDS), a Liberal Democrat government could fund the GDC to evaluate if MDS is delivering training to UK standards. If the GDC found that it was, we could automatically recognise that qualification, instantly unlocking additional dentists for the UK primary healthcare system, and freeing up space on the waiting list so other ORE applicants can take their tests sooner. Other

solutions that a Liberal Democrat government could consider include funding the GDC to increase ORE test capacity, or introducing a system of provisional registration, which would allow an overseas qualified dentist to practise in any dental setting under the supervision of a dentist who has full registration. All of these solutions would also require a Liberal Democrat government to make the UK dentistry sector be seen as an attractive place to work by overseas dentists.

4.6 Alongside dentists themselves, NHS dentistry relies on a wider dental workforce including dental nurses, dental hygienists, dental therapists, orthodontic therapists and dental technicians. These professionals already play a large role in delivering safe and effective dental care, but it has been suggested that their skills are being underused within the current NHS dental system. Expanding and better integrating the role of non-dentist professionals could help increase capacity by 10-50 per cent and give dentists the ability to focus on the most complex and clinically demanding treatments. Dental therapists and hygienists, in particular, are already trained to deliver a wide range of preventive and routine treatments, including examinations, fillings, extractions of deciduous teeth, periodontal care and oral health education. Some of the problems that are preventing us from making better use of these professionals include narrow commissioning rules, indemnity costs, supervision requirements, and uncertainty about how activity delivered by non-dentists is recognised and remunerated under the NHS contract. Some stakeholders have also raised concerns that, due to current poor levels of oral hygiene, there are higher levels of complex treatments required, which would need to be delivered by a doctor.

Questions:

Q37 *Are our existing dentistry policies still fit for purpose? What needs to be changed or added?*

Q38 *Should other professions, such as dental nurses and dental therapists, play a bigger role in NHS dentistry? What, if any, treatments would you prefer to be delivered by a professional that is not a dentist, if it meant being seen quicker or having more choice when scheduling new appointments?*

Q39 *How should we address the significant number of overseas dentists that are unable to take the Overseas Registration examination?*

Q40 *Where should the balance between delivering urgent care and prevention lie?*

Q41 *What should a contract for dentists incentivise? Should we move to a sessional-payment model instead of a model based on Units of Dental Activity?*

Q42 *Should there be a mechanism that requires newly-graduated dentists who have been educated in the UK to work for the NHS?*

Q43 *Besides salary increases, how can we improve recruitment and retention of dentists and the wider dental workforce?*

Annexe: Remit

The crisis in primary healthcare is one of the biggest challenges people face. Millions of people wait weeks for a GP appointment, and seeing an NHS dentist can be almost impossible. This is bad for patients and bad for the NHS, putting more pressure on ambulances and A&E as more people end up in hospital who shouldn't have to be there.

If we get it right, a well-functioning primary care system can help unlock a healthier life for us all, and a better and more effective NHS.

This working group will develop policies to tackle this crisis, in a way that communicates our values and helps to secure the election of as many Liberal Democrats as possible at local, regional and national level, in order to promote our vision of society.

It will set out proposals to:

- Improve early access to GP services, community pharmacies and dentists, helping to shift more healthcare out of hospitals and into communities
- Free up more of GPs' time to focus on core services for patients
- Invest in the primary care estate and upgrade out-of-date facilities
- End 'dental deserts' so everyone who needs one can see an NHS dentist in their local area
- Build on the Pharmacy First approach to give patients more accessible routine services and ease the pressure on GPs.
- Tackle medicine supply issues faced by community pharmacies, so people can get their prescriptions filled when they need them

- Tackle the particular challenges faced by rural communities in relation to primary healthcare

The group will, as a top priority, develop up to three headline policies that the party can communicate widely to help elect as many Liberal Democrats as possible – especially at the next general election.

It will build on the policies in our 2024 general election manifesto, as well the motions *Access to Dental Services* and *Our Plan to Save the NHS*, passed by conference in 2023 and 2024 respectively. (It will not look at mental health services, as these are being covered by a separate working group.)

The group will also consider the need for institutional change at central, regional and local government levels to embed these approaches firmly in policy.

It will take evidence and consult widely both within and outside the party. This evidence should inform the group's proposals, which will be presented alongside an analysis of costs and an Equalities Impact Assessment.

A policy paper of no longer than 10,000 words should be produced for debate at Autumn Conference 2026. Prior to that a consultative session should be held at Spring Conference 2026, and a draft policy paper should be presented to the Federal Policy Committee by June 2026.

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