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Welsh Government

Consultation – summary of responses

Reform of NHS General Dental Services in Wales Consultation

23 September 2025

Overview

This document provides a summary of responses to our consultation on the reform to the GDS contract. This consultation summary report was published on 23 September 2025. Information on next steps has also been provided.

Action Required

This document is for information only.

Further information and related documents

Large print, Braille and alternative language versions of this document are available on request.

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Additional copies

This summary of response and copies of all the consultation documentation are published in electronic form only and can be accessed on the Welsh Government's website.
Link to the consultation documentation: Reform of NHS general dental services | GOV.WALES

Contents

Glossary

BDA

British Dental Association

CDS

Community Dental Service

DAP

Dental Access Portal

DNA

Did Not Attend

GDS

General Dental Service

GDP

General Dental Practitioner

LGBTQ+

Refers to lesbian, gay, bisexual/bi, transgender/trans people, queer or questioning. Other letters can be added to the acronym to include other groups, orientations and identities, such as I (intersex) and A (asexual/aromantic). The + (plus) in the acronym is used as a shorthand to include and acknowledge other diverse terms people identify with and use to describe their identities and orientations, including intersex, asexual and aromantic people.

LHB

Local Health Board

NHS

National Health Service

PCR

Patient Charge Revenue

Quantitative Analysis

Involves the use of numbers and statistics to understand patterns, relationships, or trends

Qualitative Analysis

Focuses on understanding meanings, experiences, and concepts through non-numerical data (such as open-ended survey questions). Helps to explore ideas, perceptions, and motivations

RCT

Root Canal Therapy

UDA

Unit of Dental Activity

UHB

University Health Board

WGDPC

Welsh General Dental Practice Committee is the official representative body for GDPs in Wales. The WGDPC is recognised by government as having the status and authority to negotiate on behalf of all NHS GDPs on matters of terms and conditions of service, contracts, and remuneration in the GDS.

Executive Summary

1. **Respondent profile**

The consultation received 6,427 responses in total, including 6337 standard responses and 90 non-standard responses. The overwhelming majority of standard responses (90.5%) were submitted by individuals sharing their personal views and experiences, such as patients, carers, or members of the public. A small proportion of respondents, around 7.5%, identified as dental professionals. The majority of individual respondents (84.3%) identified themselves as being NHS dentistry patients who would like to continue with this arrangement.

The consultation was comprised of questions for two key audiences. Questions in Sections 2 to 5 were mostly targeted towards the general public and intended to be informed by their direct and indirect experience of existing dental services and patient care. Section 6 questions were more technical and directed towards dental professionals specifically.

2. **Approach to Reforms**

A total of 48.0% of respondents agreed or strongly agreed that changes are needed to ensure fairer access to NHS dental services in Wales, while 35.9% disagreed or strongly disagreed. Among dental professionals, 64.7% agreed or strongly agreed with this statement, compared to 46.2% of individuals from the general public. Several organisations who submitted responses also recognised the need for reform but expressed reservations at how aspects would be implemented in practice.

When asked whether NHS dental services are available to those who need them most, 46.6% of respondents disagreed or strongly disagreed, 30.6% agreed or strongly agreed, and 20.7% neither agreed nor disagreed.

Regarding the proposed reforms to the General Dental Services (GDS) contract, 77.2% of respondents disagreed or strongly disagreed that the changes would help ensure fair access, 7.5% agreed or strongly agreed, and 13.4% neither agreed nor disagreed.

Just over half of respondents reported no issues accessing dental care (53.4%). This may be linked to the majority of individual respondents indicating that they already have an arrangement as an NHS dentistry patient that they would like to continue with. Of respondents who did report barriers, the most commonly reported barriers were being unable to get an appointment (16.3%) and being unable to cover the cost of treatment while ineligible for financial help (7.9%). Additional issues raised under ‘other’ barriers included lack of local NHS provision, long waiting lists, and practices not taking on new NHS patients.

3. **Access to Routine and Urgent Services**

Respondents widely supported prioritising care for those with the greatest clinical need, as well as children, and expressed a clear preference for a greater emphasis on prevention. A large majority, around 82.8%, preferred to wait to see their regular dentist rather than attend a different practice or see a different dental professional.

Confidence in accessing urgent care was moderate, with approximately one third of respondents feeling unsure or unconfident about their ability to do so.

4. Payment for NHS Dental Services

Most respondents suggested that they understood how much they pay. However, individual respondents were less clear about where the payments they make are ultimately directed and when they are making a payment towards their treatment whether they are paying for a combination of NHS and private dental care.

More than half of respondents opposed the idea of moving to an online-only payment system. The majority of respondents also indicated that they would be happy to make a contribution to their NHS dental treatment providing it is re-invested in dental services to improve access for others.

5. Technical Contract Specific Considerations

Dental professionals expressed strong concerns about the technical elements, of the GDS proposal. The majority of dental professionals disagreed that the new payment model is fair (68.6%), improves on the previous UDA model (60.4%), or supports associate dentists and practice sustainability (66.7%). While some supported the move to the proposed care packages in principle, half of dental professionals felt that specific care packages were improperly valued, with frequent mention of undervaluation for high-complexity treatments, such as root canals, dentures, and extended restorative care. Dental professionals raised concerns that the proposed changes to the payment model could lead to underfunded delivery or compromised care quality.

In relation to the definition of ‘high needs patients’ included in the proposal, most dental professionals disagreed with the definition, criticising the threshold for being too high, arbitrary, and potentially exclusionary of patients who could not meet that threshold but may otherwise need to be prioritised for treatment. Respondents argued for a more flexible, contextual approach that considers medical complexity, vulnerability, and treatment difficulty rather than relying solely on a threshold based on the number of interventions.

6. Understanding Impacts

Most respondents in this section raised concerns about reduced access, loss of continuity with familiar dentists, and challenges related to travel, transport, and administrative systems.[1] Many criticised proposed changes to check-up frequency for patients with good dental health and expressed fears about the potential negative impacts on patients with anxiety or dental phobia. Dental professionals also highlighted the need for fair remuneration of care packages delivered and raised concerns regarding staffing, and the risk of patients being pushed towards private care.

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[1] The prevalence of concern regarding continuity of care may be linked to the respondent profile, with a large proportion of individual respondents indicating that they already have an existing relationship with a dental practice as an NHS dental patient and only a small proportion of respondents indicating that they did not currently have access to NHS dentistry.

Of respondents who provided a response regarding the anticipated Welsh Language impacts of the proposal, most indicated that they would not expect the proposals to have an effect on the Welsh language, or were unsure regarding the impact the proposals would have.

The majority of respondents who commented on equalities impacts felt the proposed changes would negatively affect individuals with protected characteristics, particularly those who are disabled, elderly, neurodivergent, or on low incomes. Key concerns included potential implications for continuity of care, increased travel and transport barriers, digital exclusion. The concerns raised in this section may be linked to the older age profile of individuals who responded to the consultation.

Under the final comments question asked, the most commonly cited impact was concern over loss of continuity of care, with around one third of respondents highlighting risks such as reduced trust, increased anxiety, and disengagement from dental services which was felt could particularly affecting vulnerable and anxious patients. Many respondents feared the proposed changes could lead to worsening outcomes in oral health for those who currently have access to NHS dentistry.

Introduction and background

On 27 March 2025, the Cabinet Secretary for Health and Social Care opened a 12-week consultation[2] on proposals to reform the NHS General Dental Service (GDS) contract in Wales. This consultation sought feedback primarily through closed questions on the different elements of the proposed reform. The consultation closed on 19 June 2025.

In April 2025, the Welsh Government commissioned Miller Research to independently analyse the responses to the consultation.

This report provides a brief background to the consultation before outlining the approach to analysing consultation responses and presenting findings.

The consultation sets out the detail of the Welsh Government's proposals to reform the NHS GDS contract in Wales and the potential effects for patients and dental teams arising from the changes. The key changes proposed are:

- creating a single route of entry for people to access NHS dental services
- the implementation of a different remuneration system that is fairer and more transparent
- disincentivising unnecessary routine examinations
- adjustment to patient charges due to changes in the remuneration system and a shift in how these charges are to be collected
- changes to contract terms and conditions, such as parental leave.

The consultation documentation highlighted the details of how these modifications would change service provision. However, it also notes that not all aspects of the laws and regulations related to NHS dental services would need to be amended to implement these changes.

The proposals were informed by input from Tripartite negotiations, which took place from September 2023 to October 2024 between Welsh Government, NHS Wales, and the Welsh General Dental Practice Committee of the British Dental Association, to design and develop a new GDS contract.

Report structure:

- Section 2 outlines the methodology and overview of consultation responses.
- Section 3 presents the complete consultation analysis for standard responses received on a question-by-question basis.
- Section 4 presents the complete consultation analysis for non-standard responses received.

[2] Reform of NHS general dental services | GOV.WALES

Methodology

Response overview

Overall, 6427 responses were received to the GDS contract reform consultation. This comprised of 6337 standard responses and 90 non-standard responses, as set out in Table 2.1. Responses which provided a response to the consultation through the standard form attached to the consultation document (see Annex A) were classified as standard responses and responses which were not set out in this format were classified as non-standard responses.

The breakdown of the responses by stakeholder group is provided in Table 2.2, with further analysis of the stakeholder breakdown available in Section 1. It is important to note that between the 19th and 30th of April, there was a substantial increase in the number of consultation responses received, totalling 1,435, most of which were from the general public.[3]

The consultation was comprised of questions for two key audiences. Questions in Sections 2 to 5 were mostly targeted towards the general public[4] and intended to be informed by their direct and indirect experience of existing dental services and patient care. Section 6 questions were more technical and directed towards dental professionals specifically. However, it is clear from the analysis that a number of respondents in both cohorts answered questions regardless of intended audience. Therefore, for each question, where relevant, the feedback from dental professionals and individuals has been analysed separately to illustrate differences in the views between stakeholder groups.

Table 2.1 Response types

Response type	No. of respondents	Percentage
Full consultation (standard responses)	6337	(98.6%)[5]
Non-standard responses	90	(1.4%)
Total	**6427**	**(100%)**

Source: Miller Research analysis

Table 2.2 Response types by stakeholder group

Stakeholder group	No. of respondents	Percentage
An individual sharing my personal views and	5736	(90.5%)

[3] 485 consultation responses were submitted on the 23rd of April alone.
[4] One statement listed is aimed towards dental professionals only.
[5] All percentages are rounded to 1 decimal place.

experiences such as a patient, carer or member of the public		
On behalf another individual	23	(0.4%)
A dental professional	474	(7.5%)
A non-dental member of health or care workforce sharing my professional views	67	(1.1%)
On behalf of an organisation	35	(0.6%)
No answer	2	(0.03%)
Total	**6337**	**(100.0%)[6]**

Source: Miller Research analysis

Quantitative analysis

Quantitative analysis was undertaken for all closed questions asked in the consultation. In total, this included 18 out of the total 26 questions; for each of these 18 questions the relevant responses are presented in a table format.

Qualitative analysis

A thematic analysis was carried out for the remaining 8 questions that had an open text response option. Analysis of an initial sample of responses was undertaken to assess general sentiment as well as the key emerging and recurring themes.

Themes were coded and grouped for each question, using Microsoft Excel to aggregate accordingly. This aggregation of response themes helped to produce an initial coding framework.

Subsequently, a full analysis of the remaining responses was conducted, with a further focus on the emergence of new themes and the evolution of existing ones. This phase allowed for the refinement and reorganisation of the thematic framework, accommodating new perspectives that were not evident from the initial sample.

Throughout the process, attention was given to changes in the relative weighting of themes based on the volume of responses. Themes that emerged more frequently were given greater emphasis, highlighting the areas of interest to more respondents.

[6] Percentages might not total 100% due to rounding throughout.

Section One: Profiling

Q1) Age

Question 1 asked respondents about their age. The largest overall age group was 55 to 65, making up 24.6% of respondents, followed closely by over 65s, making up 24.2% of respondents.

Table 3.1 Response types by age

Q1. What is your age?	No. of respondents	Percentage
Under 16	9	(0.1%)
16 to 24	93	(1.5%)
25 to 34	593	(9.4%)
35 to 44	1132	(17.9%)
45 to 54	1324	(20.9%)
55 to 65	1562	(24.6%)
Over 65	1532	(24.2%)
No answer	92	(1.5%)
Total	**6337**	**(100.0%)**

Source: Miller Research Analysis

Q2 / 3) Gender identity

Question 2 asked respondents about their gender identity. Most respondents identified as female, making up 70.0% of respondents.

Table 3.2 Response types by gender

Q2. Which gender description most closely matches how you identify?	No. of respondents	Percentage
Female	4436	(70.0%)
Male	1729	(27.3%)
Non-binary	17	(0.3%)
Prefer not to say/No answer	148	(2.3%)
Prefer to self-describe	7	(0.1%)

Total	**6337**	**(100.0%)**

Source: Miller Research Analysis

Question 3 asked respondents about whether their gender identity was the same as their registered birth sex. The vast majority (96.6%) of respondents answered 'Yes'.

Table 3.3 Response type by sex registered at birth

Q3. Is the gender you identify with the same as your sex registered at birth?	No. of respondents	Percentage
Yes	6119	(96.6%)
No	17	(0.3%)
Prefer not to say/No answer	201	(3.2%)
Total	**6337**	**(100.0%)**

Source: Miller Research Analysis

Q4) Ethnicity

Question 4 asked respondents about their ethnic group. Most identified as White, making up 94.5% of respondents.

Table 3.4 Response type by ethnicity

Q4. What is your ethnic group?	No. of respondents	Percentage
Asian or British Asian: includes Indian, Pakistani, Bangladeshi, Chinese or any other Asian background	99	(1.6%)
Black, black British, Caribbean, African or any other black background	18	(0.3%)
Mixed or multiple ethnic groups: includes white and black Caribbean, white and black African, white and Asian or any other mixed or multiple background	69	(1.1%)
Other: includes Arab or any other ethnic group	28	(0.4%)
White: includes British, Northern Irish, Irish, Gypsy, Irish Traveller, Roma or any other white background	5989	(94.5%)
No answer	134	(2.1%)

Total	**6337**	**(100.0%)**

Source: Miller Research Analysis

Q5) Health Board region

Question 5 asked respondents which health board region they were located in. The largest proportion of respondents, with 24.6%, were located in the Aneurin Bevan University Health Board region, closely followed by the Cardiff and Vale University Health Board with 24.0%.

Table 3.5 Response type by health board region

Q5. Which health board region are you located in?	No. of respondents	Percentage
Aneurin Bevan University Health Board	1556	(24.6%)
Betsi Cadwaladr University Health Board	305	(4.8%)
Cardiff and Vale University Health Board	1519	(24.0%)
Cwm Taf Morgannwg University Health Board	1161	(18.3%)
Hywel Dda University Health Board	373	(5.9%)
Powys Teaching Health Board	93	(1.5%)
Swansea Bay University Health Board	1316	(20.8%)
No answer	14	(0.2%)
Total	**6337**	**(100.0%)**

Source: Miller Research Analysis

Q6 / 7) Respondent type

Question 6 asked respondents in what capacity they were completing the survey, for example, as a dental professional, an individual, or on behalf of an organisation, among other response options. Most respondents, 90.5%, identified as an individual sharing personal views and experiences, such as a patient, carer, or member of the public. The second largest group were dental professionals, accounting for 7.5% of respondents.

Table 3.6 Response type by respondents' capacity in which they are answering

Q6. In what capacity are you responding to this survey?	No. of respondents	Percentage
A dental professional	474	(7.5%)

A non-dental member of health or care workforce sharing my professional views	67	(1.1%)
An individual sharing my personal views and experiences such as a patient, carer or member of the public	5736	(90.5%)
On behalf another individual	23	(0.4%)
On behalf of an organisation	35	(0.6%)
Declined to answer	2	(0.0%)[7]
Total	**6337**	**(100.0%)**

Source: Miller Research Analysis

Question 7a asked, "If you answered, 'on behalf of another individual' in Question 6, on whose behalf are you answering?" A total of 23 respondents indicated they were responding on behalf of another individual. Among this group, the most common response was on behalf of a child, given by 43.5% of respondents. The second largest group was 39.1% responding on behalf of a vulnerable adult.

Table 3.7 Response type 'on behalf of another individual'

Q7a. If you answered 'on behalf of another individual' in Question 6, on whose behalf are you answering?	No. of respondents	Percentage
A child	10	(43.5%)
A vulnerable adult	9	(39.1%)
An individual that cannot access or use digital technologies	2	(8.7%)
Other	1	(4.3%)
No answer	1	(4.3%)
Total	**23**	**(100.0%)**

Source: Miller Research Analysis

Question 7b asked: "If you answered, 'a dental professional' in Question 6, what is your profession?" A total of 474 respondents identified as dental professionals, with

[7] 0.03% rounded to 1 decimal place.

the largest group being dentists, representing 61.8% of this group. The second largest category was dental nurses, making up 22.8% of respondents.

Table 3.8 Response type by profession

Q7b. If you answered 'a dental profession' on question 6, what is your profession?	No. of respondents	Percentage
Dentist	293	61.8%
Dental nurse	108	22.8%
Dental hygienist	9	1.9%
Dental therapist	20	4.2%
Hospital specialist	9	1.9%
Other	32	6.8%
Prefer not to say	3	0.6%
Total	**474**	**100.0%**

Source: Miller Research Analysis

Q8) Patient type

Question 8 asked respondents who had identified as "an individual sharing my personal views and experiences, such as a patient, carer, or member of the public" how they would describe themselves as a patient. The most common response was "an NHS dentistry patient currently, and would like to continue with this arrangement", chosen by 84.3% of respondents. The second most common response was "an NHS patient, but have trouble accessing care", selected by 5.3%, closely followed by 5.2% who said they were "a private patient, but would like to access an NHS dentist".

Table 3.9 Response type by patient

Q8. As a patient, how would you describe yourself?	No. of respondents	Percentage
I am a private patient and would like to continue with this arrangement	116	(2.0%)
I am a private patient, but I would like access to an NHS dentist	297	(5.2%)

I am an NHS dentistry patient currently, and would like to continue with this arrangement	4837	(84.3%)
I am an NHS patient, but I have trouble accessing care	304	(5.3%)
I do not have access to any dentist, I do not feel the need to have one	12	(0.2%)
I do not have an ongoing relationship with a practice, but I access urgent care when I need it	137	(2.4%)
Declined to answer	33	(0.6%)
Total	**5736**	**(100.0%)**

Source: Miller Research Analysis

Section Two: Approach to Reform

1) Approach to Reform

Question 1 in Section 2 asked respondents for their opinions on the proposed approach to reform. Respondents were presented with 3 statements and asked to rate their agreement using a Likert scale. The responses are summarised in the table below.

Table 4.1 – Section 2 - Question 1 response overview

Approach to reform opinion poll	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
Changes are needed to ensure fairer access to NHS dental services in Wales.	1392 (22.0%)	879 (13.9%)	904 (14.3%)	1871 (29.5%)	1174 (18.5%)	117 (1.8%)	6337 (100.0%)
NHS dental services in Wales are available to those that need it most	1362 (21.5%)	1591 (25.1%)	1312 (20.7%)	1486 (23.4%)	459 (7.2%)	127 (2.0%)	6337 (100.0%)
The proposed reforms to the GDS contract will help ensure fair access to NHS dental care for all people in Wales.	3308 (52.2%)	1583 (25.0%)	846 (13.4%)	321 (5.1%)	149 (2.4%)	130 (2.1%)	6337 (100.0%)

Source: Miller Research Analysis

Overall, 48.0% gave a positive response (agree or strongly agree) to the first statement: “Changes are needed to ensure fairer access to NHS dental services in Wales”, while 35.9% gave a negative response (disagree or strongly disagree). Meanwhile, 14.3% neither agreed nor disagreed. These results indicate a general tendency among respondents to support the statement, though opinions were notably divided.

Most respondents gave a negative response to the second statement: “NHS dental services in Wales are available to those that need it most”, with 46.6% either disagreeing or strongly disagreeing. Conversely, 30.6% of respondents either agreed or strongly agreed with this statement, while 20.7% neither agreed nor disagreed. These results suggest negative perceptions of the current availability of NHS dental services.

Opinions on the statement: “The proposed reforms to the GDS contract will help ensure fair access to NHS dental care for all people in Wales” were strongly negative. A large majority of respondents (77.2%) either disagreed or strongly disagreed with the statement. Only 7.5% expressed a positive view (agree or strongly agree), while 13.4% neither agreed nor disagreed. These results indicate a general agreement among respondents that the proposed reforms are not viewed as an effective way to ensure fair access to NHS dental care.

The following tables examine how different stakeholder groups, namely dental professionals and individuals from the general public, responded to the statement about the proposed approach to the reform.

Table 4.2 – Section 2 - Question 1a stakeholder breakdown

Changes are needed to ensure fairer access to NHS dental services in Wales.	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**No answer**	**Total**
Dental professionals	62 (13.1%)	40 (8.4%)	47 (9.9%)	186 (39.2%)	121 (25.5%)	18 (3.8%)	474 (100.0%)
Individuals	1323 (23.1%)	830 (14.5%)	841 (14.7%)	1648 (28.7%)	1005 (17.5%)	89 (1.6%)	5736 (100.0%)

Source: Miller Research Analysis

Among dental professionals, 64.7% agreed or strongly agreed with the statement “Changes are needed to ensure fairer access to NHS dental services in Wales”, compared to 46.2% of individuals from the general public.

Table 4.3 – Section 2 - Question 1b stakeholder breakdown

NHS dental services in Wales are available to those that need it most.	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
Dental professionals	126 (26.6%)	148 (31.2%)	78 (16.5%)	95 (20.0%)	10 (2.1%)	17 (3.6%)	474 (100.0%)
Individuals	1212 (21.1%)	1403 (24.5%)	1213 (21.2%)	1369 (23.9%)	441 (7.7%)	98 (1.7%)	5736 (100.0%)

Source: Miller Research Analysis

A majority of dental professionals (57.8%) either disagreed or strongly disagreed with the statement “NHS dental services in Wales are available to those that need it most”, compared to 45.6% of individuals.

Table 4.4 – Section 2 - Question 1c stakeholder breakdown

The proposed reforms to the General Dental Services (GDS) contract will help ensure fair access to NHS dental care for all people in Wales.	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
Dental professionals	299 (63.1%)	95 (20.0%)	36 (7.6%)	23 (4.9%)	6 (1.3%)	15 (3.2%)	474 (100.0%)
Individuals	2958 (51.6%)	1455 (25.4%)	791 (13.8%)	290 (5.1%)	140 (2.4%)	102 (1.8%)	5736 (100.0%)

Source: Miller Research Analysis

Among dental professionals, 83.1% either disagreed or strongly disagreed with the statement, “The proposed reforms to the General Dental Services (GDS) contract will help ensure fair access to NHS dental care for all people in Wales”, compared to

77.0% of individuals. This indicates a strong overall negative sentiment toward the proposed reforms across both stakeholder groups.

2) Barriers to access

Question 2 in Section 2 asked respondents “What barriers, if any, are preventing you from accessing NHS dental care?” Respondents were presented with 8 options (see Table 4.5) and asked to select all that apply.

The majority of respondents (53.4% of all options selected) indicated that they did not have a problem accessing NHS dental care. As respondents were able to select multiple options, these percentages reflect the barriers as a proportion of all options selected, rather than the proportion of individual respondents.

The next most common barrier selected was ‘unable to get an appointment’, accounting for 16.3% of all responses, followed by ‘unable to cover the cost of treatment, but ineligible for financial help’, accounting for 7.9% of all responses. Additionally, 7.9% of responses fell under the ‘other’ category, which enabled respondents to provide further detail about the barriers they faced in accessing treatment which are explored in further detail below.

Table 4.5 – Section 2 - Question 2 response overview[8]

Barriers to accessing NHS dental care	Overall count	Percentage
Unable to get an appointment	1280	16.3%
Work/life demands	471	6.0%
Caring demands	130	1.7%
Emotional such as fear, anxiety or embarrassment	319	4.1%
Access to appropriate transport	224	2.8%
Unable to cover the cost of treatment, but ineligible for financial help	619	7.9%
I don’t have a problem accessing NHS dental care	4196	53.4%
Other (see below)	625	7.9%

Source: Miller Research Analysis

Other Barriers

[8] The total barriers exceed the total number of standard responses received (6335) as respondents were asked to select all barriers which apply.

While the ‘other’ option for Question 2 was provided to enable respondents to share barriers that did not fall under the barriers listed, a number of respondents highlighted barriers that were already listed but shared them in their own words. Additionally, while 25 respondents suggested that the policy on appointment recalls contained within the GDS reform proposals were a barrier to access, it is important to note this policy has not yet been implemented. The other barriers provided by individuals from the general public included the following:

- lack of NHS treatment available locally (171)
- dentists not taking on new NHS patients (167)
- availability of appointments for NHS treatment (85)
- long waiting lists for access to register as an NHS patient (50)
- desire for continuity with dental practice / dentist (45)
- privatised dental practice (41)
- distance / transport to dental practice (37)
- increased patient charge (26)
- policy on appointment recall for patients with no specific health issues (25)
- Disability (21)
- lack of communication / notice regarding appointments (20)
- inadequate service / standard of care (20)
- fewer procedures are available on the NHS (13)
- dental practice opening hours (12)
- lack of urgent appointments (11)
- mental health issues / dental anxiety (11)
- neuro-divergence (9)
- no longer have access to an NHS dentist (5)
- deregistered (sic) during Covid-19 (4)
- lack of patient choice regarding the dental professional seen (1)

Dental professionals

Although this question was aimed at the general public and their experience of accessing NHS dental care, a number of dental professionals also chose to respond to this question. Most dental professionals who provided a response (35 respondents) under ‘other’, indicated that they did not face any barriers to accessing dental care due to their profession. Furthermore, a number of dental professionals cited wider barriers they felt prevented patients from being able to access NHS dental care. These are outlined below in order from most to least frequent:

- challenges with recruitment of dental professionals (20)

- lack of funding for dental practices to undertake NHS treatment (12)
- general limitations of the current GDS Contract (5)
- high cases of did not attends (DNA's) (2)
- patient charge for treatment is too expensive (1)
- unreasonable targets for dental practices under the current GDS contract (1)

Wider comments

Overall, 24 respondents did not provide a direct response to the question asked, instead stating their general opposition to the reforms being proposed.

Section Three: Improving Access to Routine Services

1) Improving Access to Routine Services

Question 1 in Section 3 asked respondents for their opinions on improving access to routine services. Respondents were presented with 7 statements and asked to rate their agreement using a Likert scale. The responses are summarised in the table below.

Llywodraeth Cymru
Welsh Government

Table 5.1 – Section 3 stakeholder breakdown – Improving access to routine services opinion poll

There should be a process that prioritises dental appointments to those with the greatest clinical need	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	651 (10.3%)	1117 (17.6%)	1433 (22.6%)	2439 (38.5%)	552 (8.7%)	145 (2.3%)	6337 (100.0%)
Dental professionals	45 (9.5%)	83 (17.5%)	87 (18.4%)	195 (41.1%)	49 (10.3%)	15 (3.2%)	474 (100.0%)
Individuals	602 (10.5%)	1020 (17.8%)	1320 (23.0%)	2201 (38.4%)	476 (8.3%)	117 (2.0%)	5736 (100.0%)
NHS funding should prioritise children, even if it means fewer people can be seen overall	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	723 (11.4%)	1736 (27.4%)	1535 (24.2%)	1697 (26.8%)	511 (8.1%)	135 (2.1%)	6337 (100.0%)
Dental professionals	33 (7.0%)	83 (17.5%)	73 (15.4%)	162 (34.2%)	108 (22.8%)	15 (3.2%)	474 (100.0%)
Individuals	681 (11.9%)	1636 (28.5%)	1436 (25.0%)	1491 (26.0%)	384 (6.7%)	108 (1.9%)	5736 (100.0%)
There should be an equitable mechanism that supports people to gain access to routine NHS dental care	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	262 (4.1%)	360 (5.7%)	1188 (18.7%)	3097 (48.9%)	1285 (20.3%)	145 (2.3%)	6337 (100.0%)

Dental professionals	16 (3.4%)	32 (6.8%)	77 (16.2%)	259 (54.6%)	74 (15.6%)	16 (3.4%)	474 (100.0%)
Individuals	246 (4.3%)	319 (5.6%)	1097 (19.1%)	2782 (48.5%)	1174 (20.5%)	118 (2.1%)	5736 (100.0%)
Patients who do not attend their routine appointments with a dental practice on multiple occasions, without contacting the practice, should be moved to another practice	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	372 (5.9%)	544 (8.6%)	820 (12.9%)	2410 (38.0%)	2073 (32.7%)	118 (1.9%)	6337 (100.0%)
Dental professionals	64 (13.5%)	53 (11.2%)	64 (13.5%)	100 (21.1%)	178 (37.6%)	15 (3.2%)	474 (100.0%)
Individuals	289 (5.0%)	476 (8.3%)	744 (13.0%)	2275 (39.7%)	1863 (32.5%)	89 (1.6%)	5736 (100.0%)
As tooth decay and gum disease are largely preventable, the new dental contract should have a focus on prevention	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	248 (3.9%)	452 (7.1%)	1102 (17.4%)	3019 (47.6%)	1391 (22.0%)	125 (2.0%)	6337 (100.0%)
Dental professionals	16 (3.4%)	20 (4.2%)	42 (8.9%)	191 (40.3%)	191 (40.3%)	14 (3.0%)	474 (100.0%)
Individuals	227 (4.0%)	425 (7.4%)	1046 (18.2%)	2780 (48.5%)	1156 (20.1%)	102 (1.8%)	5736 (100.0%)
Patients that can, should take responsibility for looking after their own oral health	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	327	624	1097	2768	1391	130	6337

	(5.2%)	(9.8%)	(17.3%)	(43.7%)	(22.0%)	(2.1%)	(100.0%)
Dental professionals	12 (2.5%)	8 (1.7%)	36 (7.6%)	165 (34.8%)	239 (50.4%)	14 (3.0%)	474 (100.0%)
Individuals	312 (5.4%)	604 (10.5%)	1046 (18.2%)	2552 (44.5%)	1117 (19.5%)	105 (1.8%)	5736 (100.0%)
The proposed renumeration packages are an improvement compared to the units of dental activity (UDA) system of payment (profession only)	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	1048 (16.5%)	902 (14.2%)	2728 (43.0%)	328 (5.2%)	93 (1.5%)	1238 (19.5%)	6337 (100.0%)
Dental professionals	167 (35.2%)	98 (20.7%)	116 (24.5%)	55 (11.6%)	25 (5.3%)	13 (2.7%)	474 (100.0%)
Individuals	863 (15.0%)	789 (13.8%)	2572 (44.8%)	254 (4.4%)	63 (1.1%)	1195 (20.8%)	5736 (100.0%)

Source: Miller Research Analysis

Overall, 47.2% gave a positive response (agree or strongly agree) to the statement: “There should be a process that prioritises dental appointments to those with the greatest clinical need”, while 27.9% gave a negative response (disagree or strongly disagree). Among stakeholder groups, 51.4% of dental professionals agreed or strongly agreed, compared with 46.7% of individuals. Conversely, 27.0% of dental professionals disagreed or strongly disagreed, compared with 28.3% of individuals. These results indicate general support among respondents for the prioritising of appointments for those with the greatest clinical need.

The second statement: “NHS funding should prioritise children, even if it means fewer people can be seen overall”, elicited a more divided response. Overall, 34.9% of respondents gave a positive response (agree or strongly agree), while 38.8% gave a negative response (disagree or strongly disagree), and 24.2% neither agreed nor disagreed. These results indicate that respondents are evenly split on the idea of prioritising children with NHS funding. Looking at the stakeholder breakdown, 24.5% of dental professionals disagreed or strongly disagreed, compared to 40.4% of individuals. Conversely, 57.0% of dental professionals agreed or strongly agreed, compared to just 32.7% of individuals. This suggests that dental professionals are more likely than members of the public to support prioritising children with NHS funding.

The response to the third statement: “There should be an equitable mechanism that supports people to gain access to routine NHS dental care” was more clearly positive. A strong majority of respondents (69.2%) agreed or strongly agreed with the statement, while only 9.8% disagreed or strongly disagreed. In the stakeholder breakdown, 10.2% of dental professionals and 9.9% of individuals gave a negative response (disagreed or strongly disagreed). Positive responses were also very similar across stakeholder groups with, 70.2% of dental professionals and 69.0% of individuals agreeing or strongly agreeing. This suggests consistent support among both stakeholder groups for implementing a fair and equitable system to improve access to routine NHS dental care.

There was also a strong positive response to the fourth statement: “Patients who do not attend their routine appointments with a dental practice on multiple occasions, without contacting the practice, should be moved to another practice.” Overall, 70.7% of respondents agreed or strongly agreed with the statement, while only 14.5% disagreed or strongly disagreed. This indicates that respondents generally support holding patients accountable for repeated non-attendance and view transferring these patients to another practice as a fair way to ensure appointment slots are better utilised. However, there were differences between stakeholder groups. Among dental professionals, 24.7% disagreed or strongly disagreed, compared to just 13.3% of individuals. Likewise, 58.7% of dental professionals

agreed or strongly agreed, compared to a higher 72.2% of individuals. This suggests that while both groups broadly support the principle of accountability for DNAs, dental professionals were more cautious about this approach.

A majority of respondents (69.6%) agreed or strongly agreed with the statement: “As tooth decay and gum disease are largely preventable, the new dental contract should have a focus on prevention”, whilst only 11.0% disagreed or strongly disagreed. This indicates a clear preference among respondents for greater emphasis on prevention within the NHS dental contract. The stakeholder breakdown shows that only 7.6% of dental professionals disagreed or strongly disagreed, compared to 11.4% of individuals. Conversely, 80.6% of dental professionals agreed or strongly agreed, compared to 68.6% of individuals. This suggests that dental professionals are more strongly in favour of prioritising prevention than the general public.

Most respondents positively responded to the statement: “Patients that can, should take responsibility for looking after their own oral health” with 65.7% agreeing or strongly agreeing. 15.0% disagreed or strongly disagreed whilst 17.3% neither agreed nor disagreed. This indicates broad support for the principle of personal responsibility in maintaining oral health among respondents. The stakeholder breakdown shows that only 4.2% of dental professionals disagreed or strongly disagreed, compared to 15.9% of individuals. Conversely, 85.2% of dental professionals agreed or strongly agreed, compared to 64% of individuals, indicating that dental professionals are more supportive of the idea that patients should take responsibility for their own oral health.

The final statement: “The proposed renumeration packages are an improvement compared to the units of dental activity (UDA) system of payment”, was intended for dental professionals only. However, it seems that respondents outside the dental profession also chose to respond to this statement. Focusing solely on dental professionals, 55.9% disagreed or strongly disagreed that the proposed remuneration packages were an improvement over the current UDA system, while only 16.9% agreed or strongly agreed. This suggests that dental professionals were not in favour of the proposed changes to the payment system.

2) Regularity of check ups

Question 2 in Section 3 asked respondents: “Assuming timely urgent care is available, how often would you expect [to] receive a dental check-up?” Respondents were presented with 4 options as outlined in Table 5.2 below.

Table 5.2 – Section 3 - Question 2 response overview

Assuming timely urgent care is available, how often would you expect [to] receive a dental check-up?	No. of respondents	Percentage

As often as recommended by my dentist	1933	30.5%
Every 6 months	1308	20.6%
Once a year	2819	44.5%
Once every 2 years	258	4.1%
No answer	19	0.3%
Total	**6337**	**100.0%**

Source: Miller Research Analysis

The most commonly (44.5%) chosen option by respondents was that they would expect a dental check-up once a year. The second most common response was as often as recommended by my dentist, chosen by 30.5% of respondents. Notably, once every 2 years, was the least popular response, selected by just 4.1% of respondents.

Table 5.3 – Section 3 - Question 2 stakeholder breakdown

Assuming timely urgent care is available, how often would you expect the receive a dental check-up?	**Dental professionals**	**Individuals**
As often as recommended by my dentist	213 (44.9%)	1677 (29.2%)
Every 6 months	59 (12.4%)	1235 (21.5%)
Once a year	192 (40.5%)	2581 (45.0%)
Once every 2 years	9 (1.9%)	241 (4.2%)
No answer	1 (0.2%)	2 (0.0%)
Total	**474 (100.0%)**	**5736 (100.0%)**

Source: Miller Research Analysis

The stakeholder breakdown revealed differences in preferences between dental professionals and individuals. Among dental professionals, 44.9% believed patients should have check-ups as often as recommended by their dentist, followed closely by 40.5% of dental professionals who said once a year. Conversely, 45.0% of individuals expected a check-up once a year, followed by 29.2% who selected as often as recommended by their dentist. In both groups, once every 2 years was the least popular option. This indicates that dental professionals place greater emphasis

on individualised care based on clinical need, while members of the public tend to prefer an annual check-up.

3) Different dental professional or dental practice appointments

Question 3 in Section 3 asked respondents: “How would you feel about a different dental professional or dental practice handling your family’s appointments, if it meant improved access to routine dental care?” Respondents were given 4 options as outlined in Table 5.4 below.

Table 5.4 – Section 3 - Question 3 response overview

How would you feel about a different dental professional or dental practice handling your family’s appointments, if it meant improved access to routine dental care?	No. of respondents	Percentage
I value getting access to an appointment more quickly, even if it means not seeing the same dental professional or going to the same practice	702	11.1%
I only want to see the same dental care professional or going to the same practice, even if it means waiting longer for an appointment	5246	82.8%
I don’t have strong opinions on the matter	226	3.6%
Don’t know	78	1.2%
No answer	85	1.3%
Total	**6337**	**100.0%**

Source: Miller Research Analysis

The majority of respondents (82.8%) indicated that they would prefer to see the same dentist and attend the same dental practice, even if it meant waiting longer for an appointment.

4) Appointments with other members of the dental profession

Overview

Question 4 in Section 3 (see Annex A) aimed to explore the perceptions of individual respondents in relation to the acceptability of seeing other members of the dental profession.

This question received a mixed response, with the majority of the 2713 respondents who answered agreeing that they would be willing to see a wider dental professional if it meant being seen more quickly. A further 1407 respondents would be willing to see a wider member of the professional team, subject to various conditions being in place. The most commonly cited conditions included the nature of the treatment and

the patient's needs, the capability and qualifications of the professional to carry out the work required and the ability to be seen within the same dental practice that the patient normally attends.

Additionally, whilst an open text box was provided to explore the nature of the conditional circumstances under which respondents indicated they 'Maybe' would be willing to see a wider dental professional, this textbox was also used by some respondents to indicate reasons why they would or would not be willing to see a wider dental professional. This reasoning is also explored in the analysis below.

Table 5.5 – Q16 Response Overview

Response	No. of respondents	Percentage
Yes	2715	42.9%
No	2075	32.8%
Maybe (please explain circumstances)	1407	22.2%
Don't know	1	0.0%
No substantive response	139	2.2%
Total	**6337**	**100.0%**

Source: Miller Research analysis

Yes

Respondents who indicated that they would be happy to see a member of the wider dental professional team were the least likely to provide a rationale for their response. For respondents who did share their reasoning, the main reasons cited were that they already see wider dental professionals (most commonly hygienists) as part of their current dental treatment and are broadly happy with this arrangement, so long as the professional is sufficiently qualified to deliver the required treatment.

No

Respondents who indicated that they would not be happy to see a member of the wider dental professional team provided several reasons for this response. These reasons are summarised in the following paragraphs.

Preference for same dentist

The most cited justification for not being willing to see a member of the wider dental team was an expressed preference to see a familiar dentist. Respondents who responded 'No' to this question were typically members of the public who already had an established relationship with a dental practice and/or dentist. Respondents' reasons for preferring to see a familiar dentist are listed below, from most to least commonly cited:

- trust / relationship with regular dentist (46)
- anxiety / phobia of dentists (41)
- additional health needs (25)
- regular dentist is familiar with respondent's background (17)

- continuity of care (12)
- familiar routine of seeing the same dentist (5)
- standard of service received (4)
- confidence in regular dentist to meet respondent's needs (3)

Preference for a dentist over wider dental professionals

Some respondents who indicated that they would not be willing to see wider dental professionals expressed concerns regarding the capability and experience of wider dental professionals, both in terms of providing treatment as well as identifying dental issues during check-ups. Specific concerns about seeing wider dental professionals included:

- perceived increased risk of mistakes being made during treatment or dental issues being missed and potential increase in negligence claims
- potential increase in overall cost associated with treatment with wider dental professionals who may not be qualified to treat the problem resulting in the need for further appointments for repair / rework and the associated expense
- certain groups being potentially more negatively affected by the proposals outlined in the consultation.

Maybe

Respondents who selected the 'Maybe' response option and gave a further comment reflected on the circumstances within which they would be willing to see a wider dental professional. The themes that emerged are outlined below.

What is being treated

Respondents who indicated that they may be willing to see wider dental professionals indicated that this would be dependent on what treatment was required. Some respondents indicated that they would be more willing to see wider dental professionals for routine checkups or to see a dental hygienist, specifically, for hygiene appointments, rather than receiving restorative treatment from a wider dental professional. Respondents more commonly expressed concerns about seeing a wider dental professional for treatment that they considered solely within the capability of dentists, specifically extractions, fillings and root canal treatment.

Urgency of appointment / pain levels

Respondents also indicated their willingness to see wider dental professionals was dependent on how urgently they needed treatment and the level of pain they were in at the time. Although many respondents expressed concern about seeing wider dental professionals for restorative treatment (as opposed to routine checks ups or less invasive treatments such as hygiene appointments), a smaller number of

respondents suggested that they would not mind seeing wider dental professionals in emergency cases or when experiencing high levels of pain, subject to their competency to treat the issue.

Capability to treat the problem that is being presented / ability to escalate if required

Respondents indicated that they would be willing to see wider dental professionals subject to their capability (including qualifications and experience) to provide the necessary treatment. Some respondents expressed uncertainty regarding whether wider dental professionals would be suitably qualified and what treatments would be appropriate within the scope of their role.

Some respondents raised concerns that seeing wider dental professionals could lead to a waste of time or money if the wider dental professional is unable to provide the necessary treatment or provides inadequate treatment, either of which results in the patient needing to have for a subsequent appointment with a dentist. In this situation, it was suggested that patients who have initially been seen by a wider dental professional should be prioritised for an appointment with a dentist should further treatment be required. However, respondents were sceptical that this would be properly implemented and were concerned that patients may end up with an extensive wait to see a dentist, following their initial appointment with a wider dental professional.

When raising concerns regarding the implications of seeing wider dental professionals, some respondents drew parallels with the prevalence of the Physicians Associate role in GP practices, which it was suggested had led to a deterioration in standards of care in general practice.

Initial check up with / referral by my dentist

Some respondents expressed a preference for having an initial check up with a familiar dentist, who could subsequently develop a treatment plan where needed. It was suggested that wider dental professionals and even dentists who are unfamiliar with the patient may miss emerging dental issues during an initial checkup. As long as the initial check-up was completed by a familiar dentist however, some respondents stated they would be content with a referral to treatment delivered by

other dentists or a wider dental professional, subject to their regular dentist having oversight over the treatment delivered.

Same practice

Some respondents expressed a willingness to see wider dental professionals but only those based in the practice that is already familiar to them. A smaller number of respondents indicated that whilst they would be willing to see dental professionals from other practices they would prefer to be seen in a familiar practice. A number of reasons for this preference are expressed below from most to least commonly cited:

- ensuring access to medical files (20)
- trust / established relationship (12)
- proximity to home / travel constraints (7)
- continuity of care (6) particularly for those with neurodivergence / additional health needs (2)
- not attending a different practise to my children (2)
- accessibility of the practice for those with disabilities (2)

Retain access to my NHS dentist / NHS services

Respondents also highlighted the need for reassurance that if they were to take up an offer to be seen by wider dental professionals from other practices, they would not lose access to their existing preferred dentist and dental practice. Respondents also expressed that treatment offered through this channel should still be on the basis of NHS rather than private treatment, which respondents associate with higher costs.

If seen more quickly / regularly

Respondents highlighted a willingness to see wider dental professionals should this mean that they are able to be seen more quickly or to receive more regular appointments. A small number of patients expressed their views regarding how often they should be seen, with every 6 months being the most commonly cited recall period. Finally, some respondents suggested that seeing wider dental professionals

in lieu of dentists could help to increase access to NHS dentistry, noting challenges they were currently facing in accessing NHS dental care.

Criticism of the proposals

A further 17 respondents did not provide a substantive response to this question but raised general concerns about the proposals, which included concerns that the suggested proposals would be introduced as a ‘cost-cutting’ measure and that they could result in a loss of continuity of care, similar to what it was suggested had occurred in GP surgeries.

Criticism of the consultation question

Finally, a small number of respondents (9) criticised the question itself for being too ‘circumstantial’ and ‘hypothetical’, which respondents felt made it difficult to provide a categorical response regarding the exact circumstances under which they would be willing to see a member of the wider dental profession.

Section Four: Improving Access to Urgent Services

1) Improving Access to Urgent Services

Question 1 in Section 4 asked respondents for their opinions on improving access to urgent services. Respondents were presented with 3 statements and asked to rate their agreement using a Likert scale as outlined previously.. The responses are summarised in table 6.1 below.

Table 6.1 – Section 4 - Question 1 response overview

Improving access to urgent services	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
I am aware of how I access urgent NHS dental care	371 (5.9%)	748 (11.8%)	615 (9.7%)	3056 (48.2%)	1358 (21.4%)	189 (3.0%)	6337 (100.0%)
If I need urgent NHS dental care, I am confident that I will be able to get it	768 (12.1%)	1036 (16.3%)	1022 (16.1%)	2353 (37.1%)	1002 (15.8%)	156 (2.5%)	6337 (100.0%)
Access to urgent NHS care is more important to me than access to routine NHS care	803 (12.7%)	1853 (29.2%)	2187 (34.5%)	993 (15.7%)	311 (4.9%)	190 (3.0%)	6337 (100.0%)

Source: Miller Research Analysis

Most respondents (69.6%) agreed or strongly agreed that they were aware of how to access urgent NHS dental care.

Just over half of respondents (52.9%) agreed or strongly agreed that if they needed urgent NHS dental care, they were confident they would be able to access it. Meanwhile, 28.4% disagreed or strongly disagreed, and 16.1% neither agreed nor disagreed. This suggests that while most respondents feel reasonably confident in

their ability to access urgent NHS dental care, nearly one in three respondents do not.

Most respondents (41.9%) disagreed or strongly disagreed with the statement: “Access to urgent NHS care is more important to me than access to routine NHS care”, suggesting that these respondents view routine NHS care as more important than urgent care. Additionally, 34.5% neither agreed nor disagreed, which may indicate that they consider both types of care equally important. Only 20.6% agreed or strongly agreed, showing that a smaller proportion of respondents prioritise urgent care over routine care. This suggests that for many respondents, maintaining access to routine NHS dental services is at least as important, if not more so, than access to urgent care.

2) Urgent appointment priorities

Question 2 in Section 4 asked respondents about priorities when attending an urgent dental appointment. Respondents were asked: “Which do you feel is a greater priority when you attend an urgent appointment?”, with 4 options provided, as outlined in Table 6.2 below.

Table 6.2 – Section 4 - Question 2 response overview

Which do you feel is a greater priority when you attend an urgent appointment?	No. of respondents	Percentage
I would rather be out of pain quickly	1329	21.0%
I would rather receive full course of treatment (when possible), and avoid having to reattend for permanent treatment	1663	26.2%
Providing I am not in pain I would be happy to return at a future date for the problem to be resolved permanently.	2908	45.9%
I have no preference	336	5.3%
No answer	101	1.6%
Total	**6337**	**100.0%**

Source: Miller Research Analysis

Most respondents (45.9%) indicated that, provided they were not in pain, they would be happy to return at a later date to have the problem permanently resolved. Meanwhile, 26.2% preferred to receive a full course of treatment during their initial urgent appointment to avoid having to attend another. Furthermore 21.0% of respondents indicated that their highest priority when accessing urgent appointments was to be out of pain quickly.

Section Five: Payment for NHS Dental Services

1) Payment Process for NHS Dental Services

Question 1 in Section 5 asked respondents for their opinions on the payment process for NHS dental services. Respondents were presented with 5 statements and asked to rate their agreement using a Likert scale as previously stated.. The response is broken down in Table 7.1 below by overall response, dental professional response and individual response to highlight differences in views between those groups. This distinction is important given the technical nature of the question, which was aimed at dental professionals.

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Table 7.1 – Section 5 - Question 1 stakeholder breakdown – Payment process for NHS dental services opinion poll

The money you pay for dental care should be collected through an online system, rather than at the dental practice	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	1709 (27.0%)	1691 (26.7%)	2210 (34.9%)	394 (6.2%)	182 (2.9%)	151 (2.4%)	6337 (100.0%)
Dental professionals	119 (25.1%)	72 (15.2%)	142 (30.0%)	58 (12.2%)	50 (10.5%)	33 (7.0%)	474 (100.0%)
Individuals	1563 (27.2%)	1601 (27.9%)	2031 (35.4%)	316 (5.5%)	129 (2.2%)	96 (1.7%)	5736 (100.0%)
When I receive NHS dental treatment, I understand how much I pay towards it	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	319 (5.0%)	814 (12.8%)	870 (13.7%)	3016 (47.6%)	1172 (18.5%)	145 (2.3%)	6337 (100.0%)
Dental professionals	34 (7.2%)	35 (7.4%)	54 (11.4%)	167 (35.2%)	148 (31.2%)	36 (7.6%)	474 (100.0%)
Individuals	279 (4.9%)	767 (13.4%)	798 (13.9%)	2805 (48.9%)	1005 (17.5%)	82 (1.4%)	5736 (100.0%)
I understand that when I pay for NHS dental treatment that money is ultimately paid to the health board not the practice	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	539 (8.5%)	1096 (17.3%)	1904 (30.0%)	2065 (32.6%)	557 (8.8%)	176 (2.8%)	6337 (100.0%)

Dental professionals	56 (11.8%)	58 (12.2%)	64 (13.5%)	120 (25.3%)	139 (29.3%)	37 (7.8%)	474 (100.0%)
Individuals	473 (8.2%)	1021 (17.8%)	1819 (31.7%)	1913 (33.4%)	399 (7.0%)	111 (1.9%)	5736 (100.0%)
It is made clear to me when I pay for a combination of NHS and private dental care	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	352 (5.6%)	765 (12.1%)	1768 (27.9%)	2318 (36.6%)	907 (14.3%)	227 (3.6%)	6337 (100.0%)
Dental professionals	9 (1.9%)	10 (2.1%)	50 (10.5%)	154 (32.5%)	214 (45.1%)	37 (7.8%)	474 (100.0%)
Individuals	334 (5.8%)	741 (12.9%)	1693 (29.5%)	2132 (37.2%)	674 (11.8%)	162 (2.8%)	5736 (100.0%)
I am happy to make a contribution to my NHS dental treatment providing it is re-invested in dental services to improve access for others	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	No answer	Total
All respondents	448 (7.1%)	721 (11.4%)	1122 (17.7%)	2702 (42.6%)	1169 (18.4%)	175 (2.8%)	6337 (100.0%)
Dental professionals	17 (3.6%)	21 (4.4%)	59 (12.4%)	166 (35.0%)	168 (35.4%)	43 (9.1%)	474 (100.0%)
Individuals	424 (7.4%)	685 (11.9%)	1046 (18.2%)	2498 (43.5%)	978 (17.1%)	105 (1.8%)	5736 (100.0%)

Source: Miller Research Analysis

The majority of respondents (53.7%) disagreed or strongly disagreed with the statement that payment should be collected through an online system rather than at the dental practice. Only 9.1% agreed or strongly agreed, while 34.9% neither agreed nor disagreed, indicating that people are generally not in favour of moving to a fully online payment system. Among dental professionals, 22.7% agreed or strongly agreed compared to 7.7% of individuals, suggesting dental professionals are slightly more supportive of online payment systems.

Most respondents (66.1%) agreed or strongly agreed with the statement: “When I receive NHS dental treatment, I understand how much I pay towards it”, indicating they feel they understand the cost of their NHS dental treatment. This sentiment was consistent across stakeholder groups, with 66.4% of dental professionals and 66.4% of individuals agreeing or strongly agreeing. Meanwhile, 1.6% of dental professionals disagreed or strongly disagreed, compared to 18.3% of individuals. These results suggest there is a generally high level of confidence and understanding among both the public and dental professionals about the costs patients pay for NHS dental treatment, although a notable minority still feel uncertain.

Among respondents overall, 41.4% agreed or strongly agreed with the statement: “I understand that when I pay for NHS dental treatment that money is ultimately paid to the health board, not the practice.” Overall, 25.8% of respondents disagreed or strongly disagreed, and 30.0% neither agreed nor disagreed. This suggests that understanding of how NHS dental payments are distributed is mixed, with less than half of respondents demonstrating clear awareness of the fact that payments ultimately go to the health board. Even among dental professionals although awareness is higher than with individuals, 24.0% disagree or strongly disagree with the statement.
Overall, 50.9% of respondents agreed or strongly agreed with the statement: “It is made clear to me when I pay for a combination of NHS and private dental care.” Among dental professionals specifically, agreement was much higher at 77.6% compared to individuals where 49.0% agreed or strongly agreed.

Most respondents (61.0%) agreed or strongly agreed with the statement: “I am happy to make a contribution to my NHS dental treatment providing it is re-invested in dental services to improve access for others”, whilst 18.5% disagreed or strongly disagreed. In the stakeholder breakdown, dental professionals were more likely to report being happy to make a contribution with 70.4% agreeing or strongly agreeing with the statement, compared to 60.6% of individuals.

Section Six: Technical Contract Specific Considerations

1) Technical Contract Specific Considerations

Question 1 in Section 6 asked respondents their opinion on specific considerations outlined in the technical contract as outlined in Table 8.1. Respondents were presented with 7 statements and asked to rate their agreement using a Likert scale as previously,, with an additional N/A option.

This question was primarily intended for dental professionals: however, most individual respondents responded to this question. As a result, we have undertaken a stakeholder breakdown as part of the analysis for this question. The response is summarised in Table 8.1 below.

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Welsh Government

Table 8.1 – Section 6 - Question 1 stakeholder breakdown - Payment process for NHS dental services opinion poll

The contract holder should have overall responsibility to ensure that all level one routine dentistry is provided ensuring that patients are not referred for simple routine dentistry	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A	No answer	Total
All respondents	194 (3.1%)	340 (5.4%)	2197 (34.7%)	2158 (34.1%)	716 (11.3%)	6 (0.1%)	726 (11.5%)	6337 (100.0%)
Dental professionals	20 (4.2%)	28 (5.9%)	77 (16.2%)	208 (43.9%)	128 (27.0%)	0 (0.0%)	13 (2.7%)	474 (100.0%)
Individuals	174 (3.0%)	305 (5.3%)	2092 (36.5%)	1903 (33.2%)	570 (9.9%)	5 (0.1%)	687 (12.0%)	5736 (100.0%)
The new care package payment model represents a fair remuneration for the services provided	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A	No answer	Total
All respondents	1227 (19.4%)	1429 (22.6%)	2505 (39.5%)	352 (5.6%)	83 (1.3%)	7 (0.1%)	734 (11.6%)	6337 (100.0%)
Dental professionals	196 (41.4%)	129 (27.2%)	99 (20.9%)	23 (4.9%)	15 (3.2%)	0 (0.0%)	12 (2.5%)	474 (100.0%)

Individuals	1015 (17.7%)	1271 (22.2%)	2365 (41.2%)	323 (5.6%)	63 (1.1%)	6 (0.1%)	693 (12.1%)	5736 (100.0%)
The new payment model improves fairness and transparency compared to the previous UDA model	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A	No answer	Total
All respondents	1226 (19.3%)	1336 (21.1%)	2534 (40.0%)	389 (6.1%)	84 (1.3%)	9 (0.1%)	759 (12.0%)	6337 (100.0%)
Dental professionals	178 (37.6%)	108 (22.8%)	100 (21.1%)	57 (12.0%)	18 (3.8%)	0 (0.0%)	13 (2.7%)	474 (100.0%)
Individuals	1033 (18.0%)	1206 (21.0%)	2390 (41.7%)	320 (5.6%)	62 (1.1%)	8 (0.1%)	717 (12.5%)	5736 (100.0%)
The care package model supports fair payment for associate dentists and the wider dental team	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A	No answer	Total
All respondents	1052 (16.6%)	1095 (17.3%)	2882 (45.5%)	433 (6.8%)	71 (1.1%)	8 (0.1%)	796 (12.6%)	6337 (100.0%)
Dental professionals	200 (42.2%)	122 (25.7%)	100 (21.2%)	25 (5.3%)	15 (3.2%)	0 (0.0%)	12 (2.5%)	474 (100.0%)
Individuals	841 (14.7%)	951 (16.6%)	2725 (47.5%)	403 (7.0%)	52 (0.9%)	8 (0.1%)	756 (13.2%)	5736 (100.0%)
It is appropriate that there is a maximum threshold placed on high-value treatments (e.g. posterior RCT and crown/bridge)	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A	No answer	Total
All respondents	462	583	1405	2124	996	7	760	6337

	(7.3%)	(9.2%)	(22.2%)	(33.5%)	(15.7%)	(0.1%)	(12.0%)	(100.0%)
Dental professionals	110 (23.2%)	85 (17.9%)	72 (15.2%)	120 (25.3%)	73 (15.4%)	0 (0.0%)	14 (3.0%)	474 (100.0%)
Individuals	340 (5.9%)	485 (8.5%)	1313 (22.9%)	1965 (34.3%)	908 (15.8%)	7 (0.1%)	718 (12.5%)	5736 (100.0%)
I feel that the new GDS contract will allow me to be able deliver my whole contract and reduce clawback	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A	No answer	Total
All respondents	870 (13.7%)	828 (13.1%)	3144 (49.6%)	136 (2.1%)	40 (0.6%)	10 (0.2%)	1309 (20.7%)	6337 (100.0%)
Dental professionals	197 (41.6%)	121 (25.5%)	123 (25.9%)	11 (2.3%)	8 (1.7%)	0 (0.0%)	14 (3.0%)	474 (100.0%)
Individuals	662 (11.5%)	687 (12.0%)	2973 (51.8%)	123 (2.1%)	28 (0.5%)	7 (0.1%)	1256 (21.9%)	5736 (100.0%)
The new payment model will support the financial stability of my practice	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A	No answer	Total
All respondents	916 (14.5%)	796 (12.6%)	2928 (46.2%)	234 (3.7%)	54 (0.9%)	8 (0.1%)	1401 (22.1%)	6337 (100.0%)
Dental professionals	209 (44.1%)	107 (22.6%)	122 (25.7%)	12 (2.5%)	9 (1.9%)	0 (0.0%)	15 (3.2%)	474 (100.0%)

Individuals	689 (12.0%)	675 (11.8%)	2763 (48.2%)	219 (3.8%)	41 (0.7%)	5 (0.1%)	1344 (23.4%)	5736 (100.0%)

Source: Miller Research Analysis

For all statements except one, the most common response among individuals was neither agree nor disagree. In contrast, the breakdown of responses from dental professionals showed more distinct and decisive opinions on each statement. Given that this opinion poll was targeted primarily towards dental professionals, the high proportion of neutral responses among individuals likely reflects a lack of understanding of the statements' meaning or implications, particularly given their technical and contract-specific nature, rather than an absence of opinion. For this reason, the following analysis focuses primarily on the responses from dental professionals, as they provide more informed and relevant insight into the technical aspects of the proposed changes.

Among dental professionals, the majority (70.9%) agreed or strongly agreed with the statement: "The contract holder should have overall responsibility to ensure that all level one routine dentistry is provided ensuring that patients are not referred for simple routine dentistry". This suggests that dental professionals broadly support the idea of centralising responsibility with the contract holder to ensure that routine care is delivered appropriately.

Most dental professionals (68.6%) disagreed or strongly disagreed with the statement: "The new care package payment model represents a fair remuneration for the services provided", whilst 39.9% of individuals disagreed or strongly disagreed and 41.2% neither agreed nor disagreed. The strong disagreement among dental professionals, and a notable proportion of individuals, indicates concern that the proposed new model does not fairly compensate for the services provided.

Most dental professionals (60.4%) disagreed or strongly disagreed that "The new payment model improves fairness and transparency compared to the previous UDA model", while 21.1% neither agreed nor disagreed, indicating that a majority of dental professionals do not perceive the new payment model as an improvement in terms of fairness and transparency. The proportion of neutral responses suggests that some dental professionals may be uncertain about the impact of the new model at this stage.

Most dental professionals (67.9%) disagreed or strongly disagreed that: "The care package model supports fair payment for associate dentists and the wider dental team", whilst 21.2% neither agreed nor disagreed. This again highlights that most dental professionals do not believe the care package model provides fair payment, and the notable proportion of neutral responses may indicate some uncertainty about how the model would operate in practice.

Dental professionals were much more divided over the statement: "It is appropriate that there is a maximum threshold placed on high-value treatments (e.g. posterior RCT and crown/bridge)." 41.1% disagreed or strongly disagreed, while 40.7%

agreed or strongly agreed. 15.2% neither agreed nor disagreed, reflecting a clear split in opinion within the profession. Among individuals, this was the only statement where the majority did not choose neither agree nor disagree, instead, 34.3% of individuals agreed with the statement and 15.8% strongly agreed.

Most dental professionals (67.1%) disagreed or strongly disagreed with the statement “I feel that the new GDS contract will allow me to be able deliver my whole contract and reduce clawback”, whilst 25.9% neither agreed nor disagreed. This indicates that most dental professionals lack confidence in the new GDS contract’s ability to support them in fully delivering their contractual obligations and minimising clawback.

Similarly, most dental professionals (66.7%) disagreed or strongly disagreed with the statement, “The new payment model will support the financial stability of my practice”, whilst 25.7% neither agreed nor disagreed. This suggests that most dental professionals do not believe the proposed payment model will provide adequate financial stability for their practices. Again, the notable proportion of neutral responses indicates some uncertainty about the impact of the model. However, the overall findings reflect a lack of confidence among dental professionals in the financial viability of the proposed changes.

2) Valuation of care packages in the new fee scale

Question 21 in Section 6 asked respondents whether they thought any specific care packages in the new fee scale were under or overvalued. This question was a technical question aimed at dental professionals as it concerns the renumeration they will receive for performing different treatments, as opposed to the cost of treatment to patients, which this may or may not effect. With that in mind, the views of dental professionals are drawn out separately in the analysis. The proposed care packages are:

- Urgent Care
- New Patient Assessment
- Simple Caries Care Package
- Extended Restorative Care Package
- Perio Package
- Anterior Root Canal Care Package
- Posterior Root Canal Care Package
- Crown and Bridge Care Package
- Denture Care Package
- Very High Needs Stabilisation
- 3, 6, 9 and 12 month Recall Care Packages
- Assessment and Recall Care Packages for Children.

As shown in Table 8.2, 45% of respondents stated that they did not feel any specific care packages in the new fee scale was under or overvalued, while 13% of respondents suggested that they did. 42% of respondents did not answer the

question. Exactly half of dental professionals (50%) stated that they felt specific care packages in the new fee scale were under or overvalued, while 37% did not, and 13% did not answer the question.

Table 8.2 - Q21. Are there any specific care packages in the new fee scale that you feel are under or overvalued?

Q21. Are there any specific care packages in the new fee scale that you feel are under or overvalued?	No. of respondents	Percentage
Yes	823	13.0%
No	2859	45.1%
No answer	2655	41.9%
Total	**6337**	**100.0%**

Source: Miller Research Analysis

The majority of respondents (5467) did not provide additional information in response to this question. A minority of respondents who responded 'No', or did not provide a substantive answer the question, made additional comments and are included in thematic analysis below.

All Care Packages

Sixty respondents, 43 of whom were dental professionals, thought that all care packages were undervalued. Sixteen respondents suggested that the modelling used to identify fees was incorrect, with one respondent stating: "the £135 per hour calculation used to calculate the care package pricing is far too low". This included the BDA, who approved of the care package structure as an improved offer, and presented alternative fees for each care package to support "sustainable delivery" suggesting that the NHS should "no longer expect private dentistry to cross-subsidise NHS work".

Forty-two respondents suggested that all of the care packages were overvalued. Only 3 dental professionals suggested that all of the care packages were overvalued, whilst the remaining 39 were individuals who infrequently equated the care package fees with the cost of the care packages to patients, demonstrating a lack of understanding of the question.

Three respondents suggested that all of the care packages were correctly valued.

Specific Care Packages

Both anterior and posterior root canal treatment were felt to be overvalued by 4 individuals, as they suggested that they were too expensive and that the cost may lead to an increase in extractions. Sixteen respondents, 13 of whom were dental professionals, suggested they were undervalued, stating that the fee will not cover the cost of treatment due to a number of factors, including the time taken to complete a root canal treatment, the cost of the equipment used, the importance of continuing care and the potential for treatment to prove more challenging than initially thought.

Sixteen respondents, 13 of whom were dental professionals, suggested that the denture care package was undervalued due to how expensive the treatment is to carry out, including laboratory costs, 5 visits and the need for continuing care. In addition, respondents highlighted that some patients require 2 dentures. Finally, respondents highlighted that the lack of renumeration during the 2-year period of responsibility may be made difficult as they are reliant on patients caring for their dentures, with one respondent suggesting that patients lose or break dentures intentionally to “get new teeth”.

Fourteen respondents, 13 of whom were dental professionals, said that simple caries were undervalued. One stated that the £65 fee would not cover the cost of one filling. Two respondents linked this to the lack of alternatives to amalgam and the expense of composite. Regarding the care package structure, respondents suggested that including extractions and fillings in the same banding may lead to an increase in extractions that were considered simpler than fillings. In addition, respondents suggested that there should be distinct care packages for 1-2 fillings and 3-5 fillings to account for the expense.

Twelve respondents, all dental professionals, stated that the very high needs stabilisation package were undervalued, with one respondent stating it was “wildly out”. They suggested that this treatment is very time consuming and the package should specify the number of hours of treatment required under the care package. They also suggested that the difference of £11 between the extended restorative package and the very high needs stabilisation package was too low.

Twelve respondents, all dental professionals, suggested that the extended restorative care package was undervalued, stating that it would not cover the costs of treatment, particularly of composite. One respondent stated that it may “put pressure on dentists to provide sub-standard treatment or bear the costs themselves”. Respondents stated that restorative treatment “takes time to do well”, and that it would benefit from more levels, as they felt the threshold was too low.

Seven responses, (specifically 3 from dental professionals and 4 from individuals) suggested that the care package variants for children were overvalued. Respondents felt that the care packages were expensive, with several claiming children should have free dental healthcare.[9]Conversely, one dental professional thought that these care packages were undervalued due to the additional time needed and complexity of treating children. The BDA proposed that initial assessment fees for children should be the same as adults as they should not “have to compete for access”, although the children fee scale is set at a higher value to incentivise access, ongoing monitoring and preventative support.

[9] Currently children in Wales do have access to free NHS dental care and the GDS proposals do not change this arrangement.

Five respondents, one of whom was a dental professional, stated that assessments were over-valued, focusing on the expense to the patient. One individual respondent stated that they were expensive “just for looking at your teeth you are charged quite a bit” and suggested “charge for the work carried out only”.

Four respondents, 2 of whom were dental professionals, considered Urgent Care overvalued, with one dental professional suggesting that it should be lower for “simply prescription or very simple procedures” and the 2 dental professionals responding that it may make dental care inaccessible. Six dental professional respondents, thought that Urgent Care was undervalued, with respondents highlighting the 30-minute allocated time as insufficient, particularly without the dental or medical history of the patient. Respondents suggested that Urgent Care should include a separate band for unregistered patients, and that it must consider the potential for complex cases.

Three dental professionals stated that the Perio Package is undervalued due to the complexity of treatment, with one respondent requesting further explanation on what would be included.

Two individuals sharing their personal views, and one responding on behalf of another individual thought that the Crown and Bridge Care Package was “too expensive” while 10 respondents, all dental professionals, suggested it was undervalued due to laboratory fees (although the proposal states the laboratory costs would be transferred directly to the patient and not taken from the care package fee) and time taken to complete the procedures.

Two individuals suggested that check-up fees were too high and may impact the disadvantaged. This may be linked to the recall care-packages, however, that is unclear.

Other

Many (269) respondents commented that they were not sure whether specific care packages were over or undervalued, 64 respondents (58 individuals) did not understand the question, while 48 respondents (41 individuals) did not understand the care packages. One-hundred-and-fifty-seven respondents (152 individuals) thought that the question was not suitable for them as a patient or member of the public.

In addition, 113 responses, of whom 44 were dental professionals, provided inconclusive answers in response to this question, such as “all of them” or “RCT [root canal treatment] of posterior teeth”. As the question asked respondents whether they thought the care packages were overvalued or undervalued it was impossible to determine which of these applied to these comments.

In total 72 respondents, 66 of which were individuals, highlighted continuity of care as an issue, due to anxiety, effective treatment, fear, mental wellbeing and trust. Six

respondents suggested that certain groups should have free dental care, including older people and people receiving personal independence payments.

Wider comments
Many respondents (189) included comments that did not address the question, nor could be grouped into common themes. The themes that did emerge included: general opposition to the proposals, dental work being expensive for patients, that dentistry should be free on the NHS, current difficulty accessing a dentist, the complexity of the contracts and support for fee per item.

3) Definition of 'high needs patients'

Question 22 in Section 6 asked respondents whether they agreed with the Welsh Government's proposed definition of a 'high needs patient' as someone requiring ten or more dental interventions, including endodontic treatment. The definition is central to the design of a separate care pathway intended to provide support for patients with more complex or intensive treatment needs under the proposed dental reforms. It is important to note that this question was technical in nature. As such, it was primarily intended for dental professionals with direct experience of patient care and treatment planning. While members of the public were able to respond, the views of dental professionals have been drawn out and analysed separately where relevant to provide a clearer picture of concerns within the sector.

Table 8.3 – Q22.2: Do you agree with the Welsh Government's proposed definition of 'high needs patients' as those requiring 10 or more interventions, including endodontic treatment?

Response	No. of responses	Percentage
Agree	682	10.8%
Disagree	916	14.5%
Don't know	1481	23.4%
Neither agree nor disagree	2002	31.6%
No response	1256	19.8%
Total	**6337**	**100.0%**

Source: Miller Research analysis

While 682 respondents agreed with the proposed definition of 'high needs patients', most (916) expressed disagreement. Among those who agreed, only 19 provided a follow-up comment to explain their reasoning.

Disagree
Of the 916 respondents who disagreed with the proposed definition, 239 specifically cited concerns that the threshold of ten interventions was too high, while only one respondent felt it was too low. Among those who felt the threshold was too high,

many questioned the rationale for selecting ten interventions and argued that such a definition risk overlooking patients who require regular but less intensive care.

A strong theme emerging from respondents who disagreed was concern about the implications of this definition for the equity and accessibility of dental care. Specifically, 86 respondents feared that prioritising individuals who meet the ‘high needs’ definition could result in a two-tier system, where those requiring consistent or preventive care are deprioritised. There was a perceived risk that this would disrupt continuity of care for regular patients (mentioned by 67 respondents), effectively penalising those who make routine use of dental services in favour of those who neglect their oral hygiene.

Among those who disagreed, 60 respondents challenged the notion of "need" itself, arguing that it cannot be adequately captured by a set numerical threshold. Instead, it was suggested that dental needs are inherently contextual, varying according to age, vulnerability, disability, and other individual circumstances. For example, a child, an elderly person, or a patient with complex medical or social care needs may require specialised attention that would not necessarily equate to ten interventions.

In this context, there was strong support for a more flexible, case-by-case approach to identifying high-need patients. Some of these respondents argued that the proposed definition appears to prioritise treatment volume over early intervention and long-term oral health outcomes. Some suggested a preventative model would help ensure equitable access to care, particularly for those at higher risk of oral health deterioration, who may not yet have reached the threshold of significant “need”.

Agree
Among those who agreed with the proposed definition of ‘high needs patients’ and provided a follow-up comment, support was often qualified by concerns or caveats.

Some shared personal experiences of chronic conditions (such as gum disease or congenital heart defects) and emphasised the need for regular dental care. They expressed frustration at long waiting times and the lack of continuity when being referred between dentists, particularly where dental histories are not shared.

Views of dental professionals (474 respondents)
Most dental professionals (240 respondents) who responded to the question expressed disagreement with the proposed definition of 'high needs patients'. A further 106 respondents indicated agreement, 87 selected 'neither agree nor disagree', and 26 chose 'don’t know'.

Among those who disagreed, the dominant view was that the threshold of 10 interventions is excessively high, arbitrary, and lacks an evidence base. Many practitioners suggested alternative thresholds ranging from 3 to 6 interventions, with numerous respondents stating that even 5 or fewer could constitute high needs when clinical complexity, patient anxiety, or ‘co-morbidities’ are considered.

Professionals repeatedly emphasised that oral health need cannot be adequately captured by a numerical count of interventions alone. Factors such as periodontal instability, dental anxiety, poor medical health, and social vulnerability were identified as equally, if not more important indicators of high need. They noted that placing an inflexible numerical threshold risk incentivising over-treatment or misclassification while excluding genuinely vulnerable patients.

Of those who disagreed, 15 professionals expressed opposition to the inclusion of endodontic treatment (particularly root canal treatment) as a defining feature of 'high needs' status. The sentiment among these 15 was that this criterion is clinically inappropriate, overly prescriptive, and misaligned with the practical realities of dental care. For example, it was noted that patients requiring 10 or more interventions are often not suitable candidates for endodontics due to poor oral health or complex medical or social factors. It was also mentioned that prescribing root canal treatment as a marker of need excludes patients with extensive but non-endodontic requirements, such as multiple extractions, dentures, or restorative work. Others suggested that some cases involving 10 interventions could be relatively straightforward, while other complex cases could fall below the threshold but still demand an intensive level of care.

Among those 106 dental professionals who agreed with the proposed definition of 'high needs patients', comments often reflected cautious support. While some accepted the threshold as a reasonable definition of high need, many expressed concerns about the practical implications of delivering care to this patient group, particularly regarding workforce and service capacity.

They noted that such patients typically require complex, time-intensive care, and that without additional staffing and funding, services like the Community Dental Service (CDS) would be overwhelmed. There was broad agreement that the current CDS lacks the capacity to absorb this caseload. Some respondents proposed that care should instead be delivered through enhanced or salaried General Dental Service (GDS) contracts, rather than by CDS clinicians. Overall, while these respondents agreed with the principle of defining high needs patients, they questioned the feasibility of implementation under current service structures and stressed the need for properly resourced care pathways.

Criticism of the proposals

Beyond specific concerns with the definition itself, 25 respondents used the opportunity to express broader dissatisfaction with the reform proposals as a whole. For these individuals, disagreement with the ‘high needs’ definition was emblematic of a wider unease about the direction of policy reform and its alignment with the principle of patient-centred care.

Criticism of the consultation

Sixty respondents noted that they found the question confusing or poorly framed. Some of these responses suggested that it might be better directed at dental professionals rather than the general public, given the level of clinical understanding it appeared to assume.

Table 8.4 - Section 6 – Question 3 stakeholder breakdown

Response	Dental professionals	Individuals
Agree	106 (22.4%)	561 (9.8%)
Neither agree nor disagree	87 (18.4%)	1886 (32.9%)
Disagree	240 (50.6%)	649 (11.3%)
Don't know	26 (5.5%)	1435 (25.0%)
No response	15 (3.2%)	1205 (21.0%)
Total	**474 (100.0%)**	**5736 (100.0%)**

Source: Miller Research analysis

Section Seven: Understanding Impacts

1) Further aspects for consideration

Question 1 in Section 7 (see Annex A) asked respondents to raise whether there are any vital aspects for considerations that are important to GDS contract reforms that have not been addressed.

In total, 4724 respondents did not answer this question. Of the 1613 who did provide a response, the most common type of respondents were individuals (1433) sharing their own views, followed by dental professionals (140).

Overall, respondents raised a variety of issues, with a significant majority expressing negative views and concerns relating to the proposed reforms. These are explored in detail below. Where responses from professionals markedly differ from general public responses, we have highlighted them in the analysis below.

General access issues
The most frequent issue raised in response to this question related to overall accessibility for the general public. Respondents (predominantly individuals responding on their own behalf and with existing access to an NHS Dentist) expressed a strong preference for people to see their 'usual' dentist or practice (648), with significant concern at the prospect of engaging with a new, unfamiliar dentist or practice. This was primarily due to the perceived lack of an established relationship and trust with a new dentist or practice (464). The GDS reform proposals set out in the consultation document suggest that for patients that "clinically require regular access, or [for whom] an urgent need arises"10 will continue to be seen in the same practise.

Additional barriers respondents attributed to the proposed changes were in relation to travel. Specifically, respondents frequently expressed concern at the size of catchment areas (96) and how far they would potentially have to travel to secure an appointment. Issues around access to suitable transport were repeatedly raised (251), with respondents highlighting the difficulties in getting to new practices, especially if patients are elderly and or in rural locations, due to the poor transport options on offer. Respondents also cited the increased cost implications (52) that would accompany the perceived increase in travel that would result from the proposed reforms. Other concerns referenced, albeit less frequently, included the negative impact on appointment waiting times (33) and the undermining of local communities (33), as the local population no longer access local services.

Wider contract issues
In addition to the issues around access, as highlighted above, respondents also referenced wider concerns associated with the GDS contract reforms outlined in the

[10] Consultation on the reform of NHS General Dental services in Wales (2025), Page 21.

consultation document. The most frequent point raised by respondents was linked to the previous concern highlighted surrounding ‘switching’ to a new dentist or practice. Specifically, the lack of a formal system for note sharing (185) and the overall poor administrative system surrounding the NHS (137). As a result, many respondents felt there was a significant risk that their new dentist would not be aware of their medical history (48), with a small number questioning whether they would have the expertise relevant to their dental treatment plan (6). Similar worries were raised in the potential variation in approach to dental treatment that would occur due to seeing any new dentist or practice (28).

Proposed changes around the frequency of dental check-ups, which were underpinned by NICE guidelines, were widely criticised, multiple respondents felt that a 2-year recall period, or even every 12 months, was not often enough (110). In this context, respondents cited the importance of regular interaction with dentists and practices as an effective means of educating patients, as well as practicing preventative treatment (60), thus avoiding more complicated and urgent dental issues later down the line.

Expected impacts

Respondents identified a range of negative impacts they anticipated arising from the proposed reforms. These were predominantly from the perspective of individual respondents, with several respondents citing increased patient anxiety and distress (149), which may lead to reduced attendance and engagement amongst patients (65), because of not seeing their usual dentist or practice. Conversely, 16 respondents felt the reforms would increase dentist anxiety and distress. Many respondents were notably apprehensive about a perceived lack of continuity in care (167) as a result of proposed contract reforms, with some claiming that this would ultimately result in a lower standard of service for patients (30). Several felt the changes would be detrimental and lead to a deterioration in the dental health of patients who historically have good dental health (90), with frequent criticism that the proposals ‘penalise’ patients for taking care of their dental health (72).

Beyond the generic impact on patient experience, respondents also highlighted specific groups in particular they felt would be negatively affected by the changes. This included the elderly (57) and children (18) due to the challenges of access and anxiety respectively. Similarly, patients who are disabled or neurodiverse (90) or ‘vulnerable’ (36) were viewed as groups who would be at risk due to the proposed changes, as they can often struggle with changes to routine and environment.

Priority Groups

As well as outlining which groups could be negatively impacted by the contract reforms outlined in the consultation, respondents identified groups that should be given priority in terms of consideration and access when enacting changes. Naturally, there was overlap between these two groups, with children and young people (41) deemed a priority, alongside the elderly (27). Some respondents stated that individuals who either live, work or were born in Wales (14) should be prioritised.

Remuneration
An area identified as requiring further consideration as part of the GDS contract reforms was that of remuneration. This was raised almost exclusively by dental professionals, with many highlighting the need for remuneration to be fair and reasonable (37). Some professionals also expressed a preference for paid treatment by item (13), while the system around contract payments, specifically clawback, was raised as putting undue pressure on dental professionals (15).

Wider comments / feedback
In addition to the broad themes outlined above, respondents also raised a number of wider and disparate issues, many of which have already been cited under previous questions. This included feedback on the consultation process as a whole, with some respondents claiming the questions were biased, that descriptions were poor or that there was a lack of open text boxes (35). Several stated that policy makers should listen to dentists (29) and that proposals should be trialled prior to rollout (28). Others pushed back against the contract reforms, claiming no change was needed on the status quo (45) and that the proposed changes will not help (42). Some respondents stated they were unsure (17) whether there are any other vital aspects for consideration that had not been addressed.

There was a notable focus on cost implications, with several respondents stating the cost of dental treatment is too high (58), that more money should be invested into NHS dentistry (85) and that there is a need to recruit more dentists into the system (64). Related comments included the need for more dental practices who accept NHS patients (35) and the expectation that dental care should be high quality and free (31). Some respondents expressed concern that the changes will compromise the quality of care in order to provide for the wider population (27) and will force people into private dentistry (32).

2) Welsh Language impacts

Question 2 in Section 7 (see Annex A) explored the potential impacts the GDS contract reforms could have on the Welsh language and how the reforms could be formulated to increase positive effects on the Welsh language and mitigate against any potential adverse impacts on the Welsh language.

The majority of responses to this question (5128) provided no substantive response. For those who did answer the question, the largest themes identified in responses was that Welsh language is not a priority within dental care, and that other elements of dental care are more important. Regarding potential effects on the Welsh language, the most common response was that the proposals would have no impact on the Welsh language.

Positive effect
Only a small minority of respondents (7) indicated that the GDS reforms could have a positive effect on the Welsh language. These responses highlighted how the consideration of Welsh language makes Welsh speakers more comfortable when accessing care.

Negative effect
More respondents (56) indicated that the GDS reform could have a negative impact on the Welsh language. Several reasons were identified as to why or how the GDS reforms could negatively affect the Welsh language, including the reforms pushing patients to seek dental treatment in England, as well as Welsh speaking dental practices going private. The most commonly cited reason was patients having to move between Welsh speaking practices and non-Welsh speaking practices. Overall, feedback from respondents highlighted how the removal of choice for patients may result in patients not being able to choose Welsh speaking practices, ultimately being detrimental for the Welsh language.

No impact
Answers which indicated that the GDS reforms would have no impact on the Welsh language received 116 responses. Many respondents stated that the current bilingual provision within dental practices are adequate and that the GDS reforms would not change this.

Not sure
A further 118 responses answered that they were not sure what the impacts of the proposed reforms would be on the Welsh language.

Wider comments

Welsh language not a priority
Outside of non-substantive responses, the most commonly reported response to question 24 was an indication that the Welsh language is not a priority within dentistry (528). Respondents suggested that other factors like continuity of care should take priority over the Welsh language, as well as the potential cost associated with having bilingual services. Other respondents highlighted the challenge in Welsh language is not a priority for dentistry, as its implementation has the potential to create wider issues, such as recruitment.

Welsh language important for access
Conversely, 99 respondents directly contradicted this view, claiming that Welsh was an important factor for access to dental services. Respondents identified the importance of the Welsh language in making people feel comfortable when receiving care, as well as the potential negative impact on patient care in the absence of Welsh speaking practitioners / Welsh information.

Some respondents made suggestions to improve Welsh capacity within the dental system, such as each practice having a "Welsh champion" who can speak and distribute Welsh material when needed, with other respondents suggesting the creation of dedicated Welsh language practices.

Availability of Welsh speakers
For 81 respondents, the availability of dental practitioners who speak Welsh was seen as a potential barrier to enabling access to NHS dentistry. Respondents suggested that many dental practices do not have Welsh speaking staff and may find it expensive and time consuming to recruit Welsh speaking practitioners. One dentist suggested that they were happy to learn Welsh but identified the long timescales in learning the language.

Increased training / support
A further 28 respondents suggested that there is a need for increased Welsh language training and support within dental practices. Some respondents also suggested that Welsh universities could offer courses and grants in dentistry through the medium of Welsh.

Patient choice
A number of respondents (71) highlighted the importance of patients being able to choose a Welsh dentist if they wished. One respondent suggested that having a Clinipad11 could enable patients to express which language they preferred to receive treatment in.

Regional variations
A further 72 respondents answered that the potential impact on Welsh language would affect patients across Wales differently due to regional variations in the prevalence of Welsh speakers. Many respondents suggested that more Welsh language support should be available in areas with a high Welsh speaking population.

Relevance of the Welsh Language
Two respondents suggested that the contents of the contract have "nothing to do with the Welsh language".

Wider GDS contract reform concerns / comments
Finally, 160 respondents used the open-ended nature of the question to bring up general concerns and comments regarding the GDS reforms similar to those raised throughout the consultation.

[11] Clinipad is a tablet solution for in-house patient data capture.

3) Equalities impact

This question asked respondents to reflect on how the proposed parameters of practice might affect individuals and groups with protected characteristics under the Equality Act 2010.

The majority (273 respondents) indicated that the proposals would have a negative impact, with many expressing concerns that the proposals could worsen existing inequalities or create new challenges for disadvantaged groups. While a small number of respondents expressed optimism about improved access, and 123 expected no meaningful change, concerns outweighed optimism. The specific risks raised are explored in more detail below.

Positive impact
A small minority (9 respondents) expressed optimism about the proposed changes, suggesting they could improve access, particularly for individuals viewed as currently underserved by NHS dentistry, including disabled individuals and migrants.

Negative impact
The majority who felt that the proposals would have negative impacts (275 respondents) highlighted significant risks of exclusion, disruption, and inequity. Among these, the most raised concerns centred on the potential for reduced access to care, disruption to continuity, and the loss of established relationships with dental practitioners (144 respondents). Respondents feared that changes to the way dental services are delivered would disproportionately affect vulnerable groups, particularly where they may require patients to attend different practices.

The emphasis across 45 respondents was on the importance of equal access, continuity, and patient-centred care as core components of dental care.

Individuals with disabilities and long-term illnesses
Similarly, respondents identified risks for individuals with disabilities and long-term illnesses (65 respondents), or those who are neurodivergent or living with mental health difficulties (41 respondents). A recurring theme was the importance of familiarity, consistency, and trust in dental care. Having to repeatedly explain medical histories, support needs, or behavioural considerations to new practitioners was described as burdensome and distressing for patients and carers alike.

In particular, 42 respondents highlighted that neurodivergent individuals and those with anxiety were noted to benefit significantly from seeing the same practitioners in the same setting. Respondents highlighted that continuity plays an important role in building trust, reducing distress, and supporting long-term engagement with dental care. The reforms were perceived as threatening the ability of vulnerable individuals to maintain trusted relationships with their dentist, leading to concerns that these patients may disengage from care altogether.

Nine respondents raised concerns about how the proposals could negatively affect patients' ability to maintain good oral hygiene and manage chronic conditions linked to dental health. Particular attention was drawn to individuals with medical conditions such as diabetes, autoimmune disorders, or dementia, where links to periodontal disease are well-established. These groups, some of whom fall within protected characteristics, were seen as needing more frequent check-ups and proactive care yet could be disadvantaged by a model that was perceived to deprioritise regular attendance in favour of reactive treatment.

Older people

Concerns were especially pronounced in relation to older people, with 63 respondents expressing the view that the proposed changes could be discriminatory. Respondents described how elderly patients, often accustomed to a familiar dental practice, may struggle to attend unfamiliar surgeries. Some noted that such disruption could be confusing, distressing, or unmanageable due to mobility issues or the challenges of navigating unfamiliar places.

Travel and transport

Concerns around individuals with disabilities and older people were often intertwined with the issue of travel and transport (58 responses), with respondents noting that travelling to unfamiliar or distant practices could pose significant barriers, especially for those who rely on public transport.

Digital exclusion

Digital exclusion, often intersected with the themes of age and disability. A small number of respondents (4) highlighted that reliance on digital systems (for appointment booking, communication, and potentially payment) could disadvantage older people, those with disabilities, and individuals with limited internet access or digital literacy. While digital systems may enhance access for some, they were viewed as a barrier for others.

LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer, etc.)

While fewer respondents explicitly addressed sexual orientation or gender identity, the 3 respondents who did raised concerns about the potential psychological and emotional impacts of disrupted continuity of care on LGBTQ+ individuals.

Respondents emphasised that familiarity and consistent relationships with practitioners are particularly valued by those who may be navigating issues of identity, social stigma, or past experiences of discrimination. The proposed removal of a familiar practice was viewed as likely to increase discomfort for LGBTQ+ patients, particularly those who are transitioning require specific sensitivities around how they are addressed and treated.

Women and families
Concerns were also raised regarding the potential impact of the proposals on women (3 responses), mothers (7 responses), and families, particularly in relation to childcare (27 responses).

It was suggested that mothers are more likely to deprioritise their dental care in favour of their children or partners, especially when access becomes more difficult to coordinate. It was also noted that pregnant women may be unable to access the NHS maternity dental entitlement if they are unregistered or face long waiting lists, raising concerns about equity for a group with specific health entitlements under protected characteristic legislation.

The proposals were also viewed as disruptive to family-based care, with concerns that family members, including young children and those with additional needs, may be assigned to different practices. Respondents emphasised the importance of consistency in dental care for children, particularly those who are neurodivergent or anxious.

Impact on low-income individuals
Eighteen respondents expressed concerns that the proposed parameters of practice would disproportionately disadvantage individuals and families on low incomes. One of the most frequently cited issues was the increased burden of travel, particularly for patients without access to private transport and those in rural areas.

For those already facing poverty or economic insecurity, the cost of travel(alongside time away from work or caregiving) was seen as a deterrent to seeking care. Some highlighted concerns about rising treatment costs, reduced NHS availability, and the impact of payment models that may push more patients toward private care or away from care altogether.

Victims of Abuse
Three respondents mentioned the potential negative impact of the proposals on individuals with histories of sexual, physical, or psychological abuse. For these patients, trust and consistency in the clinical relationship are essential to accessing care. One respondent noted that some survivors of sexual abuse may feel unable or unwilling to see any dentist, particularly if they are unfamiliar, highlighting the vulnerability and trauma triggers that can be associated with dental surgeries.

Welsh and non-English speakers
Two respondents noted concerns regarding the impact of the proposals on Welsh speakers and individuals with limited English proficiency. One respondent highlighted the potential loss of access to services in Welsh, noting that if patients are assigned to non-local practices, they may not be able to receive treatment in their preferred language: which would be contrary to Welsh Government policy and the principles of culturally appropriate care.

No Impact
One-hundred and twenty-three respondents expressed the view that the proposals would have no meaningful impact on individuals with protected characteristics. These respondents felt that existing legal protections under the Equality Act 2010 were sufficient, and that the delivery of dental care should focus on availability and access for all. Some respondents indicated that, based on their experience, discrimination was not an issue in dental practices and that all patients were treated equally regardless of background. Other respondents believed that patients would continue to access services as needed, provided appointments were available.

4) Final comments

This question provided an opportunity for respondents to raise further issues related to the consultation. Most respondents (4,660) skipped this question. Of those who answered, many included multiple issues in their response. The most cited issues are described in the paragraphs below, whilst the number of citations of the less commonly referenced issues are listed in the subsequent table.

Continuity of access was a concern raised by around one third (820) of those who answered this question. Both dental professionals and individual respondents expressed concern that the proposed centralised DAP could result in patients attending different practices, identifying challenges around loss of continuity of care from the perspective of patients, most commonly in relation to loss of “trust” and “rapport” that can be built up between patient and familiar dentist over time, deemed to be particularly critical “with such as intimate process” as dental healthcare.

In some cases, respondents interpreted the proposals as resulting in patients attending a different practice for every check-up. The risk of this causing problems was thought to be particularly high for anxious patients or those who have had previous experience of unethical dentists.

Other projected challenges or issues for patients in relation to continuity of access included:

- The removal of patient choice over what practice they attend (including the choice to stay with an existing practice).
- The "hassle" and “stress” of having to locate and travel to a different practice.
- The creation of a perverse incentive for patients to neglect their oral health, as one practitioner reported "I've already had patients say, "I will make sure that I have a problem so that I stay at this practice."
- The potential for a fall in engagement with NHS dental services, leading to "a crisis of bad oral hygiene and tooth decay."
- The perception that it would disadvantage patient who conscientiously engage with the dental care system and adopt good oral hygiene.
- Concerns about seeing different dentists who are unfamiliar with ongoing dental problems.

- Misconception that the proposed DAP involves 'taking away' patient registration.
- Concerns about additional cost of and radiation from repeated X rays, "particularly bitewings" (i.e.: if patient data, including previous X rays, is not available to a practice when a patient attends for the first time).
- Uncertainty over the definition of "local" and what this will mean for patients having to travel.

A number of consequences for practices relating to the loss of continuity of access were also identified, primarily by dental professionals. These were almost entirely negative and included:

- Loss of the opportunity to adopt a long-term approach to treating patients, for example “monitor[ing] a lesion on an xray for a number of years” or providing consistent guidance about diet or oral hygiene.
- The risk that “spreading patients between practices will lead to more litigation”.
- Removal of an individual dentist’s responsibility for a cohort of patients: "I don't want to be sorting out other's poor quality work ".
- The risk of creating antagonism between practices by what was considered "policing" of the profession by getting patients to attend different practices.
- The likelihood that check-ups take longer if medical history is repeated each time.

Data and IT was a commonly cited issue in its own right (and is discussed below) but respondents noted several concerns about data in relation to the loss of continuity of care, including:

- Logistics of sharing patient information and medical history in a timely manner and perceived lack of IT infrastructure to enable to happen at all.
- Perceived increased risk of data breaches if sharing data between practices.
- Assumption that patients will be seen at different practices without case notes being shared.

Notably a minority of dental practitioner respondents identified an opportunity to address the unnecessary “retention” of low-need patients, suggesting the proposals will make the system fairer by preventing the current situation where "practices hold on to "good patients" for years."

Travel / logistics was the second most commonly cited theme amongst responses to this question, raised by 244 respondents. Again, this was considered a direct possible consequence of the proposed DAP and the idea that patients might be assigned an unfamiliar practice. Respondents referred to the “stress”, “fear” and “risk” of travelling somewhere new, especially for those who can walk to their current practice. The need to drive and park in an unfamiliar location was an issue for some, whilst others were concerned about the feasibility of travelling to a more distant dental practice on public transport, for instance for those in remote areas. Several respondents interpreted the definition of “a practice in their local area” as being a

practice anywhere in their health board, which was considered unreasonable. Challenges with travel and logistics was particularly considered an issue for the elderly, those who are neurodiverse, those who cannot drive, those with mobility issues, those with caring responsibilities, those who are in pain and seeking emergency treatment and those who live in rural areas. Respondents expressed concern about the collective impact on Wales' carbon footprint if patients are typically travelling further to access NHS dental services, whilst the financial cost of travel and potential need to take extended time off work or school were also mentioned.

Possible implications of the proposals for vulnerable / minority groups were cited by 171 respondents. Many of the points raised echoed responses to the consultation questions on equalities impacts and most of the comments related to the proposed Dental Access Portal and/or extended recall intervals. Identified groups who might be disadvantaged by extended recall intervals included:

- Looked after children who typically experience poor oral health and lack of regular access to dental services.
- Elderly, with access issues, potentially poorer dental health.
- Those with physical or learning disabilities, mental health problems, Additional Learning Needs, Autism Spectrum Disorder , Post Traumatic Stress Disorder, medical issues that compromised their oral health.
- Pregnant and nursing women who should have more frequent check-ups.

Groups who might be particularly affected by the proposed DAP included:

- Nervous or anxious patients who may struggle going to different practices.
- Children, who might value continuity of practitioner or may need orthodontic treatment.
- Families who for logistical reasons are likely to want appointments at the same time.
- Those without a car or access to public transport, who might be more. negatively impacted by having to travel further to access dental services.

Those with lower digital skills were also cited as potentially vulnerable to the proposed reforms, given that they may struggle with online payments.

The consultation process was raised in 170 responses to this question. In terms of the overall process, respondents suggested there had been inadequate publicity of the consultation process, which undermined the breadth of responses received and that there had been insufficient engagement with dental professionals in pre-consultation discussions.

Some respondents expressed a lack of faith in the consultation feedback being taken into consideration, suggesting that the proposals would be introduced regardless of the consultation feedback. Both dental professionals and individuals commented that it was inappropriate to have a combined consultation aimed at the public and dental professionals. Others were concerned about the cost of the consultation process, in the context of limited funding for NHS dentistry.

Some respondents were critical of the complexity of the consultation document, particularly for the general public. Others felt they had been given insufficient detail about the proposed reforms, thus undermining the validity of responses to the consultation.

Responses also included accusations of biased or leading questions, limited response options and unreasonable assumptions in the explanation of the rationale for change.

Recall intervals and the implications of extending recall intervals in line with NICE guidelines were mentioned by 158 respondents. Responses included various risks associated with extending recall intervals, primarily the risk of oral health deterioration during a longer period of time between check-ups (even amongst low-risk patients) as well as reduced opportunity for regular monitoring and early identification of dental issues (including mouth cancer), resulting in higher demand for emergency treatment in future. Many noted that this contradicts the prevention agenda. Some respondents doubted that 18-24 month recalls would happen in practice and suggested that low-risk patients could end up with recall intervals of significantly longer, further compromising the stability of their oral health, whilst there was doubt (amongst some practitioners) that extending recall intervals would result in increased access. Individual respondents expressed cynicism about the clinical rationale for extended recalls, given that 6-monthly check-ups used to be the default.

Notably a minority of individuals identified an opportunity in increasing timeframes between check-ups (unless a problem arises) for freeing up access to new patients.

Concerns about funding for NHS dental services and/or payment of dentists were mentioned in 154 responses. Most of these responses highlighted the need for more investment in NHS dental services either in terms of investment in more dental contracts or by increasing the financial imbursement to individual dentists working in the NHS. In some cases, respondents suggested increasing dental charges as a way of generating more revenue, including charging for missed appointments. Some respondents acknowledged a recruitment issue and proposed increasing the number of places in dental school, some of whom suggested offering more funding for dental students, in return for a minimum period of time working in the NHS.

Respondents commented that the proposals would be financially unappealing to or would financially disadvantage dental professionals, leading to more dentists leaving the NHS. The proposed removal of seniority payments was deemed a particular concern. A minority of dental professionals suggested that the estimated Patient Charge Revenue (PCR) generated through the proposed changes is an overestimate.

Issues with IT or data were noted by 146 respondents, relating almost without exception to the proposed DAP. Responses included:

- Concerns about data breaches and the risk of personal data being accessed inappropriately.
- Potential barriers to sharing patient data and records (e.g.: X-rays) being a challenge for the proposed DAP, with some individual respondents inferring that they would need to pay for new X-rays at each check-up.
- Issues with incompatible computer systems used by different practices and the need to invest in universal IT system, shared records database or secure data sharing platforms.
- Uncertainty over who is responsible for tracking referral data if patients move between multiple practices.

Making online payments was identified as an issue for some patients.

Access to NHS dental services in relation to the current system was mentioned in 126 responses. The majority of individuals responding to the consultation had access to NHS dentistry, and expressed concerns that access might be lost under the proposals. Some had doubts about the feasibility of increasing access without additional investment or displacement of those currently with access, whilst others questioned how access would increase if the proposed reforms resulted in more dentists leaving the NHS. Practitioners asked for clarity on how patients would be told about appointments if access is organised via a central system. Some suggestions for alternative ways to increase access included:

- Treatment being delivered by dental students.
- Establishing "access centres" manned by newly qualified dentists.
- Any treatment needed following a check-up to be delivered by CDS.

Wider implications for patients of the proposed reforms were noted in 119 responses, of which the majority were negative. These included:

- Challenges around understanding the proposed changes, if they come in (particularly around patient charges).
- Perceived element of penalising those who adopt preventative measures and take care of their oral health
- Requiring patients to take responsibility for monitoring their own oral health during (extended) intervals between check-ups.
- Implications for those who cannot afford to pay private if dentists to continue to leave the NHS.
- Patients needing to remember all medications at every check-up.
- Increase in some patient charges could lead to some patients delaying seeking treatment because of concerns around affordability.

In a minority of cases respondents identified potential positive implications for patients of the proposed reforms, for example the suggestion that the proposals would result in a fairer system overall for those wanting to access NHS dental services.

The risk of dentists moving from the NHS to the private sector was raised by 107 respondents in response to this question. This included dentists stating explicitly that the proposed changes disincentivises working in the NHS as well as patients acknowledging that it can be more beneficial for dentists to undertake private work, an issue that could be exacerbated under the proposals.

Table 9.3 – Q26 Additional themes raised

Theme	Number of responses referencing the theme
Workforce implications	102
Emphasis on prevention	89
Other	88
Need for greater patient accountability	87
The DAP	78
The care package model	57
DNAs / missed appointments	50
The remuneration model	50
Children and health education	43
Implications for dental professionals	42
Patients moving from NHS to private dental care	37
High needs patients	30
Emergency treatment	28
Implications for infrastructure	27
Child oral health	23
Online payments	19
Referrals to CDS	19
Removal of dentists' autonomy	15
Recommendations / requests to pilot the proposals	12
Clawback	11
Dental appliances	9
Welsh Language	7
Health promotion	7
Suggestions around monitoring	7
Recommendation to introduce core service	6
Technical comments	7
Reintroduction of patient registration	5
Cluster meetings	3

Source: Miller Research analysis

Non-Standard responses

In addition to the survey responses, the dental reform consultation received 90 non-standard responses via email and post. These provided free-form comments and opinions on the consultation topics. All non-standard submissions were reviewed, and analysed thematically. The resulting non-standard response's themes are presented in this section.

Table 9.4 – Non-Standard Responses

Non-standard responses	Overall Count
Organisation	11
Individual	79
Total	**90**

Source: Miller Research analysis

Most non-standard responses (79) were submitted by individuals sharing their perspectives as patients and ten were from organisations.

General sentiment

All 90 respondents expressed a generally negative sentiment towards the dental reform consultation proposals, raising objections to the suggested changes on a range of issues, including continuity of care, access, oral health, the effect on NHS dentists and the consultation process as a whole - these are explored in detail throughout this section.

However, it is important to note some respondents also acknowledged certain positive aspects relating to the proposed GDS contract reforms before entering into a wider critique. Several organisations welcomed the overarching aims of the reforms, particularly around “prevention” and improving “the focus on moderate/high-risk patients and children for increased access”, alongside the shift toward care packages in principle.

For instance, BDA Cymru commended the Welsh Government on the proposal, stating it is well-intentioned in its stated aims and objectives of improving access, prevention, workforce well-being, and value for money. Specifically, it accepted in principle proposals around the different types of care packages and care packages for children, as well as supporting the principle of speeding up the end of year reconciliation process. They also accepted in principle the commissioning of protected urgent dental care. This is despite significant reservations from BDA Cymru around how these principles would be applied in practice and disagreement

around the valuations of care packages, having provided their own alternative proposed costings for treatment (as outlined earlier in this section).

Similarly, Hywel Dda University Health Board agreed on the need for reform and that there should be a process which prioritises those patients with the greatest clinical need. They also agreed with the principle that children and young people need to be prioritised, albeit calling for greater data collection first. Llais welcomed the changes as a step forward, especially for those without a regular NHS dentist. The focus on prevention and access for children, as well as prioritising support to individuals with the greatest need to access NHS dentistry, were all praised. However, this was caveated with the need to address the risk of unintended consequences stemming from the proposed reforms, alongside the importance of ensuring improvements are applied evenly. Finally, the Congenital Heart Disease Network serving Northwest England, North Wales, and the Isle of Man welcomed the proposed changes, particularly the focus on prevention and improved access to dental services. However, they also felt there was a need to ensure the specific needs of medically vulnerable and neurodiverse patients are explicitly recognised.

Continuity of Care

Continuity of care emerged as the most frequent theme within the data, with several respondents expressing concerns about the potential disruption to continuity of care with their preferred dentist or dental surgery. Several sub-themes were identified underpinning these concerns, including loss of established relationships with their dentist, increased dental anxiety, the splitting of families across different providers, changes to frequency of and waiting times for appointments, and worries about data sharing between dental surgeries.

Sixty-six respondents voiced concerns about losing their established relationship with their current dentist or dental practice as a result of the proposed changes. Many felt that under the new system patients with good oral health would be discharged from their existing practice and potentially redirected to a different dentist at another practice in the surrounding area.

The loss of this relationship was also heavily connected to an increase in dental anxiety, with this theme highlighted by 29 respondents. The established relationship with a trusted dentist was cited by many as an important aspect to reducing dental phobia and ensuring regular attendance of appointments.

Ten respondents expressed concern that the proposal to reallocate lower-risk individuals to different dental practices, while potentially keeping others at their current surgery, could split family members across multiple practices. This was viewed as a potential significant disruption to continuity of care. Respondents, particularly those with children, highlighted the practical challenges of managing appointments at different locations. Llais explained, “Families may face extra costs if they’re sent to different dental practices. Right now, families can often get appointments on the same day, but this may not be possible if they’re split up,

especially in cities and urban areas. This could mean more travel costs or parents needing extra time off work if children and adults have appointments on different days."

A further 30 respondents raised concerns about continuity of care being undermined by the lack of a central data-sharing system between dental practices. At present, patients can request their dental records to be transferred if they move to another practice. Many understood that under the proposed changes, individuals moved to a different dentist would have no guarantee that their dental or medical history would be accessible to the new practitioner. Respondents, including individuals, organisations, and ministerial responses, stressed that if the proposal proceeds, implementing a centralised data-sharing system would be essential. The Welsh NHS Confederation noted, "our members are concerned about fragmented care due to the lack of centralised patient records and an inadequate digital infrastructure" leading to "clinical errors".

Continuity of care was also a concern in relation to the proposed extension of the interval between regular dental check-ups, a sub-theme identified by 42 respondents. Under the dental reform proposal, low-risk patients would be recalled for check-ups every 18 months, compared to the annual or dentist-recommended intervals they were accustomed to. Respondents expressed concern that being discharged from their surgery, only to be invited back after a longer period would go against what their dentist had previously recommended and is unfair on individuals who perform good dental hygiene.

Access Concerns

The dental reform proposals raised significant concern among respondents about access to dental care, with this theme identified by 57 respondents. Key sub-themes were highlighted, including: difficulties with travel to unfamiliar or more distant practices; the financial and time implications of any change in practice; digital exclusion, where some patients may struggle to book or pay for care online; the proposal of increased NHS fees for procedures; and a broader fear that the changes could ultimately reduce access to NHS dental care, potentially forcing more patients to seek private treatment instead.

Travel was a significant sub-theme, raised in 40 responses from individuals, organisations, and ministers. Many respondents highlighted worries about how they would reach a more distant practice, as well as the additional time and inconvenience of longer journeys. These concerns were particularly acute in rural areas, where respondents noted the lack of accessible public transport as a significant barrier to attending appointments at alternative practices.

Other respondents highlighted the cost of public transport for individuals who previously may have been able to walk to their local practice. Elderly patients were frequently identified as particularly disadvantaged by longer, more complicated journeys. In addition to practical barriers, respondents also described the stress

associated with travelling to an unfamiliar practice, such as uncertainty about the route, parking availability, and disabled access.

Digital exclusion was highlighted by 10 respondents, 6 of which were organisations, as a significant limitation of access under the proposed system. While several organisations acknowledged the potential benefits of streamlining dental services through a universal Dental Access Portal, many, such as Llais, also emphasised that this system risks disadvantaging individuals who lack digital access or skills. Similar concerns were raised about moving all payments online. Although this change could reduce administrative work for practices, respondents stressed that it presents barriers for digitally excluded patients. As Age Cymru also stated, “Before such changes are made, further work is needed to understand how those without digital payment means can pay for their treatment. The payment system must include the ability for digitally excluded people to be able to pay for their care offline.”

The proposed increase in NHS dental fees was identified as a sub-theme by 15 respondents. While Cwm Taf Morgannwg University Health Board described the idea of higher fees for certain treatments as “both fair and positive”, they also expressed concern about the significantly higher fees proposed for urgent care, warning, “This higher fee may price some patients out of accessing urgent care, which is a patient safety risk.” Other organisations sought clarification on when and for which treatments additional fees would apply. However, many respondents expressed clear concern about the impact of increased costs. For instance, Age Cymru welcomed the cap on maximum treatment charges but highlighted disproportionate costs for older patients needing crowns.

Respondents expressed a broader concern that the combined effects of being discharged, reassigned to new practices, facing longer waiting times, travel difficulties, and digital barriers could lead to reduced access to NHS dental services overall. Many feared that the proposed reforms would leave them with no realistic alternative but to pay for private dental care, or risk going without regular dental treatment altogether. This sub-theme, anxiety over diminished NHS access and the perceived push toward private care, was raised by 28 respondents.

Oral Health

The potential impact of the proposed dental reforms on patients’ oral health was raised by 36 respondents. Respondents expressed concern that the changes could lead to poorer outcomes due to reduced contact with dentists and delayed care. Key sub-themes identified included: delayed detection and prevention of issues; the need for more serious interventions as problems escalate; higher costs resulting from preventable deterioration; and concerns around how patients would be classified as high needs.

Thirty-one respondents raised concerns that reducing the frequency of dental appointments, as proposed in the reforms, could undermine early detection and prevention of oral health problems. Sixteen respondents also emphasised that less

frequent check-ups would make it harder to catch issues early, potentially leading to more serious conditions requiring more invasive treatment. Eleven respondents also suggested that such escalations in care are more costly for both the NHS and dental practices, contrary to the aims of the reform.

Three organisations also raised concerns with the proposed definition of ‘high needs’ patients, with one response from Morgannwg Local Dental Committee claiming “the 10-intervention threshold for defining high needs was widely criticised as too high and failing to account for behavioural or medical complexities”, whilst another response from the Welsh NHS Confederation sought clarification on “the definition of ‘dentally fit’ for discharge back to the GDS system, especially for high-risk patients who require ongoing periodontal stability”.

Effect on NHS dentists

Thirty-eight respondents commented on the impact of the proposed dental reforms on dentists, with feedback overwhelmingly negative. Key sub-themes included: concerns about an increased administrative burden; the risk of the workforce moving to private services; limited career development opportunities; and broader worries about the sustainability of NHS dentistry.

An increased administrative burden was highlighted as a concern by 12 respondents, affecting dentists, dental practices, and the wider NHS dental services. Many felt the proposed reforms would complicate rather than streamline administrative processes, placing additional strain on limited resources. One individual described the contract segmentation as “extremely complicated”, adding, “It will be difficult for primary care teams and dental practices to monitor on an individual contract basis, given the administrative resources available in both [Local Health Boards] and practices.” While some welcomed elements such as the removal of fee collection in terms of administrative tasks, they noted other aspects would likely offset these gains. A response from the Welsh NHS Confederation suggested, “The complexity of care packages will initially increase the administrative burden. Direct collection of laboratory bills from patients adds another layer of complication, raising concerns about fee escalation and handling exempt patients. The administrative burden and inefficiency for health boards and practices from repeatedly reallocating patients and managing bad debt are expected to be substantial.”

BDA Cymru expressed concern that the care packages in the new fee scale are undervalued. As such, they proposed alternative costings for all care packages on what they deemed to be conservative calculations. They stated that their proposed alternative costings were calculated based on current costs to run a dental chair on a breakeven basis. This included £105 for an urgent care package, as opposed to the £75 unit price proposed in the consultation document; £485 for a crown/bridge, as opposed to £253 and £160 for 6-month recall, instead of £90. For initial assessment

charges, they proposed these should be the same in each age group, on the basis of simplicity and equity.

A particular concern raised by 23 respondents was the risk of NHS dentists leaving to work in the private sector, further reducing availability of NHS dental care under the proposed reforms. One respondent cited findings from a recent online BDA survey remarking, “72% say they would not work under the proposed reforms in their current form, and 64% are likely to go fully private.” This online survey[12] organised by the BDA Cymru took place between the 5th May and 5th June, garnering 176 responses from general dental practitioners in Wales. These comments reflect a broader anxiety captured within these non-standard responses about the future viability of NHS dental services, particularly if the proposed changes lead to loss of experienced professionals.

Organisations also raised several additional concerns about the negative impact of the proposed reforms on dentists. While these did not emerge strongly enough to form distinct sub-themes, they were highlighted as important issues to consider. One respondent expressed worry about a reduction in career development opportunities, noting that under the new system dentists may see predominantly high-risk patients, limiting their exposure to the full spectrum of cases and hindering professional growth. Three respondents reported low morale among staff, with one reporting that dentists were “feeling demoralised, disrespected, and increasingly inclined to leave NHS work.” Concerns were also raised about insufficient payment levels for NHS dentists under the proposed contract.

Inadequate consultation

Thirty-four respondents expressed that they felt the consultation approach was inadequate including sub-themes of: poor public awareness; insufficient time; lack of explanation; accessibility; and lack of professional consultation. These feelings were identified across individuals and organisations.

Notably, 25 respondents highlighted a poor public awareness about the dental reform consultation. Many felt it was “not widely advertised”, with 11 respondents stating they only became aware of it “by accident” upon visiting their dental surgery for an appointment.

Ten respondents felt that the consultation period was insufficient to ensure reasonable public awareness and allow adequate time to respond. However, it is worth noting that one respondent referred to the consultation period as being 8 weeks, when it was 12 weeks, suggesting that some concerns may stem from a misunderstanding about the length of the consultation or consultation guidelines. A

[12] Leap in the dark could destroy NHS dentistry in Wales

number of respondents stated they only became aware of the consultation in the final weeks of the consultation.

Ten respondents raised concerns about the accessibility of the consultation. Many suggested that the consultation was only available as an online survey, effectively excluding those without digital access, particularly the elderly “who will be some of the most affected” according to one respondent. However, it should be noted that responses were also accepted through general post and email. Several respondents also criticised the limited space available within the online survey to provide detailed comments, which prompted them to submit non-standard responses. Additionally, respondents felt the survey itself was overly technical and confusing, it was felt that questions directed at dental professionals were not clearly signposted, leaving patients unsure how to respond.

Eight respondents raised concerns about the lack of detailed explanation provided in the consultation documents. They felt that more information was needed on specific functions and proposed changes to provide meaningful feedback. Areas where further detail was requested were varied but included remuneration and seniority payments. Another respondent highlighted that the additional proposed administrative tasks outlined in the consultation would require better explanation of how funding, training, and resources will be allocated to support these responsibilities.

Finally, respondents expressed their preference for there to have been further consultation throughout the process, with the British Dental Association calling for “more dialogue with the profession”.

Annex A: Consultation Questions

Section One: About you (Profiling)

1) What is your age? (optional)
- Under 16
- 16 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 65
- Over 65

2) Which gender description most closely matches how you identify? (optional)
- Male
- Female
- Non-binary
- Prefer not to say
- Prefer to self-describe (please utilise space below)

3) Is the gender you identify with the same as your sex registered at birth? (optional)
- Yes
- No
- Prefer not to say

4) What is your ethnic group? (optional)
- White - includes British, Northern Irish, Irish, Gypsy, Irish Traveller, Roma
- or any other white background
- Mixed or multiple ethnic groups - includes white and black Caribbean,
- white and black African, white and Asian or any other mixed or multiple
- background
- Asian or British Asian - includes Indian, Pakistani, Bangladeshi, Chinese or
- any other Asian background
- Black, black British, Caribbean, African or any other black background
- Other - includes Arab or any other ethnic group

5) Which Health Board region are you located in?
- Aneurin Bevan University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board

- Powys Teaching Health Board
- Betsi Cadwaladr University Health Board
- Swansea Bay University Health Board

6) In what capacity are you responding to this survey?
An individual sharing my personal views and experiences such as a patient, carer or member of the public [Move to 8]

- On behalf another individual [Move to 7a]
- A dental professional [Move to 7b]
- A non-dental member of health or care workforce sharing my professional
- views
- On behalf of an organisation [Move to 7c]

7a) If you answered ‘on behalf of another individual’ on Question 6, on whose behalf are you answering?

- A child
- A vulnerable adult
- An individual that cannot access or use digital technologies.
- Other (please utilise space below)

7b) If you answered ‘a dental profession’ on Question 6, what is your profession?

- Dentist
- Dental nurse
- Dental hygienist
- Dental therapist
- Hospital specialist
- Other (please utilise space below)

7c) If you answered, ‘on behalf of an organisation’, on whose behalf are you answering the survey?

- Charity or third sector
- Trade Union
- NHS Health Board
- Dental Care Profession
- Social care
- Local government
- Commercial
- Media

8) As a patient, how would you describe yourself? (optional)

- I do not have access to any dentist, I do not feel the need to have one

- I do not have an ongoing relationship with a practice, but I access urgent care when I need it
- I am an NHS dentistry patient currently, and would like to continue with this arrangement
- I am an NHS patient, but I have trouble accessing care
- I am a private patient, but I would like access to an NHS dentist
- I am a private patient and would like to continue with this arrangement

Section Two: Approach to Reform

1) Approach to Reform Opinion Poll (optional)

Statement	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
Changes are needed to ensure fairer access to NHS dental services in Wales.					
NHS dental services in Wales are available to those that need it most					
The proposed reforms to the General Dental Services (GDS) contract will help ensure fair access to NHS dental care for all					

people in Wales.					

2) What barriers, if any, are preventing you from accessing NHS dental care? Please select all that apply

- Unable to get an appointment
- Work/life demands
- Caring demands
- Emotional such as fear, anxiety or embarrassment
- Access to appropriate transport
- Unable to cover the cost of treatment, but ineligible for financial help
- I don't have a problem accessing NHS dental care
- Other (Please utilise space below)

Section Three: Improving Access to Routine Services

1) Improving Access to Routine Services Opinion Poll (optional)

Statement	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
There should be a process that prioritises dental appointments to those with the greatest clinical need					
NHS funding should prioritise children, even if it means fewer people can be seen overall					
There should be an equitable mechanism that supports					

people to gain access to routine NHS dental care					
Patients who do not attend their routine appointments with a dental practice on multiple occasions, without contacting the practice, should be moved to another practice					
As tooth decay and gum disease are largely preventable, the new dental contract should have a focus on prevention					
Patients that can, should take responsibility for looking after their own oral health The proposed renumeration packages are					

an improvement compared to the UDA system of payment (profession only)					

2) Assuming timely urgent care is available, how often would you expect the receive a dental check-up
Context: current guidelines suggest adults with good oral health can go up to 24 months between routine check-ups

- As often as recommended by my dentist
- Every 6 months
- Once a year
- Once every two years

3) How would you feel about a different dental professional or dental practice handling your family's appointments, if it meant improved access to routine dental care? (optional)

- I value getting access to an appointment more quickly, even if it means not
- seeing the same dental professional or going to the same practice
- I only want to see the same dental care professional or going to the same
- practice, even if it means waiting longer for an appointment
- I don't have strong opinions on the matter
- Don't know

4) The dental profession is made up of lots of different roles. These include dentists, dental nurse, dental hygienists, dental therapists, orthodontic therapists. Would you be prepared to see other members of the dental team if it meant you could get seen quicker? (optional)

- Yes
- No
- Maybe (please explain the circumstances in the space below)

Part Four: Improving Access to Urgent Services

1) Improving Access to Routine Services Opinion Poll (optional)

Statement	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
I am aware of how I					

access urgent NHS dental care					
If I need urgent NHS dental care, I am confident that I will be able to get it					
Access to urgent NHS care is more important to me than access to routine NHS care					

2) Which do you feel is a greater priority when you attend an urgent appointment?

- I would rather be out of pain quickly
- I would rather receive full course of treatment (when possible), and avoid
- having to reattend for permanent treatment
- Providing I am not in pain I would be happy to return at a future date for the
- problem to be resolved permanently.
- I have no preference

Section Five: Payment for NHS Dental Services

1) Payment Process for NHS Dental Services Opinion Poll (optional)

Statement	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
The money you pay for dental care should be collected through an online system, rather than at the dental practice					

When I receive NHS dental treatment, I understand how much I pay towards it					
I understand that when I pay for NHS dental treatment that money is ultimately paid to the health board not the practice					
It is made clear to me when I pay for a combination of NHS and private dental care I am happy to make a contribution to my NHS dental treatment					
I am happy to make a contribution to my NHS dental treatment providing it is re-invested in dental services to					

improve access for others					

Section Six: Technical Contract Specific Considerations

1) Technical Contract Specific Considerations Opinion Poll

Statement	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A
The contract holder should have overall responsibility to ensure that all level one routine dentistry is provided ensuring that patients are not referred for simple routine dentistry						
The new care package payment model represents a fair remuneration for the services provided						
The new payment model improves fairness and transparency compared to						

the previous UDA model						
The care package model supports fair payment for associate dentists and the wider dental team						
It is appropriate that there is a maximum threshold placed on high-value treatments (e.g. posterior RCT and crown/bridge)						
I feel that the new GDS contract will allow me to be able deliver my whole contract and reduce clawback?						
The new payment model will support the financial stability of my practice?						

2) Are there any specific care packages in the new fee scale that you feel are under or overvalued?

- No
- Yes (please provide further detail in the space below

3) Do you agree with the Welsh Government's proposed definition of 'high needs patients' as those requiring 10 or more interventions, including endodontic treatment?

- Don’t know
- Agree
- Neither agree nor disagree
- Disagree (please provide further detail in space below)

Section Seven: Understanding Impacts

1) If you consider there are vital aspects for consideration, which are important to GDS contract reforms but have not been addressed, please use the space below to raise them.

2) Please also explain how you believe proposed GDS contract reforms could be formulated to have:

- positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language
- no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language

3) We would like to know your views on the impact that the parameters of practice might have on groups with protected characteristics.
Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

- Do you think that the contents of this consultation will have any positive impacts on groups with protected characteristics? If so, which and why/why not?
- Do you think that the contents of this consultation will have any negative impacts on groups with protected characteristics? If so, which and why/why not?

4) We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Annex B: Organisation responses received

Organisation name
Adferiad Recovery
Age Cymru
All Wales Dental Directors Group
All Wales Forum of Parents and Carers of People with Learning Disabilities
Aneurin Bevan University Health Board
British Association of Dental Therapists
British Dental Association (BDA) Cymru
British Society of Paediatric Dentistry
Bro Taf Local Dental Committee
Cardiff and the Vale Universty Health Board
Cardiff University School of Dentistry
Chair Orthodontic MCN - SBU HD
Children’s Commissioner for Wales
Clinical Leads of Community Dental Services (CDS) Wales
Congenital Heart Disease Network
Commercial: EXACT and Dentally
Cwm Taf Morgannwg University Health Board
Cymru Older People's Alliance (COP)
Dental Protection Society
Dyfed Powys Local Dental Committee
Gwent Local Dental Committee
Healthcare Inspectorate Wales
Health Education and Improvement Wales (HEIW)
Hywel Dda University Health Board
Llais
Managed Clinical Networks (MCN)
Morgannwg Local Dental Committee
North West, North Wales & The Isle of Man Congenital Heart Disease Network
NHS Business Services Authority
Older People’s Commissioner for Wales
Pencoed Women's Institute
Powys Teaching Health Board
Public Health Wales
Somerville Heart Foundation
Swansea Bay NHS Health Board
The Association of Dental Groups
The Royal College of Surgeons of Edinburgh
The Women's Institute
Wales Community Dental Services Clinical Leads Group
Welsh Dental Committee
Welsh NHS Confederation