Morgannwg
Local Dental Committee

Survey of Views on the Proposed New GDS Contract

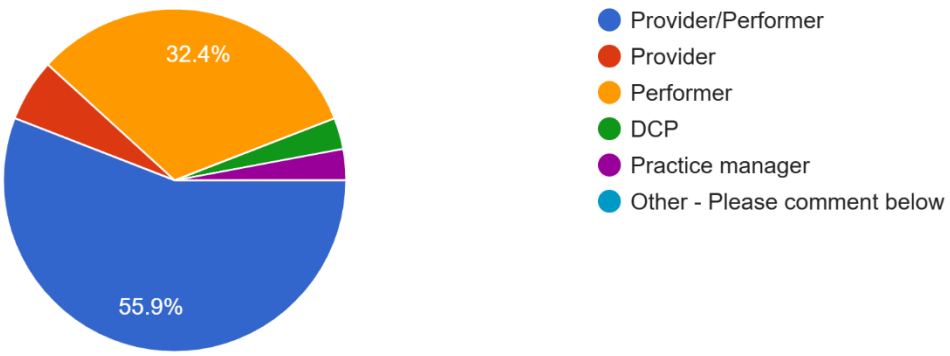
Welsh Government (WG) has entered a public consultation on a proposed new contract for NHS General Dental Services Practices, to come into effect in April 2026. The public (including dentists and their staff) were asked a series of questions on the proposed contract, many of which were leading questions in the view of the profession, the responses to which would be independently analysed to inform WG on the public and professional view of the proposals. There is a feeling among dentists that the public was not well informed of the existence of the consultation.

Morgannwg Local Dental Committee (MLDC), which represents dentists in general practice in the Swansea Bay University Health Board (SBUHB) area felt it appropriate to get the views of dentists in the area on specific parts of the proposed new contract – how it would affect them and their patients. It designed a questionnaire asking for dentists' views on various aspects of the contract. The initial question asked about the respondent's position in the practice – owner, employee etc. and there were subsequently 24 questions on the views of respondents about various aspects of the proposed new contract. Each question was multiple choice with only one answer to be chosen, and each mirrored the consultation choices, with the most frequent choices being Strongly Agree, Agree, Neither Agree nor Disagree, Disagree and Strongly Disagree. There was also a text box for further comments if the respondent wished to elaborate. 34 dental professionals responded to the survey.

The following gives the responses to each question asked as a graphic, which also gives the number that responded to that question, and a summary of the further comments given, if any.

1. Position in the Practice

34 responses

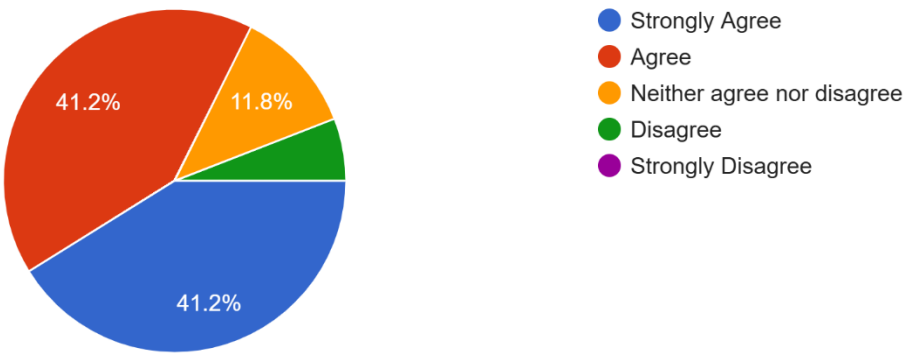


Comments:

1 non-clinician practice owner

2. Do you believe changes are needed to ensure fairer access to NHS dental services in Wales?

34 responses



Summary of comments:

Positive Comments

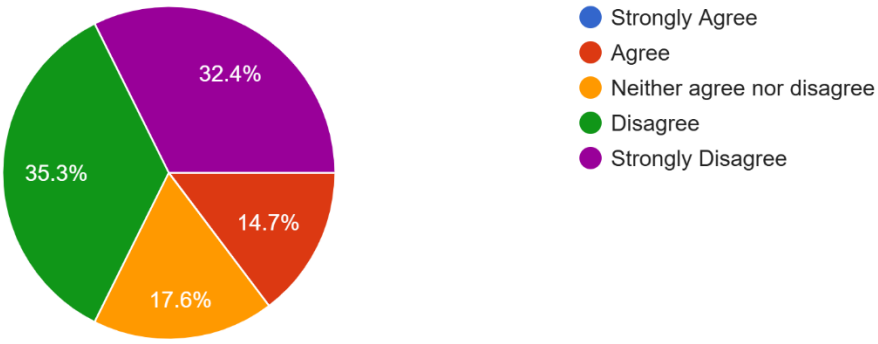
- Centralised access could create a fairer system and make it easier for patients to access NHS dentistry.
- A catchment-area model based on postcodes could ensure more equitable patient distribution.
- There is agreement that more equitable access is needed, especially prioritising children and urgent care.
- A core service for all might be a fairer approach in the context of limited funding.
- A system change is needed to reduce barriers for high-needs patients and support modern, quality care.
- The idea of reducing administrative burdens and focusing on quality outcomes is supported.
- Recognition that more training places and increased funding are needed to meet access goals and retain NHS dentists.

Negative Comments

- Lack of dentists makes regular care for the whole population unfeasible.
- Without careful planning, changes could create "dental deserts" in the long term.
- Access is currently limited by funding and workforce availability, not necessarily by the system itself.
- Concerns that the proposed changes might disadvantage long-standing healthy patients.
- Risk of simply displacing one group of patients to create access for another without addressing core issues.
- Emergency appointments might be easier to obtain, but routine care could become harder.
- Dentistry is underfunded, and the current access issues reflect this systemic shortfall.
- Without investment, centralising access may not deliver meaningful improvements.

3. Do you think the proposed reforms will help ensure fair access to NHS dental care for all people in Wales?

34 responses



Summary of comments:

Positive Comments

- Central waiting lists may offer progress in streamlining access for new patients.
- Care packages could help fund treatment for higher-needs patients.
- Some see potential for more appointments being made available under the reforms.

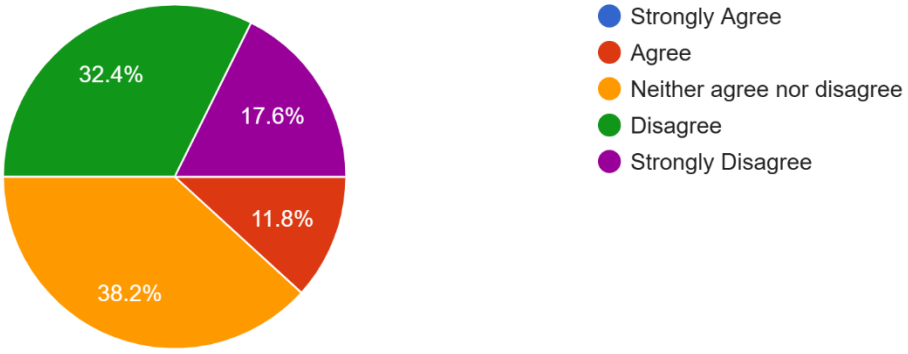
Negative Comments

- Risk of a two-tier system: more dentists may go private, leaving low-income patients with reduced or delayed care.
- Low-risk (healthy) patients may be unfairly excluded or returned to waiting lists, disrupting continuity of care.
- Proposals may displace existing patients to accommodate new ones without increasing overall capacity.
- Concerns that complex NHS treatments (e.g., molar endo, bridges) are offered when urgent care is still inaccessible for many.
- Lack of clarity: several respondents admit they do not understand the contract or need more time to assess its impact.
- Centralised access removes patient choice and weakens long-standing dentist-patient relationships.
- Prioritising urgent care may come at the expense of regular, ongoing care for the majority.
- Continuity of care will be lost, patient trust eroded, and goodwill damaged.
- Practices may struggle to meet metrics due to higher-needs patients who do not attend appointments.
- Proposed system may not address "dental deserts" or encourage work in high-needs areas.
- The cap on funding for root canals and crowns (10%) is viewed as inadequate.
- Returning stable patients to the Dental Access Portal (DAP) is seen as unfair.

- Reforms may worsen workforce shortages and result in more NHS contracts being handed back.
- Overall lack of additional funding, training, and long-term planning undermines the aim of improving access.

4. How do you feel about the proposed segmentation of the annual contract value (ACV)?

34 responses



Summary of comments:

Positive Comments

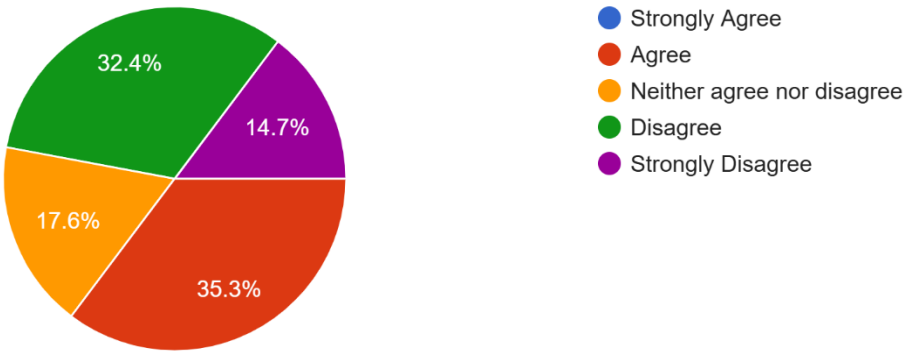
- Some flexibility for Health Boards to adapt segmentation to local needs is a welcome inclusion.
- Recognising the need for segmentation can be justified in principle, depending on implementation.
- Suggestion that the first year be treated as a **pilot year without clawback** to allow mutual learning and smoother transition.

Negative Comments

- Implementation seen as overly complicated, especially for monitoring performance.
- Increased administrative burden and risk of **clawback** may drive providers away from NHS work.
- The segmentation may divert budget disproportionately towards new patients, disadvantaging existing ones.
- Target-driven segmentation is seen as punitive and misaligned with actual patient outcomes.
- Removes practice-level autonomy to allocate ACV flexibly (e.g., for staff pay or infrastructure), impacting practice sustainability.
- Poor historical performance by Health Boards in issuing contract details and providing clarity raises doubts over practical rollout.
- Weightings for urgent care and new patient provision are seen as **unrealistic** and **not evidence-based**.
- Patient flow assumptions are flawed — not enough patients will stabilise and return to the Dental Access Portal (DAP), making quotas hard to meet.
- Lack of clarity in how over- or under-performance will be handled – concerns over possible penalties or inflexibility.
- Perceived as **threatening** and showing a **lack of respect** for dentists providing NHS care.
- Some respondents admitted they could not understand the segmentation details clearly.

5. Do you think the new remuneration model (care package model) is an improvement compared to the UDA system?

34 responses



Summary of comments:

Positive Comments

- Certain aspects are **fairer**, e.g. recognising the complexity of root canal treatment.
- The model **acknowledges** that different treatments require varying time and material costs.
- More **patient-specific funding** could better support higher-needs patients.
- The **inclusion of lab fees** is viewed as a step in the right direction.
- Some view it as a **tentative improvement**, especially compared to the much-criticised UDA system.
- The UDA contract is so unpopular that **any change** is seen by some as preferable.

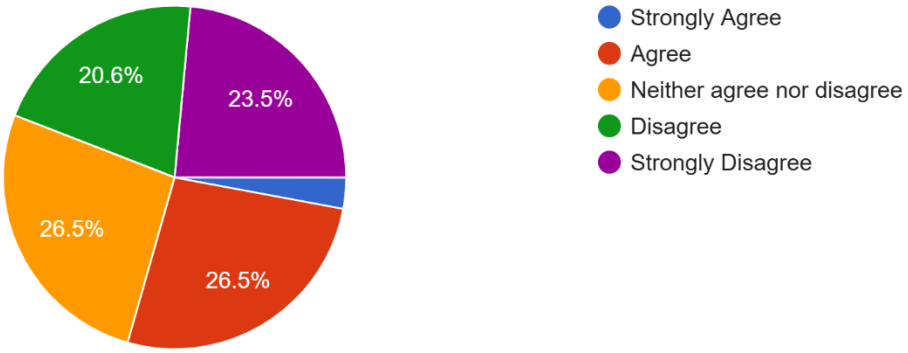
Negative Comments

- **Overly complex**, with too many bands (19 vs 4 in UDA), making it difficult for practitioners to manage or monitor.
- Lack of **transparency** around care package values and how many can be claimed.
- Still does **not cover real-world costs**—underfunded like the UDA system, with no meaningful adjustment for inflation.
- Practices may still face **financial losses** on multi-treatment patients due to uniform pricing within care bands.
- The proposed payment drop from **£60 to £37** for 1–4 interventions is seen as deeply unfair.
- Increased **risk of clawback**, especially with targets across multiple new categories (HP, NP, NUP, etc.).
- Concerns that funding is being directed to **complex treatment** while basic needs across the population remain unmet.
- The model may make it **difficult to pay associates fairly** and allocate remuneration equitably.
- Returning fit patients to the **Dental Access Portal (DAP)** is seen as impractical.

- The **two-year guarantee** requirement is seen as unrealistic and unsustainable.
- Still not close to a **fee-per-item** approach, which many feel would be the fairest and most accurate.
- Viewed by some as a **repackaged UDA system**, with core flaws remaining.
- Ongoing **lack of operational detail** and need for **piloting and feedback** before implementation.
- Perception that it continues the trend of **undervaluing the workforce** and putting pressure on practitioners.

6. Do you agree with the proposed end-of-year reconciliation process?

34 responses



Summary of comments:

Positive Comments

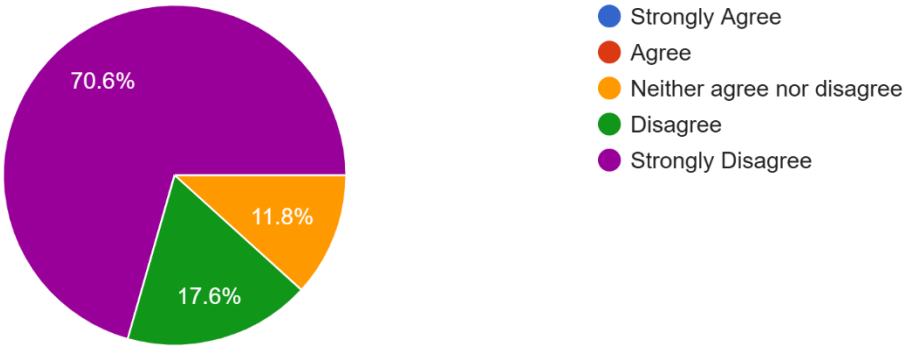
- A **quicker reconciliation process** would help with financial and workforce planning.
- Having **clarity earlier in the year** reduces stress and improves decision-making for practices.
- The current system is considered **long-winded**, so reform is welcomed in principle.
- **Knowing where practices stand** sooner is seen as beneficial overall.
- The suggested **20-day window** is viewed as more manageable by some.
- There is **personal support** for speeding up the process, as long as fairness is maintained.

Negative Comments

- **Bank holidays and staff leave** early in the year can distort mid-year reconciliation, making it unfair.
- **Unpredictable patient behaviour** (missed or cancelled appointments) may lead to work falling outside the claim window.
- Associates find it hard to manage **pay uncertainty** if reconciliation changes pay retrospectively.
- Process lacks **clarity and transparency**, especially regarding required activity levels.
- Risks of **unilateral decisions by Local Health Boards (LHBs)** to reduce contracts mid-year could conflict with existing staff agreements.
- DNA (Did Not Attend) guidance may **prevent timely claims**, causing missed payments.
- Risk of **delays and inefficiencies**, based on historical patterns, remains a concern.
- A shorter timeframe could **increase pressure** and administrative burden on practices.
- Additional admin work may be required to meet the **new deadlines**.
- Some feel that changes should only apply to the **next financial year**, not mid-year adjustments.

7. How do you feel about the proposed changes to repair and replacement responsibilities?

34 responses



Summary of comments:

Positive Comments

- Some support for practices being responsible for delivering **evidence-based, predictable care**, as long as the expectations are clearly defined and fair.
- A few respondents are **tentatively positive**, pending clarification, especially if proper caveats and exemptions are in place.
- General repairs and replacements are described by some as **small in number**, suggesting the potential impact may be limited—if carefully managed.

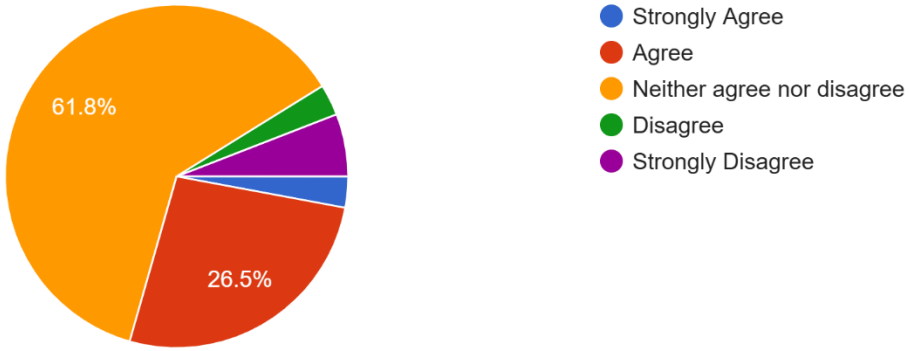
Negative Comments

- The proposed **24-month guarantee** is widely seen as **unrealistic and excessive**, especially compared to the current 12-month NHS standard.
- Restoration failure is often due to **factors beyond the dentist's control**, such as poor patient oral hygiene, diet, habits (e.g. bruxism), or material limitations (e.g. no amalgam).
- Practices in **high-needs areas** face higher failure rates and could become financially unviable.
- Risk of a shift towards more **invasive treatments (e.g. crowns or extractions)** just to meet guarantee expectations.
- Could deter clinicians from **attempting conservative or borderline treatments**, which may lead to worse outcomes for patients.
- The policy may result in **increased costs** for practices, particularly for dentures, crowns, and bridges.
- Dentists fear being **unfairly penalised** or blamed for unavoidable treatment failures.
- **Newly qualified dentists and therapists** could be disproportionately affected, especially if patients refuse ideal treatment plans.
- Patients might **abuse the guarantee** by intentionally damaging appliances (e.g. dentures) or by poor compliance.

- Concerns raised that this would **deter dentists from working in the NHS**, especially in the absence of adequate funding to cover the added risk.
- NHS dental care is not like **retail**, where consumer-style guarantees are standard—applying similar expectations is viewed as inappropriate.
- **Multiple practices** may be involved in care during the 2-year period, making guarantee administration **confusing and unworkable**.
- The policy **fails to reflect the realities** of dental care, with no care packages for tooth wear and no allowance for urgent or unpredictable treatments.
- Compared metaphorically to **guaranteeing rally car repairs**, where patient behaviour and condition make such expectations unfeasible.

8. Do you support the proposed parental and sickness leave arrangements?

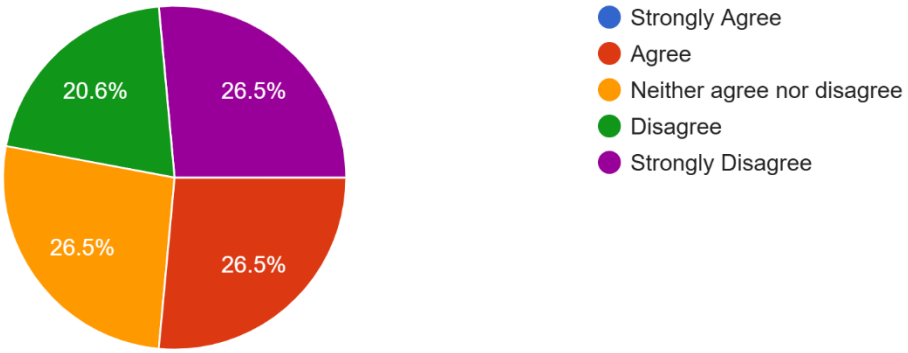
34 responses



No comments.

9. Do you agree with the proposed urgent care requirements?

34 responses



Positive Comments

- Support for **one-off emergency treatment** to alleviate pain, such as opening and dressing teeth where necessary.
- Agreement that **all patients should have access** to NHS urgent care, with management by Local Health Boards (LHBs) being crucial.
- Central coordination and a **clear pathway** for urgent cases is supported in principle.
- Some respondents feel the model offers **better remuneration** than the current one.
- Belief that urgent care should focus on **relieving pain**, not necessarily delivering full treatment.

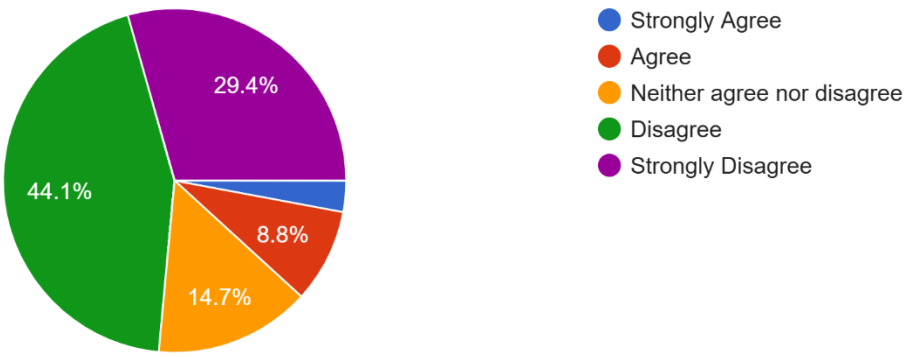
Negative Comments

- A **12-month guarantee** on urgent care is widely seen as unrealistic, especially for nervous or non-compliant patients.
- **Inadequate detail** provided on what constitutes "permanent definitive treatment" under urgent care—leads to confusion and concern.
- Concern that urgent care could shift towards **more extractions**, as this may be the only financially viable guaranteed option.
- Managing urgent care demand, especially for patients returning to the **Dental Access Portal (DAP)**, could strain practice capacity.
- Practices already struggle to fit in existing patients—adding urgent care demand could make scheduling unmanageable.
- **Unfunded or underfunded** urgent care responsibilities are unsustainable.
- Fear that expectations will **phase out in-hours access contracts**, making all practices responsible without appropriate funding.
- Worry that the urgent care model could **encourage misuse**, with patients avoiding routine care and only presenting when in pain.

- Concerns that **referrals and multiple visits** are being classified as urgent care, which is inappropriate.
- **Global oral health assessments** are poorly defined and could increase workload without clarity or compensation.
- Patients who do not cooperate (e.g. miss exams, avoid preventive care) should not receive the same level of definitive treatment under urgent care.
- A **2-year guarantee** on urgent care treatments is seen as particularly unworkable.
- Risk of **vicarious liability** when urgent care involves limited intervention and the patient is then returned to DAP

10. Do you agree with the definition of 'high needs patients' as those requiring 10 or more interventions, including endodontic treatment?

34 responses



Summary of comments:

Positive Comments

- A few respondents agree that **10 or more interventions** could reasonably classify a patient as high needs.
- Some see value in using **intervention count as a metric**, depending on what is included (e.g. if periodontal care is weighted).

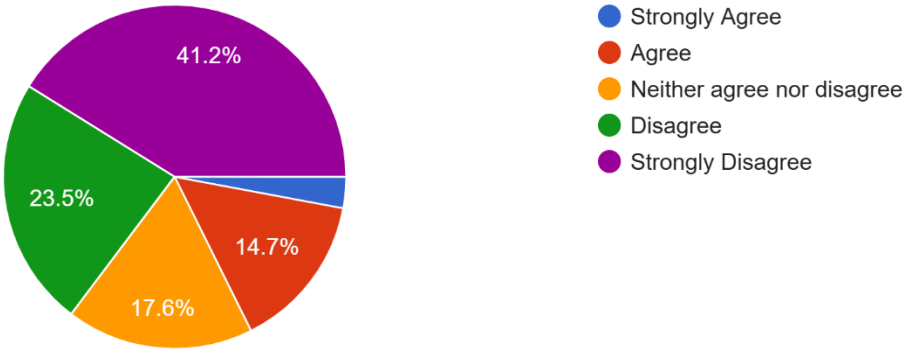
Negative Comments

- **Threshold too high**: Many respondents suggest the definition should start at **4 to 8 interventions**, not 10.
- High needs should also include **non-clinical complexity** (e.g. dental anxiety, complex medical histories, patients on anticoagulants).
- **Endodontic treatment** is often inappropriate for unstable or non-compliant high-needs patients.
- Patients needing 10+ interventions may be **unsuitable for endo** and unlikely to benefit from complex, long procedures.
- The current definition excludes patients who may have **significant needs** but fall short of the 10-intervention threshold.
- The classification lacks clarity on what **counts as an intervention**—some suggest **periodontal treatment** should carry more weight.
- Many patients who would qualify under this definition are **unlikely to improve** if bounced between services or placed back on the DAP list.
- **Behavioural and medical challenges** should be factors in defining high needs, not just the number of interventions.
- A rigid numerical threshold fails to account for patients needing **multiple complex but fewer treatments**.

- Risk that patients with 8–9 restorations or several complex treatments will be **misclassified and underserved**.
- Some responses indicate disbelief or dismissal, with remarks such as “that actually made me laugh” and “I do not believe this is practicable”.

11. Do you think the proposed measures for managing patients who fail to attend appointments are appropriate?

34 responses



Summary of comments:

Positive Comments

- Some support the idea of **clear rules for managing FTAs (Failed to Attend)** and returning patients to the Dental Access Portal (DAP).
- A few respondents agree with a **maximum number of missed appointments** before action is taken, typically suggesting 1 or 2 as appropriate.
- It is seen as **positive that practices may be reimbursed** for DNA-related losses, though this is heavily qualified by concerns around conditions.
- Agreement that **patients must be held accountable** for missed appointments.

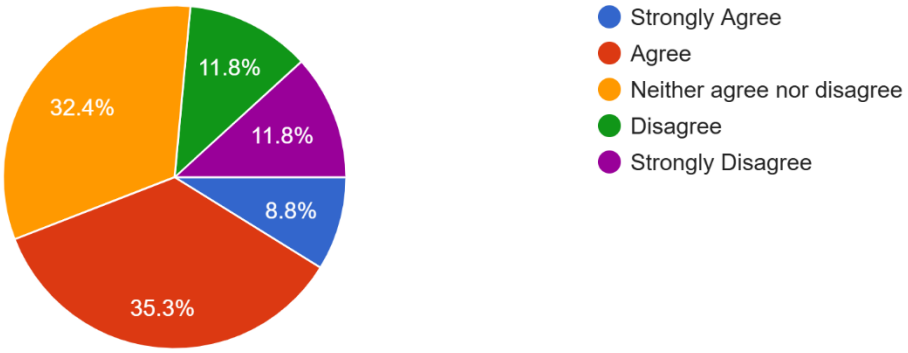
Negative Comments

- **Three FTAs** are seen as **far too generous**; many feel 1 or 2 should be the limit, particularly for new patients.
- FTAs are described as **time-wasting, disrespectful, and financially damaging**, especially in target-based contracts.
- **No fines or penalties** currently in place – strong support for introducing **financial consequences** for non-attendance.
- Practices feel unfairly burdened, especially if they are required to **prove efforts were made** to help patients attend.
- Patients who miss their first appointment should **automatically be returned to the back of the queue**, without further chances.
- Allowing multiple FTAs within a course of treatment (e.g. 3 appointments for molar RCT) results in **significant loss of clinical time and income**.
- Proposed approach is seen as **too lenient** compared to hospital or secondary care settings.

- **Short-notice cancellations** are not properly addressed and are equated with FTAs by many practices.
- Practices should have **freedom to enforce their own FTA policies**, communicated clearly to patients.
- Concern that policies **favour patients too much**, leaving dentists with unrecoverable lost time and resources.
- Lack of clarity in the proposals—many respondents note the **need for more detail**.

12.Do you support the requirement for participation in professional collaboratives?

34 responses



Summary of comments:

Positive Comments

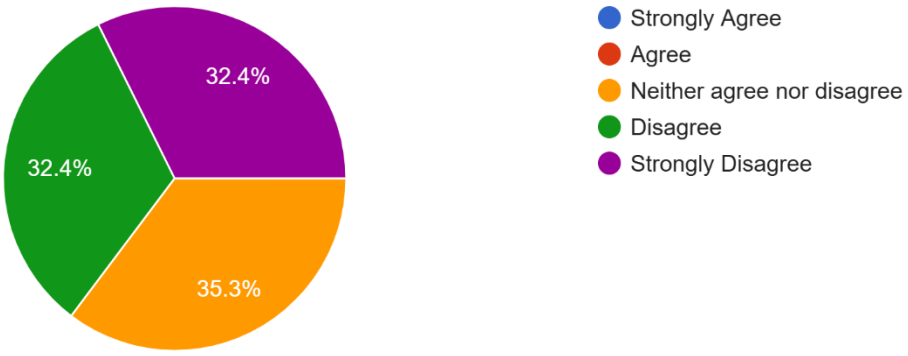
- Collaboration could be **beneficial if properly funded** and dentistry is meaningfully included.
- Dentists may have a **stronger voice** when working together and participating in wider healthcare discussions.
- Potential value if **dentists are fairly represented** and genuinely included in decision-making, not overshadowed by GPs.
- Could improve **peer insight and shared learning**, provided the environment is constructive and safe.

Negative Comments

- Seen by many as a **token gesture** with little real impact or benefit to NHS dentistry so far.
- Concerns that participation will **take dentists away from clinical work**, reducing access for patients and contradicting WG goals.
- Past experiences show **very limited involvement** of dentistry in clusters dominated by GPs.
- Perception that other services **do not understand NHS dentistry**, leading to poor collaboration.
- Lack of **tangible outcomes** or changes as a result of previous collaborative efforts.
- Risk of **litigation** may deter open discussion among peers, especially for younger professionals.
- Strong opinion that it should be **optional**, not mandatory, unless clear benefits are demonstrated.
- Current funding is considered **insufficient**, especially when meetings require time away from practice.
- Worry that dentists are being **forced to participate without additional resources** or compensation.
- Calls for **greater Welsh Government support and variation in contracts** to enable meaningful engagement.

13. Do you think the proposed contract management measures will reduce clawback and improve financial stability?

34 responses



Summary of comments:

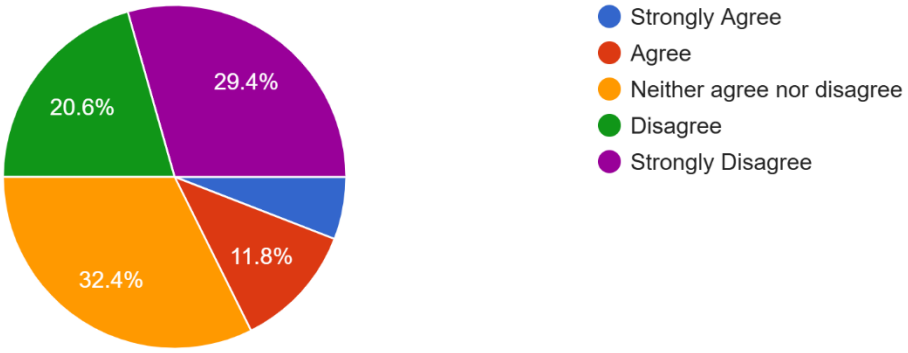
Positive Comments

- A few acknowledge the **need for appropriate use of taxpayer money**, though they question the method proposed.
- Some hope that **long-term adaptation** may eventually bring clarity, though this is heavily caveated with concerns.
- The **40% mid-year threshold** is widely criticised as unrealistic and destabilising, particularly during the transition to a new system.
- Many believe the measures will **increase clawback**, not reduce it, especially with uncertainty around new care package metrics.
- Practices are concerned about **increased financial risk and stress**, particularly heading into April 2026.
- There is a **lack of flexibility**, with no room to accommodate variability in treatment needs or unforeseen events.
- The threat of **contract reduction after two consecutive years** of underperformance is seen as punitive and discouraging.
- **End-of-year reconciliation timelines** (e.g. 20 days) are viewed as too tight to fairly account for DNAs and open courses of treatment.
- Dentists fear these changes will make **financial planning and workforce stability** nearly impossible.
- Uncertainty around **how associates will be paid** makes it hard for practices to plan or commit.
- Some argue the NHS is already **under strain**, and these measures could drive more dentists away, accelerating its decline.
- Many say it's simply **too early to judge** effectiveness, and introducing harsh performance measures immediately is unfair.

- Calls were made for any **unspent funds** due to clawback to be reinvested in dental services, not used to offset other Health Board overspending.

14.Do you agree with the removal of seniority payments to reinvest in patient care?

34 responses



Summary of comments:

Positive Comments

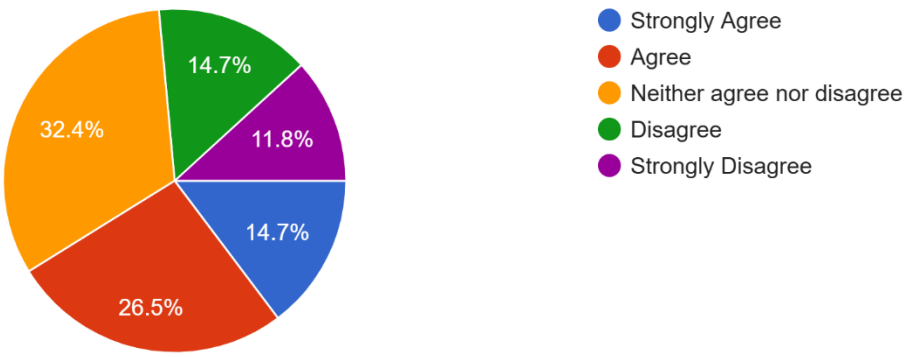
- No clear positive comments were offered in support of the removal itself.
- One respondent queried whether the payment was **capped rather than removed**, suggesting a possible misunderstanding rather than support.

Negative Comments

- Strong consensus that **removing seniority payments will drive experienced dentists out** of the NHS, likely to private practice.
- **Seniority payments are seen as a key retention tool** to keep skilled, long-serving professionals in the NHS.
- Dentistry in the NHS is described as **mentally and physically demanding**, making additional incentives vital for continued commitment.
- Several responses argue that **reward should be based on years of service**, not age—similar to the GP model—avoiding age discrimination.
- The removal is seen as **demotivating**, especially for those who have endured years of NHS service under challenging conditions.
- Losing experienced practitioners risks a **drain of talent and clinical expertise**, with no clear plan for replacement.
- The decision is viewed as **short-sighted**, potentially harming both the workforce and the quality of patient care in the long term.
- One comment described the proposal as **"laughable"**, reflecting strong disapproval.

15. Do you support the proposed changes to patient charge revenue collection and determination?

34 responses



Summary of comments:

Positive Comments

- Many support the **removal of responsibility from practices** for collecting payments, viewing it as a reduction in administrative burden.
- Seen as an **improvement** by some, especially if it allows practices to focus on care rather than financial transactions.
- A **more proportionate fee structure**, moving away from a blunt band system, is viewed as a step in the right direction.
- Could reduce **bad debts for practices** and make PCR more transparent as a **visible health tax**.
- Positive that **health boards will manage payments**, provided practices are paid regardless of patient compliance.

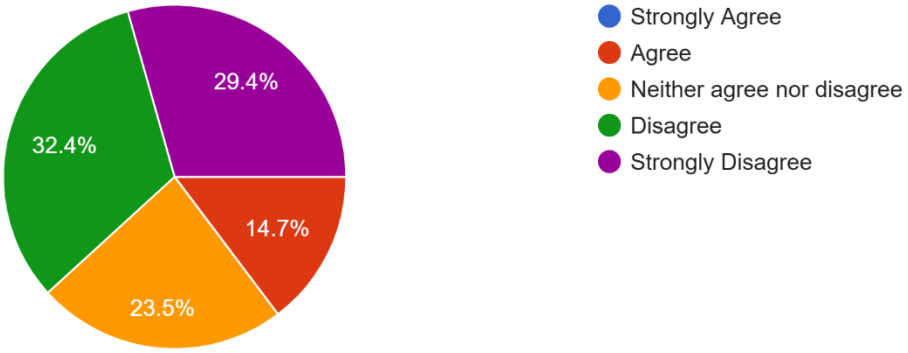
Negative Comments

- Strong concern that **many patients will not pay**, leading to deficits for Welsh Government and potential cuts in GDS budgets.
- Risk that **non-payment** by patients may lead to practices **not being reimbursed**, affecting cash flow and financial stability.
- Doubts about whether **practices will be paid promptly** if payment is not made upfront.
- **Patients without online access** or those who prefer cash may struggle, creating **logistical challenges**.
- **Administrative burden may shift** from practices to health boards, which are seen as ill-equipped to handle large-scale payment collection.
- Potential increase in **patient complaints or disputes**, especially if payment is expected after treatment.

- Some fear a rise in **unpaid debts** and believe fees should be collected **before treatment**, as in private practice.
- The plan is viewed by some as **unclear and under-explained**, especially around how practices will be credited and what happens in case of bad debts.
- **Lab-made appliances** present a particular area of concern, with uncertainty around when and how payments are applied.
- Several suggest the **maximum charge needs updating**, as it has remained largely unchanged since 2005.

16. Do you think the new contract will improve access to NHS dental services for patients?

34 responses



Summary of comments:

Positive Comments

- May **help some high needs patients** and those currently without a dentist gain initial access.
- Could allow the Welsh Government to **demonstrate an apparent improvement** by directing patients to available practices via the Dental Access Portal (DAP).
- May offer **urgent care solutions** for some patients, fulfilling short-term access needs.

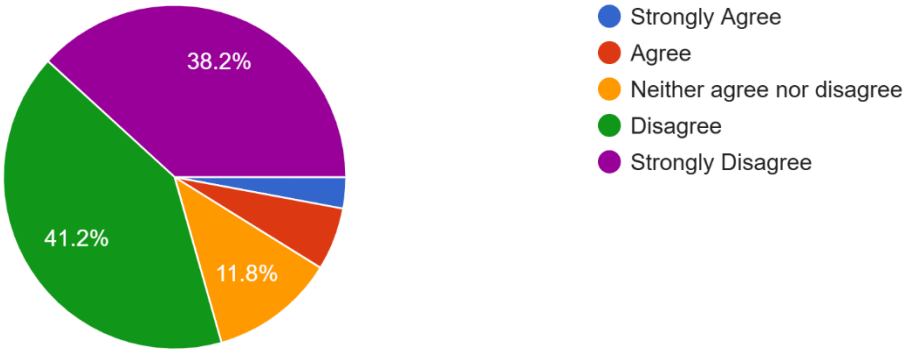
Negative Comments

- Strong concerns that **many NHS providers will leave** due to contract terms, reducing overall capacity.
- Dentists may **move to private practice**, leading to fewer NHS appointments and **less continuity of care**.
- **Access gains for new or high needs patients** may come at the **expense of stable patients**, who face longer waits and limited recall opportunities.
- The system encourages **cycling of patients through the DAP**, causing confusion, fragmented care, and difficulty building **ongoing patient-dentist relationships**.
- **Referrals and clinical consistency** may be compromised due to patients being passed between practices.
- Practices will be **overwhelmed by high needs patients**, many of whom may never stabilise, putting further pressure on resources.
- **Funding and workforce levels are inadequate** to meet the increased demand implied by the contract.
- **Patients may miss appointments or fail to complete care**, disrupting workflows and care package completion.
- The contract is viewed as part of a **"managed decline"** of NHS dentistry, spreading resources thin and risking contract breaches for underperformance.

- **Access improvements may be only superficial**, serving political needs rather than addressing real patient care challenges.
- **Confusion around DAP reassignments** will make access feel more chaotic and reduce patient satisfaction.

17. Do you believe the new contract will reduce administrative burden for dental practices?

34 responses



Summary of comments:

Positive Comments

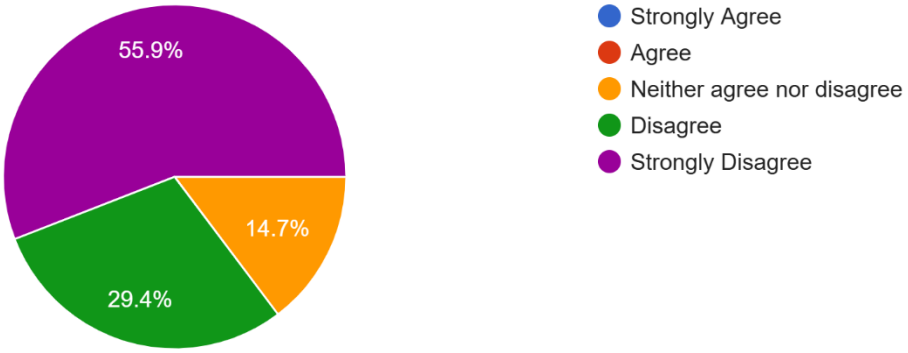
- **Removal of responsibility for collecting patient charges** may reduce some admin tasks.
- Potential for reduced financial handling **could benefit practices**, depending on how it is implemented.
- Impact may vary depending on **how well software systems automate** new reporting requirements.

Negative Comments

- Overall belief that **administrative burden will increase**, not decrease.
- Need to manage **new care packages, patient payment statuses, and segmentation metrics** adds complexity.
- **Paying associates and DCPs** under the new system is seen as time-consuming and unclear.
- Practices will still need to **log DNA data, unfilled appointments**, and respond to queries from NHSBSA/LHBs.
- **More metrics to report**, including QI tasks and contract usage, increase pressure on administrative staff.
- **Lab fee collection and calculations** may add another layer of complication.
- **New patient intake** brings its own extra paperwork and data entry.
- Continued use of tools like **ACORN and Compass** suggests no real reduction in form-filling or compliance tracking.
- Concerns about how contract payments and **claim processes** will actually be administered under the new system.
- The **complexity of the system overall** makes it highly unlikely to ease workload for dental teams.

18. Do you think the new contract will encourage dentists to commit more of their time to providing NHS services?

34 responses



Summary of comments:

Positive Comments

- No clear positive support was expressed in these responses for the contract encouraging increased NHS commitment.

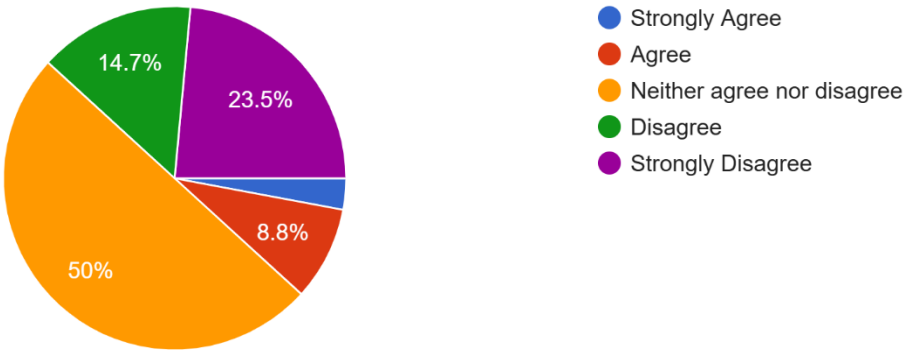
Negative Comments

- **Removal of seniority pay**, lack of competitive pay, and absence of in-hours CPD make the NHS less attractive, especially compared to private practice.
- Dentists feel the contract **removes the most satisfying parts** of NHS dentistry, such as building long-term patient relationships.
- **Target-driven structure** is demotivating and increases stress, reducing job satisfaction.
- Many report intentions to **increase private work** or transition fully out of the NHS.
- Widespread **lack of trust** in Welsh Government due to shifting policies and unclear communications—**goodwill has been exhausted**.
- The contract is seen as **confusing, overly vague, and unconvincing**, especially regarding DAP processes.
- **Uncertainty around associate pay structures** further undermines confidence and planning.
- **Remuneration remains poor**—with treatment fees viewed as insufficient, especially for complex care, leading to the **impossibility of operating sustainably**.
- The system still relies heavily on **practice owners to handle workforce issues**, without support for training or investment in staffing.
- The **'swings and roundabouts' approach** to fees (e.g., same pay for 1 or 4 restorations) is viewed as unfair and unviable.

- Rising **costs (indemnity, technology, wages, utilities)** are not matched by funding, increasing the appeal of private practice.
- The **administrative burden** is also a key driver of dentists leaving the NHS, not just financial reasons.

19. Do you think the new contract will enable better skill mixing and utilization of the dental team?

34 responses



Summary of comments:

Positive Comments

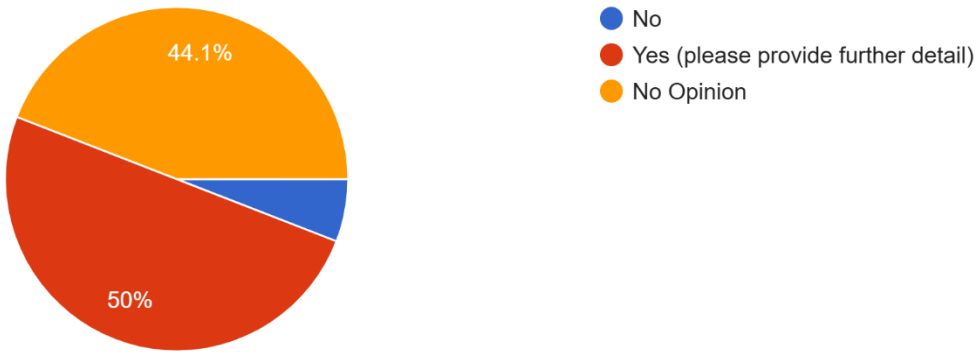
- Some acknowledge that **therapists and salaried dentists** may fit well into the model.
- There is **potential for DCPs** to carry out more dental check-ups and restorative work under the new structure.

Negative Comments

- **No financial investment** in practices to support skill mix—contract value remains the same.
- **Skill mix is not viable in all practices** due to infrastructure needs (e.g. chair time, assistants, room availability).
- Many areas **lack access to DCPs or therapists**, especially in rural or underserved locations.
- The contract offers **no real change** to current position on direct access or team utilisation.
- **Fee structures are inadequate** to fund the additional staffing required for effective skill mix.
- **Associates' pay models are unclear**, making it difficult to incorporate skill mix within existing systems.
- **24-month warranty** expectations complicate matters, especially if professionals are no longer with the practice when rework is needed.
- **Only 5% of the contract value is allocated to prevention**, ignoring evidence from previous trials that recommended more (e.g. 10%).
- **Enhanced skills DPAs (Dental Practice Advisors)** appear to be devalued or no longer required under the new model.
- NHS-employed DCPs are said to be **inefficient under current systems**, with no evidence the new contract would change this.
- Several responses state the contract **does not improve upon the status quo** regarding team use or skill mixing.

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

34 responses



Summary of comments:

Positive Comments

- Very few positive views were expressed. A few respondents acknowledged that it's **too early to tell** or that more **detail and evaluation are needed**.

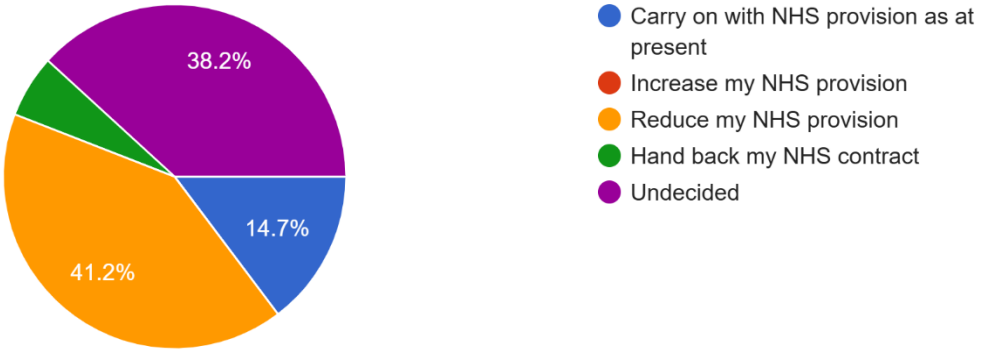
Negative Comments

- **Restorative treatments are widely viewed as undervalued**, including fillings, root canal treatments (especially without adequate cover for crowns), and dentures.
- The **24-month warranty** on repairs and replacements is seen as problematic, especially if fees don't reflect the cost and time commitment.
- **New patient assessments and routine exams** (especially for older children and teens) are seen as underfunded despite being more complex than early-years check-ups.
- **Simple caries treatment** is believed to be undervalued.
- **Lab fees and extra-coronal coverage** are not adequately supported in current package values.
- The absence of **prevention-only care packages** is criticised, especially for a system based on preventive care.
- Packages related to **skill mix** (e.g. treatments by therapists or hygienists) are lacking or undefined.
- The **fee structure is widely seen as unclear**, with many unsure how multiple treatment needs (e.g. fillings, perio, assessments) will be bundled or priced.
- The use of "**up to**" pricing (e.g. for endodontics) is viewed as inappropriate and unfair for more complex cases.
- Concern that **high-value 3- and 6-month reviews** may undermine NICE recall guidelines and could drive patient churn back into the DAP.
- General sentiment that **many or most packages are undervalued**, making it hard to provide care sustainably.

- Multiple responses expressed confusion or frustration, stating that the **care package system is not well explained**.

21. If the new contract is implemented in line with the consultation document, what is your intention with regard providing NHS GDS services?

34 responses



Summary of comments:

Positive Comments

- A few respondents stated they would **try to make it work**, though often with strong reservations and conditions.
- Some are waiting for **clarification on details** (e.g. associate pay, contract specifics, FD arrangements) before making a final decision.

Negative Comments

- Many respondents stated an intention to **reduce or withdraw from NHS provision**, citing demoralisation, complexity, and lack of clarity.
- Several expressed that this was the **first time they had seriously considered leaving the NHS**, despite previous long-term commitment.
- A common theme was that the proposed contract **removes job satisfaction**, with increasing admin and reduced autonomy.
- Concerns about **loss of continuity of care** and long-term patient relationships were highlighted as critical issues.
- Practices expressed serious concern over **remuneration, sustainability, and unclear mechanisms** for associate payments.
- The contract was widely criticised as an **"enhanced UDA contract"**, failing to resolve the issues it set out to fix.
- There is **widespread distrust in Welsh Government and contract reform**, with the new proposals seen as vague, poorly designed, and disconnected from reality.
- One respondent noted the **lack of incentive for UK-trained dentists** to remain in or return to the NHS, criticising suggestions of using temporary visas to bring in foreign dentists.
- Feelings of **disappointment, frustration, and a sense of betrayal** were common throughout.

- Several respondents stated they would **hand back contracts entirely** or only retain them to support other performers while personally focusing on private dentistry.

22. Do you have any additional comments or suggestions regarding the proposed GDS contract reforms?

Summary of comments:

Positive Comments

- One respondent felt the proposal **seems a better overall system**, though this was not elaborated upon.
- Some support the idea of a **Prototype-style model**, where practices are funded per patient group with greater autonomy.
- Recognition that **stabilisation of high-needs patients** is an important goal, though how it's implemented is critical.

Negative Comments

- **Strong overall dissatisfaction** with the contract: seen as rushed, poorly communicated, and disconnected from dental reality.
- **Loss of continuity of care** raised as a major concern, especially regarding anxious patients and long-term clinical oversight.
- Concerns that **patients will be discharged to DAP** rather than retained in practices, undermining trust and leading to care fragmentation.
- **Inadequate explanation of the fee structure and banding system** left many unsure about implementation and financial implications.
- **Amalgam phase-out** seen as unworkable for certain restorations, increasing treatment difficulty and cost.
- The **lack of proper consultation with the profession** and abandonment of BDA negotiations were heavily criticised.
- **Unclear provisions for Foundation Dentists and training support** may discourage practices from keeping NHS contracts.
- **Skill mix not supported**—no care packages for therapists or hygienists, making workforce development difficult.
- The **warranty requirement** (e.g., 24 months) is widely viewed as unrealistic and counterproductive.
- **Low treatment fees** across packages do not reflect actual clinical time or costs (e.g. same payment for 1 or 4 restorations).
- **Lack of greener dentistry considerations** and patient allocation based on geography were noted as missed opportunities.
- The proposal **threatens the survival of family-oriented practices**, weakening patient relationships and practice goodwill.
- **No evidence shared** from years of reforms and trials (e.g. ACORN) to justify the new direction.

- Widespread belief the new contract will **accelerate the shift to private dentistry**, especially for patients wanting continuity.
- Strong objections to assumptions in the contract document, including **claims about misuse of NICE recalls** and motivations for leaving the NHS.
- Calls for **fee-per-item models** or simpler, trust-based funding systems rather than heavily segmented, target-driven ones.
- Many expressed **anger, disillusionment, and disbelief** at the direction of reform and its potential impact on the profession and patients.

23. Do you think the proposed reforms will have any positive impacts on groups with protected characteristics? If so, which and why?

Positive Comments

- **High needs patients** may benefit, particularly those who currently lack a regular dentist.
- The use of a **central register** (e.g. DAP) could help **vulnerable or socio-economically disadvantaged groups** access care.
- Some respondents acknowledge that **socio-economic inequalities** could be partially addressed through targeted access.

Negative Comments

- Many believe there will be **no positive impact** on protected groups.
- Concerns that **good dentists with stable patient lists will be penalised**, leading to loss of continuity and care quality.
- Reforms may cause **reduction in overall NHS availability**, disadvantaging all patients, including those in protected groups.
- Patients may have **less choice of dentist**, undermining trust and consistency in care.
- Reform does not address **geographic inequalities** (e.g. dental 'deserts'), meaning some groups will remain underserved.
- **Uncooperative or complex patients** may cycle through the system without continuity or stable relationships.
- Several respondents felt it is **too early to judge** potential impacts due to lack of detail or real-world testing.

24. Do you think the proposed reforms will have any negative impacts on groups with protected characteristics? If so, which and why?

Summary of comments:

Positive Comments

- A small number of respondents stated **no perceived negative impact** or that it is **too early to tell**.

Negative Comments

- **Fewer NHS providers** will result in **reduced access**, affecting vulnerable and protected groups disproportionately.
- **High needs patients** may face longer waits, especially for community or specialist referrals.
- **Loss of continuity and rapport** with a regular dentist could negatively impact **anxious or neurodivergent patients** who rely on familiar care relationships.

- The shift may lead to **fragmented care for families**, with members potentially sent to different practices.
- The emphasis on **urgent treatment over routine care** could lead to a deterioration in **long-term oral health**, particularly for those with existing conditions or barriers to care.
- Patients from **protected or high-risk groups** may avoid seeking care due to anxiety, confusion, or past negative experiences, worsening health inequalities.
- The reforms may lead to a focus on **numbers over quality**, disadvantaging patients who need consistent, tailored care.

25. Do you have any related issues which we have not specifically addressed?

Summary of comments:

Positive Comments

- No positive comments were explicitly provided, though some respondents expressed hope that **more detail and clarity** would be provided in future.

Negative Comments

- **DNA policy is too lenient** allowing three missed appointments wastes NHS time and resources.
- **Lack of continuity in care** is a major concern, especially when patients are redirected to different practices without access to previous clinical records.
- **Fragmented care increases clinical risk**, including unnecessary radiographs and repeated interventions.
- The contract is seen as focused on **cost-cutting rather than workforce investment**, making NHS dentistry unattractive to new graduates and DCPs.
- No mention of **NHS pensions for nurses, therapists, and hygienists**, unlike GP counterparts.
- Concerns about **how to transition and communicate changes** to current patients.
- **Unclear operational questions**: how does the contract year begin, and do practices start with existing or DAP patients?
- **Amalgam and deciduous restorations** lack payment guidance or clarity.
- Expectation for practices to cover **urgent care for 2 years** without registration or continuity is confusing and unrealistic.
- **No clear method** for handling rolling recall cycles across financial years—difficult for associate pay and practice planning.
- Practices can no longer **retain ACV portions for operational costs**, creating financial uncertainty.
- The contract fails to address the **importance of long-term patient relationships**, particularly for children and nervous or vulnerable patients.
- Data used to justify the contract is seen as **unreliable and unrepresentative**, raising concerns about evidence-based policymaking.
- Many respondents call for **clearer definitions and guidance**, especially to resolve grey areas and ensure consistent interpretation.
- Lack of detail on **associate and practice payment mechanisms** leaves practices uncertain about future viability.