Qualitative research with dental professionals delivering private dental services across the UK nations

Research report

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REVEALING REALITY

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1. Definitions used within this report

The table below outlines the definitions used throughout this report.

Term *incl. abbreviations*	**Definition**
Associate dentist	A self-employed dentist who pays to use the facilities, premises, and support staff of a practice or dental group, typically splitting the cost of materials and fees with the practice.
Care Quality Commission (CQC)	The healthcare regulator responsible for inspecting and regulating health and social care services in England.
Case types: clinical non-urgent, clinical urgent, and cosmetic	Case types were used in this research to help ensure interviewing included sufficient coverage of different types of case. These definitions were developed for this research and are clinical non-urgent (e.g., check-ups, hygiene appointments, fillings, root canal treatment), clinical urgent (e.g. dental abscesses, acute pain and trauma), and cosmetic cases (tooth whitening, veneers, composite bonding and orthodontics).
Cosmetic treatment	Private dental services that are generally undertaken to improve the aesthetics of teeth or smile, and where there is generally no underlying clinical disease or functional impairment requiring treatment.
Dental care professionals (DCPs)	A person qualified to practise specified aspects of dental care. The term covers a number of titles eligible for GDC registration, each with its own qualifications and scope of practice. Titles included under the umbrella term DCP are: dental nurse, dental technician, dental therapist, dental hygienist, orthodontic therapist, clinical dental technician.
Dental professionals	Refers to dentists, specialist dentists, and dental care professionals.
Dental services	Dental treatments provided by dental professionals, including preventative, clinically necessary and cosmetic dental treatments.
Dentist	A qualified professional responsible for diagnosing and treating oral health conditions. Dentists in the UK are registered with the General Dental Council (GDC), which sets standards for education and practice.
Four largest dental groups (FLDG)	BUPA, MyDentist, PortmanDentex, Rodericks Dental Partners.
General Dental Council (GDC)	The regulatory body for dental professionals in the United Kingdom. It maintains the registers of dentists and dental care professionals, sets and upholds standards for dental education, ethics, and clinical practice, and investigates concerns about professional conduct.
Healthcare Improvement Scotland (HIS)	The healthcare regulator responsible for inspecting and regulating exclusively private dental practices in Scotland.
Healthcare Inspectorate Wales (HIW)	The healthcare regulator responsible for inspecting and regulating private dental practices, and inspecting NHS dental practices in Wales.

Term *incl. abbreviations*	**Definition**
Independent	An independently owned dentistry business with 1 to 2 practices, not part of a dental group.
Large dental group (LDG)	A dental group with 30 or more dental practices in its portfolio.
Mixed practice	A practice that offers both NHS and private dental services.
NHS	National Health Service. NHS dental contracts are commissioned and managed separately across the four UK nations.
NHS Dentistry	Dental services provided under publicly funded health systems across the UK. As health is a devolved matter, services are delivered separately within each nation. In England, Scotland and Wales, these services are provided through NHS systems, while in Northern Ireland, they are delivered through the Health and Social Care (HSC) service.
Practice	Premises from which dental services are supplied in a specific location. Practices may be operated under various business models
Practice manager	Terminology varies across dental practices. For clarity, in this report (excluding quotes), the term practice manager refers to a normally non-clinical, in practice management role responsible for the day to day running and business side of the practice.
Principal dentist	A dentist who typically owns the practice, and is responsible for its clinical standards and performance.
Private dental services	Dental services that are not funded or part funded by governments.
Private only practice	A practice that only offers private dental services.
Regulation and Quality Improvement Authority (RQIA)	The healthcare regulator responsible for inspecting private dental practices or practices providing both NHS and private provision.
Rural/Urban/Suburban	A self-reported classification of a practice's catchment area, provided by interviewees when registering for the research.
Small to mid size dental group (SMDG)	A dental group with 3 to 29 dental practices in its portfolio.
Specialist dentist	A dentist who has completed additional training or qualifications in a particular area of dentistry (e.g. endodontics, periodontics, oral surgery) and focuses almost exclusively on this area of treatment.
Specialist-only practice	A practice that participants self-reported as providing specialist-only dental services (e.g. endodontics, periodontics, oral surgery).
Specialist private dentistry	Includes specialist dental services in orthodontics, periodontics, prosthodontics and oral surgery.
Treatment coordinator	A role, sometimes held alongside another DCP role such as dental nurse, that acts as a bridge between clinical staff and patients, helping to map out treatment plans and explain costs.
Units of Dental Activity (UDA)	The model used in England to pay NHS dental practices, based on the units of activity they complete against a contracted target.

2. Executive summary

Revealing Reality conducted 102 qualitative interviews with 58 dentists, 20 specialist dentists, 20 dental care professionals, and 4 treatment coordinators, delivering private dental services across the UK between May and August 2026. Below is a summary of the findings across each of the key topics discussed during interviews.

2.1 Accessing and choosing a practice

Most practices generally accepted new private patients. NHS acceptance in mixed practices depended on capacity, and most dental professionals agreed it was harder to join a practice as an NHS patient than as a private one. For some, this was because their practice only had certain dentists who dealt with NHS patients. For others, private appointments took priority over NHS appointments for any available slots once contract requirement for NHS patients had been met.

Waiting lists were more common for NHS patients than private patients, with lengths ranging from a few months to several years. Private waiting lists were rare and usually tied to specific specialist treatments rather than general registration.

Registration fees were uncommon. A small number of practices, mostly in Northern Ireland and Scotland, set specific conditions on registration, most often around children joining as NHS patients only where a parent was already registered.

Practice ownership was usually communicated to patients. Large dental groups tended to do this more formally, through branding and patient facing materials, while independent practices relied more on informal recognition in the local area, built over time when operating within the community and becoming known to local people.

A majority of practices relied on informal marketing, particularly word of mouth, and this was more pronounced in rural areas with high existing demand. Dental professionals reported that their practices were largely not investing much in marketing, particularly around their NHS availability, but where promotional offers existed, these were mostly linked to cosmetic treatment.

Most dental professionals did not see their practice as being in direct competition with other local practices, and there was a wide consensus among dental professionals that there were no obstacles for patients who wanted to leave the practice.

2.2 Treatment options, consent and costs

Treatment options were usually discussed verbally during consultations, sometimes supported by written treatment plans or discussions with treatment coordinators. The number of realistic options depended on the type of case. Clinical urgent cases often had few viable options, while cosmetic cases typically offered more choice.

It was widely reported by dental professionals that the pros and cons of different options would be set out rather than making explicit recommendations, though many said they would share a personal view if a patient asked directly.

Costs were usually communicated both verbally and in writing, and most dental professionals said agreed costs did not change once treatment began. Practices varied in whether they gave patients an estimate or an exact figure, often depending on how much of the treatment was already known at the point of quoting.

Consent was typically obtained after costs had been discussed, usually through a mix of verbal and written processes. A majority of dental professionals said they checked patient understanding before starting treatment.

2.3 How prices are set

Pricing was usually set at practice level in independent practices, and at dental group level in small to mid size and large dental groups, though how much input individual dental professionals had into this varied.

Many dental professionals described some discretion to adjust individual charges depending on case complexity, though a small number said prices were fixed within practice software with no flexibility.

Pricing information was usually publicly available, most often on a website or displayed in the practice, though this did not always include NHS pricing. A smaller share of dental professionals, more concentrated in Scotland, said pricing was not made public.

2.4 Dental plans

Most practices offered a dental plan, usually through an external provider, typically framed as maintenance cover with a discount on further treatment. A minority of dental professionals, more often at independent or specialist-only practices, worked somewhere with no plan on offer.

Plans were most commonly introduced at a patient's first appointment, and could be discussed by a range of staff including reception, treatment coordinators, and dentists.

Most dental professionals believed plans offered good value to patients, though a small number felt plans could lead to unnecessary treatment, unnecessary visits, or receiving poor value for money in some cases.

Cancelling a plan was generally described as straightforward, with little friction reported.

2.5 Monitoring performance and targets

Many dental professionals were aware that practice software recorded activity and income, though few saw this as performance monitoring, and almost all said it did not affect their clinical decisions.

Whether practices set formal targets varied by type. Independent practices were less likely to have them, while small to mid size and large dental groups more often did. Where targets existed, they covered measures such as private conversion, chair occupancy, income, and NHS contract requirements.

Few dental professionals reported facing consequences for missing targets, and most said a change in ownership had little effect on the targets in place.

2.6 Expectations around cosmetic treatment

A majority of dental professionals reported no expectation to offer private or cosmetic treatment. A small number described an informal expectation to raise cosmetic options during consultations, usually coming from practice management rather than as a formal target.

2.7 Financial incentives and rewards

The majority of dentists spoken to for this research were associates. This means they were self-employed and not salaried by the practice they worked at, earning based on the fees and work they completed. Therefore, for most dentists, financial incentive was built into their self-employed pay model rather than delivered through separate bonus schemes. A majority said this did not shape their clinical decisions, aside from a small number who described it influencing how they approached cosmetic work specifically.

Additional financial incentives, such as bonuses tied to specific treatments or referrals, were uncommon among dentists, and more often applied to salaried staff such as receptionists.

2.8 Reflections on regulation, GDC Standards, and nation specific regulators

The sector was widely described as heavily regulated, with dental professionals citing the administrative burden of record keeping and inspection preparation. There was a broad consensus among dental professionals that this was a necessary part of running a practice.

Most dental professionals said the GDC Standards translated well into day to day practice, describing them as embedded in training rather than something actively consulted. Criticism was directed more often at how the

GDC handles complaints and fitness to practise cases than at the Standards themselves, with some describing these processes as disproportionate, costly, or slow.

Awareness of nation specific regulators was lower than awareness of the GDC, with around half of dental professionals having little to say about them. Where dental professionals did have a view, most saw the GDC and nation specific regulation as complementary, though a small number saw them as duplicative.

A small number of dental professionals felt regulation had not kept pace with changes in the sector. The area raised most often was cosmetic treatment, followed by patients seeking treatment overseas, and online advertising.

2.9 Complaints and conduct concerns

Nearly all practices had a complaints process, usually owned by the practice manager, with escalation to the owner for more serious cases. Around half of dental professionals had personally dealt with a complaint, most commonly relating to clinical outcomes, cost, or cosmetic results.

A majority of dental professionals said they would raise a conduct concern within the practice first, though a small number described negative experiences of doing so in the past. Awareness of routes to escalate concerns beyond the practice was limited, and some dental professionals were reluctant to use them.

3. Background and approach

3.1 Focus of this research

In March 2026, the CMA launched a market study into private dental services in the UK. This qualitative research, commissioned by the CMA as part of the study, focuses on the experiences and views of dental professionals working in the UK. The research explored interactions between dental professionals and patients, and the factors influencing treatment recommendations, commercial incentives, and the role of the regulatory framework.

The specific research objectives were to:

- Understand how dental professionals interact with consumers when making clinical, cosmetic, and referral decisions, and what guides those interactions across different scenarios.
- Understand how and when dental professionals recommend private treatment options to NHS patients, and how they present prices to all patients.
- Understand the extent to which business ownership structures, commercial incentives, and practice-level targets influence those interactions.
- Understand how the existing regulatory framework, primarily the General Dental Council's (GDC) Standards for the Dental Team, shapes day-to-day practice in reality.

3.2 Research approach

The main fieldwork was conducted by Revealing Reality between May 2026 and August 2026.

Revealing Reality conducted 102 in-depth interviews with 58 dentists, 20 specialist dentists, 20 dental care professionals, and four treatment coordinators. All interviews were conducted remotely, lasting 90 minutes for dentists and specialists, and 60 minutes for DCPs.

Interviews were conducted one to one, with participants assured that their participation would be anonymised and their responses would not be attributed to them in research outputs. The length of the interviews allowed researchers to explore topics in depth, enabling participants to speak openly about their experiences and perspectives within the profession, which were arranged flexibly around dental professionals' own availability. The format and length of the interview, as well as the condition of anonymity within the research, allowed dental professionals to speak frankly and honestly about their experiences in the sector.

Set-up and sampling	Recruitment	Fieldwork	Analysis
• Purposive sampling approach across key characteristics. • Careful quota development to reflect different practice types and roles. • Developing a sample frame from the GDC list of registered dental professionals	• Consecutive random samples contacted, including targeted quotas. • Staged invitation process with detailed screener completed by dental professionals. • Repeat follow-ups to encourage participation	• Development of a structured discussion guide. • Flexible interview slots offered to dental professionals. • Pilot fieldwork phase • Main fieldwork phase	• Grid analysis, filled in by researchers and compared across the full sample. • Interim findings session with the CMA. • Final reporting phase.

Research design

The research materials were developed in collaboration with the CMA case team and were structured around the research objectives. Interview guides included a section designed to focus on dental professionals' most recent case, ensuring that insights were grounded in concrete, recent examples rather than general opinions. Researchers ensured a spread of case types were discussed across interviews, including clinical non-urgent, clinical urgent, and cosmetic cases.

To capture a comprehensive range of perspectives from all dental professionals, researchers also included broader, open-ended questions throughout, giving dental professionals the opportunity to share their experiences and perspectives openly.

The discussion guide for dentists and specialists was designed for a 90-minute interview. This was then adapted for DCPs to accommodate a shorter interview length of 60-minutes that focused on areas of particular relevance to DCP roles.

All research materials were piloted prior to mainstage fieldwork with a random selection of three dentists, two specialists, and one DCP. Research materials were also adjusted throughout fieldwork after reflecting on the data collected with the CMA.

Full interview guides are available in the annex of this report.

Recruitment and sampling

The recruitment approach was designed to be systematic and rigorous. The GDC list of registered dental professionals was used as the sample frame for this research, which was supplied by the CMA. The frame was randomised and consecutive random samples drawn, with a structured process in place to identify a range of participants and remove selection biases.

Invitations were sent exclusively to these samples via email with a link to register for the research, with researchers cross-referencing those who registered with the contacted sample to remove the potential for self-selection without invitation. The research team also carefully monitored sign-up across sub-samples and made targeted efforts to recruit less-engaged dental professionals, with multiple recontact attempts and follow-ups.

Once dental professionals registered for the research, a purposive sampling approach was adopted across each of the four UK nations, to ensure a breadth of experiences. Dental professionals completed a detailed screening form to gather key information and ensure a range of quotas were met across the research.

Key sampling criteria included:

- Nation (including an equal spread across each of the four UK nations)
- Practice ownership (ensuring a spread across independents, small to mid size dental groups, and large dental groups, including the four largest dental groups)
- Practice location (including rural, suburban, and urban areas)
- Private only and mixed (private and NHS) practices
- Professional experience, based on length of registration with the GDC
- Dental professionals who had moved between practice types
- Dental professionals who had experienced ownership change at their practice

A breakdown of the sample can be found in the annex, with exact numbers for each quota (except nation and practice type) removed to protect the anonymity of those involved.

58	20	20	4
Dentists	Specialists	DCPs	Treatment coordinators

Analysis and data

All interviews were recorded with participants' consent and stored securely along with additional evidence, such as research notes. The research team built a qualitative analysis grid which included a row for each participant and a column for each theme. Researchers populated this grid after each interview was completed, creating a consistent, structured record of evidence against each topic. This method meant every participant's perspective fed directly into the analysis, with no individual accounts overlooked.

Analysis was conducted collectively, drawing on the perspectives of all researchers involved in the interviews, rather than being led by a single analyst. After 71 interviews were completed, Revealing Reality held an interim findings session with the CMA. These findings were presented on 14th July 2026.

Methodological note on qualitative research

This is a qualitative piece of research that aims to understand the experiences, decision-making, and influences of dental professionals, and does not aim to produce statistically representative findings. This qualitative sample was designed to be purposive and meet quotas relating to a range of characteristics, including practice type, UK nation, and patient catchment. This approach means findings should be interpreted as the prevalence of themes heard in the sample rather than as proportions of all dental professionals working in the UK.

Where terms such as "majority", "most", or "many" are used in this report, they describe how frequently a theme was heard across the 102-interview sample, not a numerical or statistical measure. Similarly, when differences are highlighted between nations, this should be read as differences noted between quota-driven subsets of the sample and are not representative of the entire population of dental professionals in each nation.

All insights are based on participants' recall, personal experience, and understanding, which can be imprecise and, to some extent, post-rationalised. For this reason, discussions were grounded in dental professionals most recent cases.

4. The landscape of private dental services

Within dentistry, there are several contextual elements that help shape understandings of how the sector works, and the roles of different dental professionals, institutions, and bodies within them. Some of these elements are consistent across the four UK nations, while others are specific to just one nation.

How dental practices are structured, and the roles within them

The majority of dentists spoken to for this research were **associates**. This means they were self-employed and not salaried by the practice they work at, earning based on the fees and work they completed. While exact cost and revenue arrangements varied between practices, they typically followed an approximate 50-50 split, under which associate dentists would share the cost of materials as well as the fee paid for their services with their practice. Many associates worked across more than one practice.

Associate dentists are supported in their work by a team of **dental care professionals (DCPs)**, including dental therapists[1], hygienists, technicians, and nurses. Each role had a remit of care that they were able provide to patients, who were usually referred on by a dentist. DCPs employment arrangements varied, with some dental therapists and hygienists working at practices as self-employed dental care professionals, while nurses were typically salaried by practices.

Some dental care professionals held multiple qualifications, sometimes from abroad that allowed them to practice as a DCP in the UK, but not as a dentist. This included some hygienists and therapists in the sample. Other DCPs held more than one role within the practice, such as a nurse also working as a **treatment coordinator**.

Treatment coordinators acted as a bridge between clinical staff and patients, helping map out extensive or complex treatment to patients, or help explain costs involved.

All dentists and dental care professionals answered to a **practice manager**, a normally non-clinical role that was responsible for the day-to-day running and business side of the practice. Practice managers make decisions along with **principal dentists**, who typically owned the practice. They would be responsible for the clinical standards and performance of the practice.

[1] The GDC Scope of Practice (2025) describes the role of dental therapists as promoting oral health, preventing and treating disease, while also carrying out a range of restorative dental treatments and extracting primary teeth within the scope of their practice. There are procedures outside of their scope of practice, such as indirect restorations and permanent tooth extraction. https://www.gdc-uk.org/docs/default-source/information-standards-and-guidance/scope-of-practice/scope-of-practice-guidance-2025-(1).pdf?sfvrsn=18b7c40e_11 (page 15)

The interplay with NHS services

Many of the practices interviewed for this research were **mixed** practices, meaning they offered NHS and private dental services. However, NHS dental contracts are commissioned and managed differently across the four UK nations.

For example, in England, the NHS operates on a Units of Dental Activity (UDA) model, where practices are paid per UDA they complete. This varies between NHS contracts, and practices often had targets to meet. Once practices exceeded their UDA, they received no more income for the NHS work they completed.

In contrast, Wales was moving towards a needs-led NHS dental contract that allocates care according to patient need and risk, replacing the UDA model. Dentists often reflected on the changes to the NHS contract during interviews, describing NHS lists as more centralised, with patients allocated to a practice when necessary, rather than having to register at a specific practice.

Details like this differed between each of the four nations, providing useful context to the ways private dental services were provided, and practices' relationship with NHS patients.

Regulatory bodies

The General Dental Council (GDC) regulates dental professionals across the UK. It maintains the register of dental professionals, sets standards for the dental team, investigates serious concerns about fitness to practise, and quality-assures dental education and training.

Nation-specific healthcare regulators inspect and regulate dental services, with a focus on safety, premises, governance and compliance requirements. This includes:

- Care Quality Commission (CQC) in England
- Healthcare Improvement Scotland (HIS) in Scotland
- Healthcare Inspectorate Wales (HIW) in Wales
- Regulation and Quality Improvement Authority (RQIA) in Northern Ireland

Differences between these nation specific regulators contributed to a varied landscape across the dental sector, including differences in routine inspection arrangements for private only practices and in how dental practices were categorised by regulators.

5. Consumer journey and choice

This chapter includes reflections on how patients access and choose dental services, including:

- How patients registered with and accessed NHS or private care, including waiting lists and any conditions of joining.
- How practice ownership and services were communicated and promoted to patients.
- What happened when patients wanted to leave a practice.
- How treatment and cost options were presented and communicated, and how consent was obtained

Key findings

- Most dental professionals reported that their practices were open to new private patients, but registering as an NHS patient often depended on capacity. The majority did not charge a registration fee for joining the practice, although a minority did have conditions attached to registering, most of which were in **Scotland and Northern Ireland.**
- Private practices did not generally see themselves as being in direct competition for patients, but those that did were largely serving a more **urban** catchment. Practices also reported a limited need for marketing and promotion.
- Treatment options were usually communicated verbally, with risks and benefits explained to the patient, which were sometimes supported by written treatment plans. Dental professionals emphasised that there were often limited courses of appropriate treatment, especially for clinical urgent treatment, compared to multiple options available for cosmetic treatment.
- Costs were usually communicated verbally and in writing, although initial costs prior to consultations were handled in different ways, such as through estimates or ranges of costs for treatment. However, all dental professionals said consent for treatment was obtained once final costs were communicated.

5.1 Accessing and choosing a practice

5.1.1 Most practices were accepting new private patients, though NHS acceptance among mixed practices depended on capacity

A large majority of dental professionals reported that their practice was accepting new private patients at the time of interviewing. Of the approximately two-thirds of the sample that worked at mixed NHS and private practices, most of these did accept new NHS patients when capacity enabled them to do so.

> *"Recently, when one of the dentists took on some new NHS patients, there was quite a huge amount of interest, as you can imagine... But again, our default would always be to register them as NHS because realistically, there's no reason why we can't register them as NHS."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

> *"I guess the practice is accepting NHS patients. I am not myself, apart from kids of adult patients that I have already registered. The other dentist in the practice is accepting NHS patients."*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

> *"I know we're taking on a lot more NHS now because we have got that one person doing NHS, so people can pretty much get registered on straight away."*
> **Dentist, FLDG, Mixed, England, Urban**

However, there was broad consensus among dental professionals that joining a practice as an NHS patient was harder than joining privately, due to high demand and limited capacity for NHS appointments. For some, this was because their practice only had certain dentists who dealt with NHS patients. For others, private

appointments took priority over NHS appointments for any available slots once contract requirements for NHS patients had been met.

> *"We're overwhelmed... there's only really two of us now that see health service patients, and the practice still has a lot of NHS patients, so it's just a lot for me and the other associate to see. We just have no capacity to see any new patients."*
> **Dentist, FLDG, Mixed, Northern Ireland, Urban**

> *"I haven't got the time to see new NHS work… If there's availability they [new patients] can be put on the NHS. If there's not and you're meeting your NHS requirements in terms of output and you're operating at full capacity…[and] the targets are fulfilled from what they [the practice managers] can see from the metrics, then they won't take on any more because if you overshoot, of course, you don't get paid. So then the patients are told they can come on privately."*
> **Dentist, FLDG, Mixed, England, Suburban**

Many of the practices that were accepting new NHS patients did so on an irregular or ad hoc basis when individual dentists in the practice had capacity, rather than being consistently open to new NHS patients throughout the year.

> *"I think it's got on a little bit of a freeze, but we do tend to take [NHS patients] on in dribs and drabs."*
> **Specialist, SMDG, Mixed, England, Urban**

> *"We have two new dentists, that's the reason why we're accepting new NHS patients."*
> **Dentist, FLDG, Mixed, Scotland, Urban**

Only one dental professional described recruiting new NHS patients as a route to converting patients to private care; this was not mentioned elsewhere in the sample. However, others spoke about a proportion of NHS patients also wanting certain private treatments on a pay-as-you-go basis.

> *"I'm seeing more private now because obviously we aren't established there, but most of those probably were NHS patients I've converted… They know they've got to see new [NHS] patients. That's how they're going to convert to make them private."*
> **Dentist (owner), Independent, Mixed, England, Suburban**

> *"It's not just the fact that we've got the private base or the private referrals in. A lot of our NHS patients also wanted the private as well."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

5.1.2 The majority of waiting lists were for NHS patients, with few practices having lists for private patients

Almost half of the dental professionals interviewed reported that their practices had waiting lists. The majority of these were for new NHS patients in mixed practices or for specific NHS treatments, and waiting times ranged from three months to seven years.

> *"With orthodontics, we've had to close our new patient waiting list because it was getting towards 6 or 7 years for treatment. Our treatment waiting list, we've got over 400 on that and we can see about 120 patients a year, so we're not ready to open the waiting list again. Private treatment, there's no waiting list. We'll see you that week or the next week for a new patient examination."*
> **Dentist, Independent, Mixed, Wales, Suburban**

> *"Because there are low numbers of orthodontists and high demand, and we have a waiting list - to see me, you have to wait 3 years. So there's another reason why the private side exists, because there will be people that don't want to wait, or there will be people that don't qualify and are waiting to be seen for three years to find out they don't qualify."*
> **Specialist, FLDG, Mixed, England, Urban**

Most dental professionals said their practices did not have waiting lists for registering new private patients, as they were generally booked in for initial appointments straight away. The few dental professionals who did mention private waiting lists described them as typically being for specific specialist treatments, or referred to the time until the next available appointment rather than a registration waiting list.

> *"Yeah, [the waiting list is] about 9 months for NHS treatment and about 2 weeks off the top of my head for private treatment."*
> **Specialist, Independent, Mixed, Scotland, Urban**

> *"Yes, we have a [waiting] list [for private patients]. We will work through the list. Obviously, if we have late cancellations and there's gaps in the books, they will work through that list. So just because we have a 6-month waiting list, we may have 4 cancellations one day, and patients are contacted, whoever is willing to accept an appointment on the day will get an appointment on the day."*
> **Dentist, LDG, Mixed, Wales, Rural**

> *"There are certainly for some treatments. For my paediatric care, there is a bit of a waiting list. Same for endodontics and complex restorative work… I think, as far as I remember correctly, the endo and complex restorative is a couple of months."*
> **Specialist, Independent, Private only, England, Urban**

A few dental professionals also mentioned that their practice accepted emergency, one-off patients, often tourists or visiting family members. One practice charged an emergency surcharge for these patients; others charged standard pay-as-you-go prices.

> *"We've got loads of holidaymakers from abroad and from down south, and they maybe break a tooth or lose a crown...The prices are the same, but they've got an emergency visit fee attached to that which registered patients wouldn't have."*
> **Dentist, Independent, Mixed, Scotland, Rural**

> *"So new patients will have to pay a new patient examination charge when they first come. If they're not registered, they would need to pay more to be seen as an emergency."*
> **Dentist, Independent, Private only, England, Urban**

In Wales, several dental professionals described a centralised 'dental access portal' through which NHS patients were allocated to practices.

> *"So in Wales we can only accept through the dental access portal or the siblings of patients that are already registered with us."*
> **Dentist (owner), Independent, Mixed, Wales, Urban**

> *"We have to see patients from the portal. So it's not like we are accepting, we are obliged to take at least a couple of new patients. Like for me personally, every week I see two new people from the portal."*
> **Dentist, FLDG, Mixed, Wales, Suburban**

One dental nurse from Wales reflected that since NHS waiting lists became centralised through the portal system in Wales, waiting lists for private patients had also become longer. She thought this was due to the increase in patients registering privately to avoid the longer NHS waiting times.

> *"I think the wait times are significantly less for private dentistry, but there is an increase in the people that are wanting private dentistry now because of the changes with the NHS. So I think that is having a knock-on effect with private patients…I found that more recently, we are at a stage where with our private patients, we're not able to offer them an appointment within the same week sometimes because we just don't have the capacity to do it."*
> **Dental nurse (practice manager), SMDG, Mixed, Wales, Urban**

NHS patients were often given choices once their eligibility ended

Dental professionals largely reported that patients were given a choice on how to proceed once their eligibility ended. Across the sample, practices had a variety of approaches to handling the changing eligibility of NHS patients. This included joining the practice as a private patient or remaining eligible for NHS treatment but paying fees for consultations.

> *"It's 26 now in Scotland. When they turn 26, they'll be given the option to go on one of the plans, or else they can go and see one of the NHS dentists… There'd be a conversation, say, this is your last exam that the NHS is providing for you, and these are your options going forward."*
> **Dentist (owner), Independent, Mixed, Scotland, Rural**

> *"They are told that they are no longer eligible as an NHS patient. You can either find another practise which can provide you with an NHS treatment… or you can attend the practise as a private patient or a plan [patient]"*
> **Specialist, Independent, Mixed, Northern Ireland, Suburban**

> *"Their NHS registration would come to an end and they'd be given notice of that six months prior to that happening and informed that then they'd be transferring over to either [plan] or pay-as-you-go, whichever one they choose the next time they'd be in."*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

This was sometimes managed proactively by practices in advance of a patient's eligibility changing, with practices reaching out to inform them of their choices.

> *"The treatment coordinator will send out information that they are welcome to remain as a pay-as-you-go, or here's our payment plan. And previously, your dentist recommended you two hygiene visits and two examinations a year, so to continue that, this would be the cost. They would receive an email with all the options if they wish to remain as a private patient with us."*
> **Dental therapist, Independent, Mixed, Scotland, Urban**

> *"About three months before their 18th birthday, they're sent a letter, detailing that three months from the date of that letter, their NHS registration will cease and their options are laid out as either join the practise privately or go somewhere else as an NHS patient."*
> **Specialist, Independent, Mixed, Scotland, Rural**

> *"It would just be verbally saying, from the age of about 23, 24. We would then, be chatting about private and membership options then."*
> **Dental nurse, Independent, Mixed, Northern Ireland, Rural**

A few dental professionals believed patients could continue seeing NHS dentists as an adult, as long as they continued attending appointments. In some cases, patients would be told they would now be charged for their appointments, but were still eligible for NHS treatment.

> *"They would carry on, they wouldn't be considered ineligible, unless they didn't turn up for appointments."*
> **Dentist, SMDG, Mixed, England, Urban**

> *"Their registration doesn't change, just their exemption changes. They're still an NHS registered patient."*
> **Dentist, Independent, Mixed, Northern Ireland, Suburban**

> *"At this practice, they would stay on as an NHS patient. We wouldn't say 'see you later unless you pay us'."*
> **Dentist, Independent, Mixed, England, Suburban**

5.1.3 Most practices had no registration fee, for private or NHS patients

Nearly all practices had no registration fee for private patients. Only one dental professional reported a fee, of £30, at a private only large dental group practice in Northern Ireland.

> *"So the patient is given an option if they want to pay-as-you-go private or if they want to join the plan, and there is no registration fee."*
> **Dental therapist, LDG, Mixed, England, Urban**

> *"They don't take payment over the phone before their first appointment, nothing like that."*
> **Dentist, SMDG, Mixed, Scotland, Rural**

> *"No, they will take a deposit of the exam fee, a part of the exam fee in advance if you want to book an appointment. There's no registration fee or anything like that."*
> **Dental therapist, Independent, Mixed, Wales, Suburban**

Outside of registration fees, a handful of practices attached specific conditions to registering as a patient. Most of these were among practices in Northern Ireland or Scotland, with only a couple of dental professionals reporting conditions for practices in England and Wales.

The most common registration condition that dental professionals reported was only allowing children to join as NHS patients where their parents were already registered privately with the practice, or if parents joined privately.

> *"We're not accepting NHS patients, unless they're, say, kids of parents who are already registered… the remuneration for NHS is not great."*
> **Dentist, Independent, Mixed, Scotland, Rural**

> *"If patients want to see me as an adult, they'll be private, but I will see their kids' NHS... I'll take on new kids' NHS if their parents join private."*
> **Dentist, SMDG, Mixed, Scotland, Rural**

> *"I don't think the dentist wants people to know that we see kids on the NHS because then people are trying to take advantage of that."*
> **Dental nurse, Independent, Mixed, Northern Ireland, Urban**

Other conditions reported were new patients having to pay a full or part of the examination charge as a deposit to secure a new booking or requiring attendance at a first appointment. Some conditions were also not strictly about new people registering as patients, but conditions patients needed to meet so they would not be de-registered. Examples included requiring patients to attend regular check-ups or requiring attendance every two years to retain NHS registration.

> *"For the [dental plan provider], we do charge an assessment fee for that initial appointment that covers your examination and any necessary x-rays. That has to be paid up front to guarantee the appointment. If you miss the appointment, you don't get your money back. But we've had to bring that in because we just get too many time wasters otherwise."*
> **Dentist (owner), Independent, Mixed, Wales, Urban**

> *"NHS patients, we make them aware that they will need to attend, otherwise they'll lose the registration after 23 calendar months… Private patients, we're a bit more flexible with that really. We do give them reminders that their checkups are due every six months and that, but I guess there's a bit more flexibility with them."*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

> *"Generally it's that you attend your first appointment, otherwise you won't be given another chance."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

One dentist from an independent practice in a rural area of Scotland restricted registration to patients from a local postcode, due to the volume of no shows.

> *"We really only take our new patients within our postcode…because what was happening, you could get somebody that was like a 45-minute drive away… then we were finding we were getting quite a high failure rate with those patients."*
> **Dentist (owner), Independent, Mixed, Scotland, Rural**

Examples of conditions to accessing and remaining registered at dental practices

While the majority of practices did not report to have conditions for patients registering at practices, the following examples were heard from a minority in the sample:

- Allowing registration of a child as an NHS patient if the parent registers privately.
- Paying a deposit for appointments or check-ups to limit no-shows.
- A new patient examination to assess oral health and hygiene.
- Attendance between specific time intervals for check-ups.
- Payment of a registration fee.
- Geographic or catchment restrictions.

5.1.4 Practices generally presented ownership to patients, although how they did this varied by practice type

Dental professionals working in large dental group practices often described their practices communicating ownership prominently, through branding, signage, staff uniforms, patient materials, websites, and social media.

> *"It's very much offered up as a group offering. In our reception area, the TV that sits there, it talks all about the [LDG name], all the services under that umbrella. I don't think patients are left in any doubt that it's part of a bigger, wider group."*
> **Dental nurse, LDG, Mixed, Scotland, Rural**

> *"It's known as [FLDG name] and there's a big, massive banner that says [FLDG name]. We don't go out of our way to tell them that they're owned by [FLDG name]. They come in already knowing that. [In] the reception room, there's massive logos, advertisements, TVs everywhere, advertising [FLDG name] and the different services that we offer."*
> **Dentist, FLDG, Mixed, Wales, Suburban**

Most dental professionals from small to mid size dental groups described displaying dental group ownership on the practice website or social media, though how prominent this was varied. For example, some spoke about branding being clearly displayed in the practice itself, whilst others said that whilst dental group ownership might be present on the website, it wasn't necessarily obvious. A few also displayed dental group ownership on patient-facing materials such as notice boards, leaflets and signage.

> *"They do know, they have the videos running in the waiting room about all the staff as well as the practice ownership and everything so that they do know that... We also have the Instagram page where [the principal dentist] regularly posts the videos of any smile makeovers or anything, so social media as well along with it."*
> **Dental therapist, SMDG, Private only, Scotland, Suburban**

> *"I don't recall seeing it inside the practice, but I've seen it on the website. It says part of [SMDG name], but it's not hugely obvious really."*
> **Dental therapist, SMDG, Private only, Wales, Rural**

> *"If they want to see the owner of the practice, or if there's an ongoing complaint, or patients aren't happy, for example, for whatever reason, they'll be passed to the main owner. And the other way that I would say it's presented is probably on the website, so [the owner] would be labelled as the principal dentist/owner."*
> **Dentist, SMDG, Mixed, England, Urban**

Most independent practice dental professionals also reported that their practices displayed practice owners on websites, and a few also said their practices presented this on social media or notice boards within the practice. However, dental professionals from independent practices more often described communicating ownership informally, such as through word of mouth or existing recognition within the local area, than those from dental group practices.

> *"On the public facing websites, it's available to see that it's the [family] who own the practice."*
> **Specialist, Independent, Private only, England, Urban**

> *"Well, if anyone asks, a lot of the patients have been going there for years and they knew that [their relative] used to own it. And then we say, oh, you know, [they are] the practice owner... if anybody asks who owns the practice."*
> **Dentist, Independent, Private only, Wales, Suburban**

5.1.5 Most practices relied on informal channels for marketing, though this varied by practice type

The majority of dental professionals across the sample described relying primarily on word of mouth to attract new patients or advertise their services, with many of these perceiving it to be unnecessary to focus on marketing due to high existing demand. Around a quarter explicitly described putting little or no active effort into marketing at all.

> *"We generally ask new patients, how did you hear about us? And the most common [answer] is word of mouth."*
> **Dental therapist, Independent, Private only, Wales, Rural**

> *"I think word of mouth just gets around, that people walk by and see it's a practice and they knock on the door, they ring up. No, I don't think there's been any marketing push at all."*
> **Dentist, SMDG, Mixed, England, Urban**

However, many practices did have online channels to attract new patients, mostly by sharing information about available treatments and services on social media or on their websites. Principal dentists or practice managers usually made these decisions over marketing, though treatment coordinators were also involved in a small number of cases.

> *"We advertise it on our social medias mostly, or usually word-of-mouth patients will get in contact with us as well. It's all over our social medias that we're accepting new patients… It'd be Facebook and Instagram."*
> **Dentist, Independent, Private only, Northern Ireland, Suburban**

> *"Marketing is done by the treatment coordinator. We do take pictures of the patients after and before the smile makeovers, and we take video consents or picture consents from the patients and post it on the social media."*
> **Dental therapist, SMDG, Private only, Scotland, Suburban**

A few dental professionals described more active or paid marketing efforts, such as actively improving their search engine optimisation by paying for Google adverts or enabling patient reviews, and a small number paid for social media advertising.

> *"They have a website. I think they have something that they pay that makes it show on Google when people are searching."*
> **Dentist, Independent, Private only, England, Urban**

> *"There's also paid external marketing to promote the scopes of practice, that we can offer implants or that we can do certain open days. So you do an implant open day, you do an aligners open day where patients can come in."*
> **Dentist, FLDG, Mixed, England, Suburban**

Many dental professionals from rural practices spoke of relying on word of mouth or not needing to actively promote their services due to existing high demand, and fewer reported having formal marketing strategies than for practices in urban or suburban locations.

> *"I want to say 100% of the people [new patients] are word of mouth patients... We don't advertise. I've never needed to advertise. I've been there for 21 years and we've never advertised, and we're at capacity."*
> **Dental hygienist, Independent, Private only, Wales, Rural**

> *"We do get lots of new patients. I might see anywhere from two to six a week, and normally they are recommendations from friends or family."*
> **Dentist, Independent, Private only, England, Rural**

While practices often emphasised their private dental services in marketing communications, they rarely mentioned the availability of NHS services, most commonly because they were not accepting new NHS patients at the time of the interview.

> *"I guess the only way they would know is word of mouth… But as I say, we're not publicly seeking NHS patients. We're not really advertising that we're taking them on."*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

> *"Privately, yes, NHS no, because we don't need to do it [marketing] NHS wise. Privately, they've done things like leaflet drops, so introducing the plan, they've done leaflet drops for that to say this is what we offer, this is the cost."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

One dental professional from England mentioned NHS Choices as a way patients in England could find new NHS or mixed practices.

> *"What we would tell patients is to go on NHS Choices, type in their postcode, and look at the list of practices that are closest to them, and then they can see whether they are or aren't accepting patients."*
> **Dentist, SMDG, Mixed, England, Urban**

A few dental professionals working in specialist practices said their primary audience was other practices and dental professionals who referred patients to them, rather than patients themselves. For these dental professionals, marketing centred on professional relationships and conferences rather than patient-facing channels.

> *"The practice principals have organised open days for the specialist service they provide. For example, a specialist facial aesthetics evening and so on… it might be an open evening to meet the clinicians and maybe they might have introductory offers."*
> **Specialist, Independent, Private only, England, Suburban**

> *"Because we're specialists, we do quite a lot of educational evenings for referring dentists. So, that's one of our big marketing opportunities… It's referring dentists and hygienists we're looking for rather than the patients themselves. And it's the same with our social media, it's more targeted towards referring dentists than it is to getting patients."*
> **Specialist, Independent, Private only, Northern Ireland, Urban**

One treatment coordinator directly referenced "promoting" cosmetic treatments as part of their role.

> *"Anyone who shows interest in anything cosmetic, they'll be talking to us… we can explore options with them and see what offer is available, what's appropriate, what's not appropriate, and obviously get the dentist's opinion on that as well… if they do want to improve anything aesthetically about their appearance, maybe we promote whitening or anything that's needed."*
> **Treatment coordinator, FLDG, Mixed, Wales, Rural**

5.1.6 The majority of dental professionals reported limited use of promotional offers at their practices

The majority of dental professionals did not report that their practice used promotional offers or discounts. Where offers did feature, these most commonly related to cosmetic treatments, such as tooth whitening or aligners. A small number of these were linked to specific events, holidays or patient groups such as teenagers, and included open days, smile makeover days, or branded teeth whitening events.

> *"There's a lot of posting on social media and we run a lot of promotions in the practice targeting different groups. So we've got one running for parents of teens going through treatment at the moment."*
> **Specialist, FLDG, Mixed, Scotland, Urban**

> *"Very occasionally they might do, in the run-up to Christmas, 20% or something off of tooth whitening, but it's usually just a wee promotional thing in the run up to summer or the run up to a Christmas party or something like that."*
> **Dental therapist, Independent, Mixed, Scotland, Suburban**

One dental professional, working within a large dental group, described optional corporate promotions on cosmetic treatments that individual practices or dental professionals could choose whether to take part in.

> *"For the implant stuff, there was a recent offer and it was put into a group with all the implant dentists, and anyone could opt in and opt out from it… There is one offer that I'm aware of that goes out to all the practices, and it markets to all the patients about the whitening. I can opt out of it in the sense that I say I don't want to do this, someone else can do it."*
> **Dentist, FLDG, Mixed, England, Suburban**

In comparison to the other nations, Scottish dental professionals more often spoke about their practices having specific time-linked promotional offers. These offers were typically tied to a seasonal or local event such as Christmas or Scotland-wide gala days. Only a few English and Welsh dental professionals mentioned them, and only one Northern Irish practice had any.

> *"There's a bonus fair day on Friday and they have, it's kind of a huge thing around Scotland, they have kind of gala days and stuff, so it's an offer that they do every year on tooth whitening as a slightly reduced price."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

"We always do a whitening deal during the summer. We do some competitions for kids and stuff like that... we've done some open days for clear correct, for braces, for implants."
Dentist, SMDG, Mixed, Wales, Rural

"We don't really run promotions, so we don't, we're fairly competitively priced... So, we generally don't have to run promotions or anything like that."
Dentist, Independent, Mixed, Northern Ireland, Rural

The majority of promotions were tied to cosmetic treatments, except for one practice that had a new patient discount, and another that had a referral scheme.

"The website has a special offer at the moment, 50% off. I've had quite a few patients in the last few weeks booking via that."
Dentist, Independent, Mixed, England, Suburban

"A patient that's had treatment can offer a [promotional code] to a friend or family for these discount codes."
Specialist, FLDG, Mixed, England, Urban

5.1.7 Most dental professionals reported no challenges for patients who wanted to leave the practice

Many dental professionals reported that they would often not know if a patient had left the practice, since patients had no obligation to inform the practice. This was true across both private only and mixed NHS and private practices, and those on a dental plan.

"They just leave the practice and go where they want… They are free to do what they want, to go where they want."
Dental hygienist, SMDG, Mixed, Northern Ireland, Suburban

"They can leave, they just need to let us know. Well, they don't even need to let us know. Some of them just leave and don't let us know. And if we call them after a year and a half or something, we say, oh, look, you're due your checkup. And they say, oh, sorry, I moved to Australia, which was what happened with my patients."
Dentist, SMDG, Mixed, Wales, Rural

"There's quite a few pay-as-you-go, so I assume there are quite a few people that leave that maybe we never know about because they do pay-as-you-go, so they're free to go wherever they want. Then if they're on the plan, I think they just do it online. They just cancel the plan, and then we get an email to say they've cancelled the plan, and that's it."
Dentist, Independent, Private only, Wales, Suburban

A few dental professionals said they would advise patients against leaving mid-treatment, though nothing was in place to stop this if a patient did want to leave during their course of treatment. However, there were very few examples of this happening in the cases that dental professionals spoke about.

"What we have had is patients that have moved away and they're like, oh my gosh, I'm sorry, because we'll contact you if your treatment plan is open… And most of the time they do say, oh my gosh, I've moved away, I totally forgot. And we say, you know, you really do need to get that treatment finished, especially if they've had the first stage of root canal and they need the second. So we normally do just advise that they find another practice or come back to us and we'll finish the treatment."
Dental nurse, SMDG, Mixed, Wales, Urban

"No, you can just advise somebody that if they're in the middle of a root canal treatment or something, that you'd need that seen elsewhere. But everybody can go if they want. There's nobody trying to pressurise them."
Dental nurse, Independent, Private only, Northern Ireland, Suburban

No dental professionals reported that their practice charged patients for transferring records when switching practices. However, the majority said there is rarely a need to transfer records across practices because they can get all the information they need during initial examinations. Dental professionals said they would only request previous records if a patient had recently had an X-ray, scan, or specialist treatment, and wanted to know the contact details of the dental professional who carried it out. Otherwise, dental professionals were clear that patients could request their records from their previous practice if they wished.

"The new patient exam is spent taking their medical history and talking through their dental history. We don't probe into every single thing they've ever got done. When we look in their mouth, we see what we need to see, and that tells us the history. But we'll ask about any relevant past experiences, other dentists that we should be aware of before we start treatment."
Dentist, Independent, Mixed, Northern Ireland, Suburban

"Do you need somebody else's notes? You're going to start fresh anyway. You're going to have a good look yourself…And you may not necessarily agree with the previous plan that somebody may have. It's a new patient…There are certain times where I would ask for records…like if they've had an OPG taken…[Or] If they've had specialist treatment or seen somebody for implants."
Dentist, SMDG, Mixed, England, Urban

"Dental records don't get passed around like medical records. If a new patient comes to us, they start off as a brand new patient. If they've been to a practice recently and have had x-rays taken, we will ask them for the name of the practice, and we'll contact them for their x-rays, mainly just to try and reduce radiation."
Dental therapist, Private only, Wales, Rural

There were specific cases where patients leaving the practice could cause some difficulties

A small number of dental professionals described some difficulties when patients on a dental plan wanted to leave the practice. Further detail can be found in the market conduct section.

A few dental professionals described cases where there was some friction for patients leaving mid-treatment due to complications over fees. One dental professional described having to claim back a deposit after lab fees had already been incurred, whilst others described issuing refunds where a patient had already paid the full treatment cost upfront.

"They can leave. At the end of the day, everyone's got free will… Let's say you've paid a deposit onto a treatment and halfway through the treatment you decided to stop, your deposit will be claimed because that's still our clinical time… especially if there's any lab fees associated. I've had patients in the past where they opted for private work where there's lab fees and halfway through they changed their mind, they don't want it anymore. But I'm still getting a lab fee, so they have to pay for that lab fee."
Dentist, FLDG, Mixed, Wales, Suburban

"It might be a challenge to find someone to take over the treatment. I wouldn't have a problem with them doing that, but it just may overly complicate their treatment going forward. That's all. But no, I'm happy if somebody wanted to [leave]. I'd have to arrange and work out some sort of payment system for them to get a refund if they paid upfront, or a partial refund."
Dentist, Independent, Private only, Wales, Suburban

5.1.8 Dental professionals generally did not perceive their practice to be in competition with other local practices

Among those who spoke about a lack of local competition, this was either because they were located in a high-demand area, particularly for those where their practice was the only one accepting new NHS patients, or because they were in a suburban or rural area with lower numbers of nearby practices.

"There's no other dental practices within 10 miles or more…Because we're the only dentist in quite a large area, we would get wider towns coming to us a lot…So it's quite a mix of patients."
Dentist, Independent, Mixed, Northern Ireland, Rural

A small number of dental professionals said they were not worried about competition because they believed the quality of their services was better than that of other dental practices in the local area.

"I don't know what they do. I don't honestly care. They would, from hearing from everybody, you might find that they would do an awful lot less work, charge an awful lot more. But you would get an appointment with them next week, whereas I'm booking into February."
Dentist, Independent, Mixed, Northern Ireland, Rural

Only a small number of dental professionals said that their practice was in direct competition with other practices in their local area. The majority of these were in urban areas where there were a high number of dental practices.

5.2 Treatment options, consent and costs

Treatment options, consent and cost were closely linked in how they were communicated to patients. In many cases, all three were communicated simultaneously, and dental professionals did not always distinguish clearly between them as they would not present them separately in practice. However, these categories have been separated below for clarity.



Treatment options Consent Costs

5.2.1 Treatment options were typically discussed during consultations

Most dental professionals reported that treatment options were explained verbally by dentists during appointments, often accompanied by lists of available options for patients to look through during appointments, or printed treatment plans for patients to take home.

> *"I always discuss all the options. No active treatment and risks and benefits. Direct restoration, risks and benefits. Seek a second opinion, another GDP or private or NHS. And I explain that will take a bit longer and postpone treatment. But I include everything on this case. I didn't offer indirect because it was not appropriate."*
> **Dentist, Independent, Private only, England, Urban**

Many dental professionals described more general information about available treatment options being provided through websites, social media, reception staff, posters and printed materials. Personalised treatment options were provided following initial appointments through treatment plans, follow up appointments, or treatment coordinators.

> *"I know on the website it gives the list a breakdown of all of the treatments and how much they are."*
> **Dentist, Independent, Mixed, Northern Ireland, Suburban**

> *"The principal, she does a lot more aesthetic and [clear aligner brand] and things like that. She has an Instagram page for that, where she just puts pictures up for her aesthetic work."*
> **Dentist, Independent, Private only, Wales, Suburban**

> *"We've got pricing leaflets and things like that. And then obviously, the clinicians discuss them as well... We've got NHS prices displayed. We've got the private prices displayed. We've got the plans displayed as well."*
> **Dentist, SMDG, Mixed, Wales, Rural**

> *"If it's an option between maybe crowning or putting an onlay or trying to put composite in, then they would have the option to speak to [the treatment coordinator] and she would be able to explain to them in much more detail the different options of treatment that has been recommended."*
> **Dental therapist, Independent, Private only, Wales, Rural**

Dental professionals were clear that they felt patients understood the treatment they agreed to. The majority of dentists reported limited use of some specific branding terminology when presenting options to patients, such as 'smile makeovers', but few reflected on any problems use of different labels for treatment may cause for patients.

> *"Our clientele would probably see straight through that [terminology]."*
> **Specialist, Independent, Private only, England, Suburban**

> *"We call things by their clinical names like aligner therapy or composite bonding… the only branding you would see as a patient are probably [dental plan provider] and [clear aligner brand], and our own brand."*
> **Dentist, Independent, Mixed, Northern Ireland, Suburban**

However, several dentists from across all practice types were using various branding and labelling for their services, including in promotional material and 'open evenings' for patients. Sometimes, this was related to specific brands they offered, such as clear aligner brands. A few highlighted that, while the practice offered 'smile makeovers' they would not use that terminology themselves.

> *"We do them, but we don't advertise them. If somebody asks me about a smile makeover, then I'll chat about it. I don't say 'who wants a smile makeover, come and see me', we don't do that. We are busy enough. [FLDG name] probably want us to, but we all do our own thing."*
> **Dentist, FLDG, Mixed, Scotland, Suburban**

> *"It was mainly a 'smile makeover', I suppose is what you call it, or something along those lines… We don't promote [smile makeovers] as a specific treatment."*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

> *"I suppose we use those words… we've got digital boards in the waiting room, and when people come through, they'll ask what that means."*
> **Specialist, Independent, Mixed, Scotland, Rural**

Dentists were primarily responsible for discussing treatment options. Several specialists and DCPs described the treatment options as having already been decided with the dentist before they themselves saw the patient, so they were less involved in presenting initial options.

> *"It was very much, this [is] the referral. You've been referred to me for extractions. Happy to go ahead. Here's the consent. Yeah, let's take the teeth out… The extractions were part of the orthodontic plan, so they might have a wider orthodontic plan, and then my little bit would be as part of that."*
> **Specialist, Independent, Private only, England, Suburban**

> *"Well, her treatment plan would have been of sorted out with the dentist. She would have been coming in for two visits, cleanings and oral hygiene instructions for her… They would have given her that treatment option plan."*
> **Dental hygienist, LDG, Private only, Northern Ireland, Rural**

The degree to which treatment coordinators were involved in presenting treatment options to patients varied. Some were clear that they could discuss treatment options directly with patients, while others explained that their remit was limited to what had been presented by dental professionals during consultations, with their role being to answer any questions about proposed or agreed treatment plans.

> *"When the patients come in, they come up with a treatment plan [with the orthodontist], then once you've got a treatment plan, I would discuss all the different options they have available to them."*
> **Treatment coordinator, Independent, Mixed, Wales, Rural**

> *"I'm the middle person. If a patient says they want to know their options about anything, they would come to me."*
> **Treatment coordinator, FLDG, Mixed, Wales, Rural**

> *"I reiterated what the dentist [said]. Sometimes it's a lot to take in on the initial consult, and they sort of rely on a nurse or a treatment coordinator just to clarify things and just give a bit more detail that maybe was not available in the appointment time. So I did discuss the treatment options again after the consult."*
> **Treatment coordinator, FLDG, Mixed, Northern Ireland, Urban**



5.2.2 Most dental professionals reported that patients were given time to consider cosmetic and non-urgent treatment options

The majority said patients always had the option to go home and consider clinical non-urgent or cosmetic treatment options before starting. However, a number also reported that patients had already decided what treatment they wanted before or during the initial appointment.

"I don't do treatment on the same day normally. They take things home, take time to think, consider all the options, again, risks and benefits."
Dentist, Independent, Private only, England, Urban

"The older I've got, the less I've been inclined to convince somebody to have the treatment there and then when it comes to surgical extractions. But it does mean extra time. And you might say, well, how do you then get that money back for the extra time you've spent? Well, that's very much one of the things that you've got to think about."
Specialist, Locum, Private only, Wales

"She came in and said she wanted [clear aligner brand], so I didn't really discuss the alternatives because she's not interested in fixed appliances."
Specialist, LDG, Mixed, Scotland, Suburban

Dentists reported there was no equivalent cooling off period for clinical urgent treatment.

"In an emergency case like that, you can't, unless you're going to send them away and get them back the next day or something, you can't really give them too much time."
Dentist, SMDG, Mixed, Scotland, Rural

"Huge facial swelling, like I've not seen in 10 years since university…And instantly I knew this was a possible life-threatening situation. And so yeah, I just got her in straight away. Told the patient that was in the chair that I'm sorry, I have to cut the consultation short and got the patient in, assessed the swelling, called the hospital."
Dentist, FLDG, Mixed, England, Suburban

Dental professionals rarely mentioned a second opinion in the cases discussed

Few dental professionals described cases where patients sought a second opinion. Dental professionals explained that patients were often eager to begin treatment as soon as possible, particularly for more painful clinical cases, and so were unlikely to delay this by seeking a second opinion. Similarly, where there was only one clear treatment option, dental professionals explained that patients didn't view a second opinion as necessary.

"If somebody wants time to think about a treatment, They're welcome to it. You know, if they want a second opinion, that's fine. I'd rather they have time to think about it than feel rushed into a decision that they later regret, because again, it'll come back to haunt us…he [this patient] wanted it sorted. He said, that's fine, can you do it now?"
Dentist, LDG, Mixed, Wales, Rural

"No [second opinion]. I think she realised that there wasn't an alternative treatment, the teeth needed to be taken out."
Dentist, Independent, Private only, England, Urban

"I think I was her second opinion. I think she'd already spoke to someone about it in the past…I think she just, she felt more comfortable with me."
Dental therapist, Independent, Mixed, Scotland, Suburban

Among dental professionals who did discuss a second opinion as part of the treatment journey, there was a relatively even spread across nations, geographies, and practice types. However, among this small sample, it is worth noting that the majority were discussing a cosmetic treatment.

5.2.3 A small minority of dental professionals described cases where they referred onwards for further treatment

As dental professionals were asked to reflect on their most recent case example, only a small number reported they made or actively considered an onward referral. These were typically due to the patient requiring specialist treatment that the dental professional themselves were not equipped to provide.

> *"I'm not a gum specialist, but I'm a dentist within a general area that can still do what I can do to this level to try and stabilise your condition. However, in [this] instance, which I said at the time, it would be wise to consider me referring to either the dental hospital or to a private specialist periodontist within the area because their disease is quite advanced and progressive."*
> **Dentist, LDG, Mixed, Scotland, Urban**

> *"We discussed treatment options of possible root canal treatment with either us or a private specialist, and we give differing success rates. With us, it would be around 60-70% [success], but with a private specialist, it would be around 95% [success]… the patient was interested in a referral, which I also encouraged because it [was] a front tooth, so I put a referral through to a practice that I usually refer my root canals to… I also said they were welcome to look around for a specialist herself, if they would like to do that."*
> **Dentist, SMDG, Mixed, England, Urban**

In some instances, referral partners were chosen based on informal or existing relationships, whereas others described in-house referrals.

> *"That's a very much symbiotic relationship, if there's colleagues in the practise who are referring teeth for extraction that then need implants to you, that's very much a give and take."*
> **Specialist, Locum, Private only, Wales, Multiple areas**

> *"I don't tend to do physical referrals. I tend to say to my colleague who does implants, oh, this patient needs an implant, I'll book it in with the [treatment coordinator]."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

> *"You can basically choose who you like. I think it goes on if you know them as a clinician, you know their work is good, then that's who you'd naturally refer your patient to. They always have a choice to do their own research and go elsewhere."*
> **Dentist, Independent, Private only, Wales, Rural**

5.2.4 Several dental professionals said there were often a limited number of clinically appropriate treatment options

Particularly within urgent clinical practice, dental professionals reported that there were often few options for patients to consider, due to only a small number of treatment options being clinically appropriate.

> *"There aren't too many options with these ones. He hasn't got that much choice, just because of the nature of the cavities. I wouldn't be pursuing crowns or, I mean, there's obviously the option of having the teeth extracted, but between us, we wouldn't want to take teeth out needlessly. So yeah, fillings in this case were pretty much a done deal."*
> **Dentist, Independent, Mixed, Wales, Urban**

> *"There was no option today. The teeth had to be removed. You know, we had discussed that before. We had said it was likely the teeth would have to be removed. He was totally prepared for that. He was happy."*
> **Dentist, LDG, Mixed, Wales, Rural**

Several dental professionals also said that doing nothing was always an option, for both cosmetic and clinical cases. However, many of these dental professionals felt this was not advisable for clinical cases, as it could cause complications for the patient later on.

> *"You always say to a patient we can do nothing, but when they're in pain, they're not usually going to grab that option."*
> **Dentist, LDG, Mixed, England, Suburban**

> *"Well, the other option was she could do nothing, which is always an option. In which case the filling might fail, she might get infection, or if the tooth weakens and breaks, then she might lose the tooth. So not doing treatment's always an option."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

A few specialists in particular described limited options once patients reached them, particularly when referrals were made for a specific treatment. For example, one periodontist described that, for patients with severe gum disease who are referred to a periodontist, the only viable course of preventative treatment was antibiotics.

> *"Treatment basically was going to involve two appointments for deep cleaning, followed by systemic antibiotics…The only alternative really is either you don't do it, and you let it progress."*
> **Specialist, Independent, Private only, Northern Ireland, Urban**

Similarly, an oral surgeon specialist described a case where a patient had been referred to him as an emergency after a general dentist attempted to extract an upper molar but failed, with the root ending up displaced into the patient's sinus. He explained that, given the risk of the situation worsening, there was effectively only one viable course of action.

> *"Do the surgery and prevent a hospital stay or don't do the surgery and go to the hospital. So it was a fairly easy decision. It wasn't a long conversation."*
> **Specialist, Independent, Mixed, Scotland, Urban**

However, there were often a broader range of treatment options for cosmetic cases, as being for aesthetic purposes, there were generally more options that patients could choose between. This included different treatments, brands, materials, and durability, often at different price points.

> *"We did definitely recommend changing the crown for her. She was fairly keen not to cut teeth, so we did decide on the composite bonding. I suggested then if she was doing composite bonding because the teeth underneath were fairly dark, it's always useful to try and bleach them first."*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

> *"We discussed keeping the teeth in their position they're in and maybe just using a little bit of composite or veneers to just align them... But he didn't want to cover his own teeth... we discussed just repositioning the front two teeth that had moved, using [clear aligner brand] and then trying to whiten them and just using his own teeth to just improve the appearance of his own natural teeth."*
> **Dentist, SMDG, Mixed, Scotland, Suburban**



5.2.5 A substantial minority of dental professionals reported their practices having treatment coordinators who helped communicate treatment options to patients

Several dental professionals reported having treatment coordinators within their practices, often as a distinct job role or sometimes combined with another role, such as a dental nurse or practice manager. Treatment coordinators were present across all practice types, and did not vary much by nation.

Treatment coordinators would talk through treatment plans with patients, answer questions about what was involved and the associated costs, help plan and schedule appointments, as well as checking patients had the information they needed to make an informed decision. Most dental professionals did not mention providing clinical advice as part of the treatment coordinator's role, with a small number explicitly emphasising this point.

> *"So their [treatment coordinators'] job is to discuss the treatment and any worries that they [patients] don't think to ask me at the time of us chatting, then to facilitate the appointments in the diary to make sure it's right, to make sure the finances are in place that they need or that the patients are aware and informed of what money they're looking at to have to be able to spend at the appointment."*
> **Dentist, Independent, Private only, Northern Ireland, Urban**

> *"Well, they're not clinical, so they shouldn't really do that [advise on treatments]. So again, you hear on the grapevine that there are some practices that the treatment coordinator is a car salesman effectively, and they're there to bump up numbers. But I'm quite clear on all of my treatment plans that they are not there to do that, you know? Otherwise, what's the bloody point of seeing a dentist?"*
> **Specialist, Independent, Private only, Wales, Suburban**

Among dental professionals whose practice did not have a treatment coordinator, one said they had considered introducing the role as a way to offer treatment options more systematically and to focus their own clinical time on assessment and treatments, rather than providing information.

"Maybe they just need to work more on having a treatment coordinator for someone to discuss more with the patient… someone that has marketing skills to help follow up with the patient with bigger treatment so they can make sure that they book them back and then they come to do the treatment… [The benefit is] the patient will come and do treatment that you have planned for them for sure, and then it will increase the income."
Dentist, SMDG, Private only, Wales, Urban



5.2.6 Most dental professionals said they explained the pros and cons of different treatment options to guide decisions without recommending specific treatments

For cases where there were multiple feasible treatment options, many dental professionals said they described the pros and cons of each option to ensure the patient had all the options laid out for them and to enable patients to make an informed decision. Several dental professionals reported that they do not 'recommend' specific treatment options, but would still advise on what they thought the best option was in scenarios where there was a clear best course of treatment on clinical grounds.

"I don't recommend. I just tell them the options, risks and benefits, and they make a decision."
Dentist, Independent, Mixed, England, Urban

"I never really recommend, to be honest, I just explained root canal or extraction… it depends on the patient really, if they're young, I steer them towards keeping it [the tooth]. If it's compromised in other ways, I'll try and say it's probably not worth them having a root canal."
Dentist, Independent, Mixed, Wales, Suburban

"I don't recommend as such because they've got to make their own choice, but probably, in the way I'm describing things to them, I probably would have suggested to him that we attempted at least to repair and save the tooth."
Dentist, LDG, Mixed, England, Suburban

A small number of dental professionals reported that patients directly asked them what they would choose for themselves. In these cases, some dental professionals said they used phrases such as 'if it were my family' or 'if it were me' in order to guide the patient's decision.

"I can start with your gold standard treatment option, but it's also the most expensive one. You're saying all the things that you would, that I would do. I assume people would take that as, this is what I would pick."
Dentist, SMDG, Mixed, Scotland, Rural

"My classic line would be, if you were my brother or you were my father, this is what I would do for you. So take from that what you will."
Dentist, Independent, Mixed, Scotland, Rural

Where there was not a clinically preferable option – for example, in cosmetic cases – dental professionals described discussing trade-offs, including appearance, durability, complexity of treatment, and cost, when going through options with patients.

"I always say to my patients, look, there's three different costs with everything you do. There's the financial cost, the biological cost, and the mechanics or the longevity cost, in that you're always going to compromise on something."
Specialist, Independent, Private only, Wales, Suburban

"We can do the whitening, and then moving up from less invasive treatment to more invasive treatment and discussing obviously the long-term outcomes of it…composite bonding isn't permanent, so if that can maybe last on average around about five years and then whenever that starts to fail, part of the consent you need to inform them about, they may eventually need to go into something more direct like veneers or crowns."
Dentist, FLDG, Mixed, Northern Ireland, Urban

5.2.7 The majority of dental professionals described always taking a patient-first approach when advising on treatment

Dental professionals emphasised that they prioritised the patient's needs over financial considerations when discussing treatment options, primarily based on clinical need and urgency.

> *"We are following our clinical judgment… You know, as a clinician, of course, we are making sure that it's patient interest first. If you find a disease, we have to communicate that accordingly and give them all the treatment options."*
> **Dental therapist, Independent, Mixed, Scotland, Urban**

> *"You have to put patients first. You have to get them out of pain first. That's the principle. There are standards, there is protocol. You have to go with them, but you are ultimately guided by the patient's request."*
> **Dental hygienist, Independent, Private only, Wales, Rural**

Beyond clinical need, other considerations included treatment availability, waiting times, affordability, patient preferences, the expected longevity of treatment, follow-up requirements, and the patient's overall oral health and ability to maintain treatment outcomes.

> *"It's the situation of the tooth, the oral hygiene of the patient, how regularly they visit the dentist and how they take care of other teeth. If they have other conditions like paroxysms or anything else, the condition of other teeth, if they have other teeth missing, other teeth decayed or something like that. And for sure, the financial situation of the patient himself."*
> **Dentist, SMDG, Private only, Wales, Urban**

> *"If it's a patient I know very well, and I've been seeing them for many years, there are some patients who cope well with treatment. There are other patients who will do anything to avoid treatment, and you have to perhaps coax them into it. You know, there are… there's myriad reasons, really, in making a decision."*
> **Dentist, LDG, Mixed, England, Suburban**

Only a few dental professionals reported not discussing potential treatment options with patients; in these cases, dental professionals explained it was because they did not consider those options clinically appropriate for the individual patient, or because the options would not help the patient save their teeth.

> *"The only one I can think of is antibiotics, but I wouldn't offer that… I know it's a backup option if we can't do any of the other two options. But I won't lead with that or give it as an option because it's, it's not really first choice. So I'll only suggest that if we can't really do the others, or he's really reluctant."*
> **Dentist, Independent, Mixed, Wales, Suburban**

> *"She first came in because she wanted all her teeth removed and get full dentures, which obviously we wouldn't do that. She wanted to explore that option. She wanted to explore bridges, which wasn't an option. Her teeth were all healthy underneath. It was just the appearance of them didn't look well. We didn't really discuss dentures because that just wouldn't have ever happened. We'd never have taken them all out… I just don't think you can ethically take out perfect teeth."*
> **Dental nurse, Independent, Mixed, Northern Ireland, Urban**

5.2.8 Most dental professionals reported checking patient understanding before treatment

The majority of dental professionals reported checking patients' understanding verbally, both during consultations and immediately before treatment began. This included asking whether they understood the proposed treatment, what it involved, and whether they had any questions.

> *"I asked her again, do you fully understand what we're doing? Would you like to repeat it back to me? And then she'll repeat it back. And when they repeat it back, then I know it stuck, you know."*
> **Dentist, FLDG, Mixed, Wales, Suburban**

> *"We went at the end, I asked if [he] had any questions. He said, no, because we had quite a lengthy discussion. So we covered everything... I asked [him] several times. Does it make this make sense? Do you have any more questions? Is there anything else we can do?"*
> **Dentist, SMDG, Mixed, Scotland, Suburban**

> *"And then whenever it gets to the point that they have agreed they want to go ahead with it, there's like a 10- or 11-page consent form that goes out to them and they need to read each page, initial the bottom of each page, and then there's questions at the end that literally say, 'do you understand this?' And they have to circle yes or no under it so it's a full sort of content with that they do before we even get them in for their surgery."*
> **Dental nurse, Independent, Private only, Northern Ireland, Suburban**

Where dental professionals described patients asking questions, these most commonly related to questions about the treatment itself, such as whether it would be successful, what the process would be, how long it would take, and whether it would hurt. Other common questions that dental professionals reported patients asking included questions about treatment costs and follow-up care.

> *"They ask about what's the failure rate for this? Do you think this can be successful? How long it will take? They ask about the price."*
> **Dentist, SMDG, Private only, Wales, Urban**

> *"She asked questions more about the procedure than anything... she asked about the success rate…is the procedure different to the procedure that she had for the original root canal?"*
> **Dental nurse, SMDG, Mixed, Wales, Urban**

> *"I think when we talked about sort of long-term... they asked a few more questions around about that and what could be done if things sort of chip away and stuff, and how they could be repaired."*
> **Dentist, FLDG, Mixed, Northern Ireland, Urban**

5.2.9 Most dental professionals reported that costs were communicated verbally and in writing

While several dentists reported that initial consultation costs were given by reception when patients first contacted the practice, for treatment, most dentists described discussing costs themselves verbally with patients.

> *"When I say [the options], this is what we do. These are the pros and cons and risk, and this is the cost. And then I move on to the next one, and I discuss it with the cost… when they decide, we give them a written estimate and they sign it."*
> **Dentist, SMDG, Private only, Wales, Urban**

> *"It's before any planned treatment, they do sign a written estimate, but not before emergencies. Usually we just do that verbally because we don't always know. So for example, in some cases, if it was an emergency appointment and he needed the tooth out or something like that, that would not all be covered by the plan. So then we'd verbally tell them, this is how much it would cost to have the tooth out. This is how much it would cost to do this... And we don't really get them to then sign it, but we just do it verbally."*
> **Dentist, Independent, Private only, Wales, Suburban**

Treatment plans that included detailed cost breakdowns and the treatment options, were given to patients at the end of the consultation or shortly after.

> *"It would be discussed in the room. But the treatment plan and the costs associated will always be sent to reception so that they can make sure the patient signs to confirm they've seen it."*
> **Dental nurse, LDG, Mixed, Scotland, Rural**

Only a small number of dental professionals described not discussing costs themselves, focusing instead on clinical options available to the patient. In these cases, other staff members at the practice would discuss costs with patients.

> *"So I don't discuss [payment options], that's not my job, especially working in a corporate. We direct them to a treatment coordinator that works for the practice, so they discuss the options."*
> **Specialist, FLDG, Mixed, England, Urban**

Of the four treatment coordinators interviews, all described speaking through costs and payment options as an integral part of their role, often being a touchpoint for patients to ask questions about the financial side of treatment.

> *"I would tell them the price and give them a breakdown of the different ways they could pay for it. We offer an in-house financial option, we also have external finance options. There's a few ways they could pay for it, so I just discuss with them and I give them an information leaflet and everything we discussed."*
> **Treatment coordinator, Independent, Mixed, Wales, Rural**

> *"As a treatment coordinator, [my role] would be discussing finance with patients."*
> **Treatment coordinator, FLDG, Northern Ireland, Urban**

A small number of dental professionals reported that where care was covered by a dental plan, treatment costs were not routinely discussed. In these cases, dental professionals assumed that patients already understood what was included, based on earlier conversations and transparency about prices and discounts within the plan, or information provided online or directly by the plan provider.

> *"They get emails from us, emails from [dental plan provider], everything that's covered and not. There's information on our website, there's people to talk to. We have a [dental plan provider] champion who is able to explain it all to them."*
> **Specialist, Independent, Private only, Northern Ireland, Suburban**

> *"As he was a dental plan patient, money didn't really come into it, so there was no cost implication to him… They pay a monthly fee and it covers all their treatment apart from cosmetic work."*
> **Dentist, LDG, Mixed, England, Suburban**

Whether costs were discussed sometimes depended on prior conversations and professional roles

A small group of specialists and dental care professionals reported that discussing costs was not part of their role, as patients had typically already received pricing information and consented to treatment before being referred to these dental professionals. In some cases, for example for specialist appointments, patients had already paid deposits before seeing the specialist.

> *"So, most of these patients, when they see me, they already have a signed treatment plan in place. If they don't, then I might get them to sign a treatment plan. But if I'm honest, most of that's done at the time of consent, and they pay a deposit. So before they even get an appointment, most of these patients would have paid a deposit to be actually booked in."*
> **Specialist, Independent, Private only, England, Suburban**

A small number of specialists described providing patients with an information pack including costs ahead of treatment starting.

> *"They get sent a pre-pack of information beforehand… we will always send that to patients before they come for treatment, usually by email… we give them like a basic cost. So we say like root canal treatment can range from £500 to £700 and an additional 25% on top. We write that in the letter, but they're told the cost of consultation."*
> **Specialist, Independent, Private only, Wales, Urban**

5.2.10 Most dental professionals reported that treatment costs remained as initially agreed

The majority of dental professionals reported that costs did not change throughout the course of treatment in the cases spoken about, and few dental professionals described adding unexpected costs. Several emphasised the importance of maintaining patient trust by avoiding additional costs, or by overestimating rather than underestimating costs during initial appointments so patients were aware of the maximum they would pay.

> *"I try to avoid [additional costs]. I try to avoid patient dissatisfaction. I try to always aim to stick to [treatment plans]. It's better to overquote isn't it, than underquote. It's always best to over deliver [for] them."*
> **Dentist (owner), Independent, Mixed, England, Suburban**

> *"You start with the kind of the max it could be, but actually throughout the treatment or throughout the treatment plan decisions, it might actually be lower depending on their mouth and preferences, but you give the maximum."*
> **Specialist, Independent, Mixed, Northern Ireland, Urban**

A small number of dental professionals described carrying out additional treatment that had not been included in the original treatment plan, but chose not to charge extra, feeling the initial fee was sufficient overall for their time.

> *"No, there usually would be [additional costs], but I didn't choose to execute those costs. So like I said, I would normally have a consultation fee, but I didn't feel like it was necessary at that point because I'd already seen her on the previous Friday and knew the scenario. You know, like I said, everyone operates on their own little business. In my head, you charge for time… in that specific scenario, the fees were adequate for the job that needed to be done."*
> **Dentist, FLDG, Mixed, England, Suburban**

> *"There were things added, but we didn't charge for them. Just because we'd already given her an estimate and we'd explained that. It was when we were taking off one of the veneers, there was decay under one of the veneers. So we had to do quite a lot of work to one of the teeth and make a fit, like get a filling placed underneath. But it was fine. And the dentist didn't charge for that."*
> **Dental nurse, Independent, Mixed, Northern Ireland, Urban**

Of the small number of dental professionals who said there could be situations where additional treatment requiring extra charges arose, they would discuss this with the patient and issue a revised treatment plan before proceeding.

> *"Raising [costs] if they're more complex, something like, what was a small filling on a tooth, but it then just goes deeper, deeper and deeper, and there's more work to do on it. Then you just inform the patient, look, actually there's more, I have to put more layers in to protect your tooth, so then there's going to be this additional charge."*
> **Dentist, FLDG, Mixed, England, Urban**

5.2.11 Treatment costs were referred to as both 'estimates' and 'exacts' by most dental professionals

A similar number of dental professionals said they presented costs to patients as an estimate or as an exact figure. Where a reason was given for using an estimate, this was most commonly because the final cost depended on something not yet known, such as lab costs, or how much work would be needed once treatment began.

> *"We never give quotes. We always give estimates… If we do the treatment in the estimate, the price is fixed, but if it turns out we need to do something else, the cost could change."*
> **Dentist (owner), Independent, Mixed, Wales, Suburban**

> *"We'll send out an actual estimate for the patient so they know the costs involved in the treatment as well."*
> **Dental therapist, Independent, Mixed, Scotland, Urban**

> *"I said roughly cost, I wouldn't know 'til the assessment, until the lab got back."*
> **Dentist (owner), Independent, Mixed, Northern Ireland, Rural**

Managing patient expectations and avoiding complaints were some of the key reasons why dental professionals gave exact costs.

> *"You don't want them to turn around later, 'I didn't know this, I didn't know that'. And it's best to be upfront with people... because nobody wants complaints and arguments, especially when it comes to money. You've got to be upfront."*
> **Dentist (owner), Independent, Mixed, England, Suburban**

Rather than an estimate that could move in either direction, a small number of dental professionals specifically said they gave patients a maximum figure so the patient would never be charged more than that amount.

> *"We try to give absolutes… it will never be more than X."*
> **Specialist (owner), Independent, Mixed, Northern Ireland, Urban**

A small number of dental professionals described a single flat fee for common, routine treatments and, most often, emergency appointments rather than an estimate or itemised cost.

"We have a flat fee for an emergency appointment that covers the vast majority of the things that people come in with."
Dentist (owner), Independent, Mixed, Scotland, Urban

"If I know for a fact, say if they're coming back for like a buccal composite or something, if I'm 100% sure it's only going to be that, the cost would be exact. Now, I appreciate sometimes when you're actually treating or actually working on a tooth, sometimes something could change. If I've told a patient it would be that, it stays at that, that's on me to absorb that. Usually I do try to give exact costs, usually."
Dentist, SMDG, Mixed, Northern Ireland, Suburban

Some dental professionals described a two-stage approach: an estimate first, then an exact cost once the treatment plan was confirmed

A number of dental professionals across nations and practice types described giving a rough estimate early in the consultation, followed by a written, itemised, exact cost once the full treatment plan had been finalised.

"They get a printed treatment plan when they're going out the door and they are advised that it might change slightly if you have to do an extra surface on a filling or something like that."
Dentist, Independent, Mixed, Northern Ireland, Rural

"They see the treatment coordinator first, who sometimes gives them an idea of the pricing. Then they come to see me for the full assessment. We discuss all of the options, make our plan, then I show them the costs, which sometimes is similar to what the treatment coordinator showed them. Sometimes it's a bit less."
Dentist, SMDG, Mixed, Scotland, Suburban



5.2.12 The majority of dental professionals reported discussing treatment costs before obtaining consent

Almost all dental professionals reported obtaining consent only after patients had been given the treatment cost. Roughly half of dental professionals described consent being obtained both verbally and in writing, with verbal-only consent notably more common for clinical urgent cases.

"Consent we do once they've thought about things and decided about what they're doing, that's when we discuss the treatment plan. When we're signing that [the treatment plan] and the risks, then the consent for the treatment [is signed] as well."
Dentist, SMDG, Mixed, Wales, Suburban

"He said he understood what I was doing and happy to proceed with everything. So I took that as consent."
Dental therapist, LDG, Private only, Wales, Rural

Many dental professionals described patients signing the treatment plan to confirm they understood the proposed treatment and associated costs; this was reported across all four nations.

"Before any treatment is done, the patient is given a written treatment plan, which they sign. So if there are a range of options, then the cost of different options are given. So patients are always aware of the cost of any treatment before they have it."
Dentist, Independent, Private only, England, Urban

"I would always make sure there's a printed estimate given and signed. And then usually if they're in for treatment, say if it's composite bonding, it's usually one long treatment. So we'll just maybe check with them that they're okay to move forward on the day of the treatment."
Dentist, LDG, Mixed, Northern Ireland, Urban

A small number of dental professionals reported obtaining initial consent before treatment costs had been finalised. In these cases, patients first consented based on an estimated cost, before providing further consent once a detailed treatment plan and final cost breakdown had been agreed.

"So obviously you've verbal consent to get the assessment done, and once the assessment's done, then you get written consent from them, the email, to go ahead with the course of treatment."
Dentist, Independent, Mixed, Northern Ireland, Rural

6. Market conduct

This chapter includes reflections on market conduct in dental practice, including:

- How prices for treatment were set, adjusted, and made available to patients.
- How dental plans were offered, promoted, and discussed with patients, including patients' experiences of leaving them.
- Where practices have set targets for dental care professionals and the software and systems used to track performance.
- The presence of softer pressures and financial incentives within practices.

Key findings

- For **independent** practices, prices were typically decided at a practice level, but those in **small to mid size or large dental groups,** prices were often determined by the dental group. Dental professionals often reported a degree of flexibility to adjust prices, but instances of fixed prices on practice software were heard across practice types.
- Prices were widely reported to be publicly available, although a small number, more concentrated in **Scotland,** reported their prices were not publicly available.
- The majority of practices offered a dental plan, usually provided by an external organisation. A minority of practices did not offer a plan, the majority of which were serving an **urban** catchment, although reasons for not offering a plan varied between practices. Plans differed between practices, but dental professionals working in **rural** practices reported offering tiered plans more often than urban or suburban practices.
- Dental professionals reported discussing plan options with patients, but there were often multiple members of staff who were able to speak to patients about plan options. A few dental professionals said they referred patients on to other members of staff to discuss plans.
- Dental professionals were often aware of their practice software recording their activity and income levels, but reported it to have no bearing on their clinical decisions.
- While most dental professionals working at **independent practices** did not report formal targets, targets were more commonly reported by dental professionals in **small to mid size and large dental groups.** However, across all practice types, there were few reported consequences for missing them.
- Most dental professionals also reported no informal expectations around offering private and cosmetic treatment at their practice, although a few were expected to raise these as options during consultations.
- Being self-employed associates, most financial incentives reported by dental professionals were built into their payment models, taking a percentage of the treatments they completed, rather than delivered as separate bonus schemes. This was also not reported to influence their clinical decision making.

6.1 How prices are set and by whom

6.1.1 Most independent dental professionals in the sample reported that prices were determined at practice level

Most dental professionals reported that prices were set within the practice by the owner or principal dentist, sometimes in conversation with the practice manager. These dental professionals were primarily working at independent practices, and many of them said they were able to feed into pricing decisions, either informally by raising it with the owner, or with other dental professionals at practice meetings.

> *"It's normally decided by the practice owners, and they will normally come up with a list of prices that they think are justified to charge patients."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

While a few dental professionals did not have sight of exactly how prices were decided, when dental professionals were aware of how pricing decisions were made, they often described considering practice overheads, laboratory costs, equipment, materials, staff costs, and benchmarking against other local practices.

> "*We do look at costings elsewhere, we want to be fair. We don't want to be overcharging and things. And I think that, I like to sleep at night.*"
> **Specialist (owner), Independent, Mixed, Wales, Urban**

> *"The prices are decided based on the cost of providing the service to the patient, the time it will take and the materials cost and the running cost of the business. We know what it costs us to have a surgery open and running and staffed. And then we go from there."*
> **Dentist (owner), Independent, Mixed, Scotland, Urban**

Prices for dental groups were commonly set at the dental group level

Most dental professionals working within small to mid size and larger dental groups, including FLDGs, reported that prices were determined centrally by the wider organisation for consistency across practices. Within these organisations, there were varying degrees of input that dentists and practices could have into pricing. For some, prices were reported to be issued and fixed by the dental group, whereas for others there was a wider process that involved input from individual practices.

> *"[Pricing decisions are] from higher up. That's the corporate that decides the prices."*
> **Dentist, FLDG, Mixed, Scotland, Urban**

> *"The pricing is generally decided by the company. We did have a say in it because us dentists thought the last price rise was excessive, because they were trying to bring in standardised pricing across the country... Our community is very different to the South East [of England]. And we did manage to persuade them to reduce the price rises."*
> **Dentist, LDG, Mixed, Wales, Rural**

> *"Senior management decide [prices], so they will probably be looking at prices in the area and then just matching that within reason."*
> **Dentist, SMDG, Private only, England, Urban**

6.1.2 Many dental professionals reported discretion to adjust individual charges

Although prices were largely decided by practice owners, managers, or dental groups, many dental professionals across practice types described having discretion to adjust charges on a case-by-case basis. Dental professionals reported considering various factors when adjusting the prices of treatment, including the complexity of the treatment, materials required, as well as the time the treatment would take. These prices could go up or down, depending on the case the dentist was treating.

> *"We have a standard price for a checkup and a scale and polish, and the x-rays. Those are set in stone for the patient, and then we have the starting price for fillings, extractions, and the more variable things like different types of crown… if somebody had six crowns, I might reduce the price by 10% across the board."*
> **Dentist, Independent, Private only, Wales, Suburban**

> *"We do have, as a practicing clinician, the discretion to increase the fee if we wanted to, depending on whatever reason we decide to go by, which I assume would be a good reason."*
> **Dentist, LDG, Mixed, Scotland, Rural**

> *"There's general costs that are on the system, but it's very much the dentist's discretion to adjust or amend as they see fit... [The owners] just say it's up to you what you want to cost, crack on and do it."*
> **Specialist, Independent, Private only, England, Urban**

In a few instances, dental professionals reported that software at practices contained default treatment pathways or charging options for patients. However, they largely reported that they were able to amend or override these default settings when they felt it was clinically appropriate to do so.

> *"I mean, the default is always NHS on the screen, and so you have to do a little bit more to actually get the cost of the privates and add them on, but it would never [stop me from doing it] it just takes a couple of extra seconds... so it can be [a bit of a hassle]."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

> *"The prices are all set in the computer. I can't adjust those prices. If something is simpler, I can go to the manager and say, 'It wasn't as much work as this should have been.' And they can adjust the prices. I can adjust the price up, but I'm not allowed to adjust the price down. But in all fairness, whenever I've said I want the price adjusted down, I've never had it refused."*
> **Dentist, LDG, Mixed, Wales, Rural**

A small group of dental professionals reported no flexibility to alter prices

A few dental professionals and dental care professionals reported that treatment fees were fixed within their practice management systems, or required sign-off from a practice manager to change. This was described across a range of practice types.

> *"When we charged the treatment, it automatically comes up onto the file, so it's not something that I would adjust or we don't want to adjust prices. It's just depending on the surface, the size, what you're doing. There's no hidden cost with us."*
> **Dental therapist, Independent, Mixed, Scotland, Urban**

> *"That's from higher up. That's the corporate that decides the prices."*
> **Dentist, FLDG, Mixed, Scotland, Urban**

There was some variation by nation. Dental professionals in England more frequently reported that they were unable to alter prices in comparison to other nations – with a majority of these dental professionals in England being the four largest dental groups.

> *"You can always raise prices, but you can't lower them as clinicians. To get them lowered, you have to go practice manager or that lady on reception."*
> **Dentist, FLDG, Mixed, England, Urban**

> *"I don't have the flexibility I wanted, to be able to say, okay, this is a kid I treated [a few] years ago, they didn't wear the retainers, this is going to take [a few] visits. They don't need to pay £3000 for that treatment…. I can't do that anymore [since joining FLDG]."*
> **Specialist, FLDG, Mixed, England, Urban**

6.1.3 Almost all practices made pricing information publicly available

Most dental professionals said that pricing information was publicly available and most commonly found on the practice website, displayed within the practice, or both. A small number said pricing was not publicly available at their practice.

> *"We have a price list up on our wall in reception, the waiting room area, and then the price list is on our website as well."*
> **Dental therapist, Independent, Private only, Wales, Rural**

> *"Not on the website, I don't think, but we have a price list up in the practice if anybody wants to have a look at that."*
> **Dentist, SMDG, Mixed, Northern Ireland, Rural**

Several dental professionals specified that the prices available were indicative or 'starting from' prices, since eventual costs were often case dependent.

> *"Although, of course, you know, every patient is different. Every treatment, I mean, I could be doing a filling on you and I could be doing a filling on somebody else, but the price could be different… I don't think private treatment [prices] are [available] because even the reception don't know how much it is going to cost… until and unless we've done a consultation, we really don't know."*
> **Dentist, SMDG, Mixed, Scotland, Rural**

Of the dental professionals who were specifically asked about the type of pricing available, the most common pattern for mixed practices was displaying private pay-as-you-go and dental plan prices, but not NHS prices. A similar amount said only pay-as-you-go were shown.

> *"All the prices are displayed, we've got NHS prices displayed, we've got the private prices displayed, we've got the plans displayed as well."*
> **Dentist, SMDG, Mixed, Wales, Rural**

> *"We have posters within the practice, so the patients often see the poster and say, oh, can we join the plan?"*
> **Dentist, SMDG, Mixed, Scotland, Suburban**

> *"The practise has a cost written down for private treatment... it's on a sheet that's laminated and stuck to the wall for everyone to see."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

Where a practice displayed only one type of pricing, this didn't necessarily mean it was the only payment option on offer. Of the practices that only displayed pay-as-you-go pricing, most also offered a dental plan and treated NHS patients. Reception and practice manager staff, rather than the public price list, were often described as the route by which a plan was actually promoted to patients.

> *"It's more for the practice manager and receptions [sic] to try and convert people to it."*
> **Dentist, SMDG, Mixed, England, Urban**

A small number of dental professionals did not think prices were publicly available

This spanned a mix of roles and practice types, though most were clear prices were still discussed or told to patients directly during consultations, rather than published for anyone to see in advance. Analysis across the nations in the sample also highlighted some differences in the public availability of prices. In Scotland, just over half of the dental professionals interviewed said pricing was public, compared to almost all the dental professionals interviewed in the other nations.

> *"They're available to our patients, but they're not publicly available. We don't put them on Facebook or advertise our prices… They're just in the surgeries."*
> **Dentist (owner), Independent, Mixed, Northern Ireland, Rural**

> *"Through the estimate, I would say they get to know what the prices are. We can just print out the estimate… I don't think there are any prices on the website, but they can check in the reception. They can check over [sic] the [treatment coordinator]."*
> **Dental therapist, SMDG, Private only, Scotland, Suburban**

> *"I've not been on our website, but I would doubt there's any strict pricing because you could say 'starting from' potentially, but when you see a patient, you don't really know… I find when it comes to dental, it's really hard to be able to give prices out like that because it can be very misleading. It's not fair."*
> **Dentist, LDG, Mixed, Scotland, Urban**

Researchers also verified whether prices were publicly available online prior to speaking to dental professionals. In a small number of cases, dental professionals believed their prices were available online when they were not.

6.2 Dental Plans

6.2.1 Most practices offered dental plans as a payment option to patients

Most practices had a dental plan option available to patients, most commonly through an external provider. A minority in the sample, across different practice types, offered their own dental plan.

> *"The practice has got their independent [dental] plan for recalls, so that means checkups, scan and polishes, basic x-rays are covered with a monthly fee… That's again fully independent and run in-house. Nothing external involved with that."*
> **Dentist, Independent, Private only, Wales, Suburban**

> "*There's [dental plan provider option]… covers you for all your routine treatment that's clinically necessary. It will not cover you for cosmetic treatment. And if you have a lab bill, so if you need, say, a crown or a denture, then you pay the laboratory's charge only... If you do [another dental plan provider option]… that is based on each practice individually, but in our practice you have 3 choices and it only covers patients' routine examination, routine x-rays, and as many hygienist visits as they want to put into their plans."*
> **Dentist, LDG, Mixed, England, Suburban**

A small number of practices did not offer a plan, which were primarily independent practices and smaller dental groups, and the majority of which were in urban locations. Several of these practices were offering specialist-only treatment, where the plan model was unsuitable for patients requiring one-off or a single course of treatment. However, a small number of independent and small to mid size dental group practices also did not offer a plan, feeling it was poor value or would shape the services they offered.

> *"We looked into [dental plans] a few years ago, but there's two reasons why we didn't. One, bad for the patient, there's another person in this to pay other than us. And then the other one was it wasn't great for us because sometimes you get tied into these plans and then they start getting more control over how you run your business… They can start dictating prices or things that you should be providing or things that you shouldn't be providing. Whereas whenever you're completely independent, somebody can come in, need a filling, which takes 2 minutes, and I wouldn't even bother charging them. But then whenever you get somebody else looking over your shoulder, then you might find that you have to charge them to make ends meet. So it reduces a degree of control, which I think is important."*
> **Dentist (owner), Independent, Mixed, Northern Ireland, Rural**

> *"No, [we don't have a dental plan], because we don't have any repeat customers."*
> **Specialist, Independent, Mixed, Scotland, Urban**

Plans were most commonly framed as maintenance plans, with some practices also offering more comprehensive cover

Most plans were described as maintenance plans, typically covering routine examinations and hygiene appointments. The number of these appointments included in the plan varied between practices, with several offering different 'tiers' of their dental plan to patients that offered more frequent checkups and cleans with a higher monthly payment. Rural practices offered tiered plans more often than suburban or urban practices.

> *"There's plan A, B, and C. A is one checkup, one cleaning [a year]. B is two checkups, two cleanings [a year]. And C is three. So it's just hygiene and examination. Obviously, that would include radiographs and basically anything that you would do on a general exam."*
> **Dentist, FLDG, Mixed, Wales, Suburban**

Many plans also included a discount, often between 10-20%, on additional treatment, such as fillings, root canal work, and crowns, that were not covered by the plan. When specified in interviews, dental professionals were divided on whether the discount extended to cosmetic treatment, with some excluding it and others including it within their dental plans.

> *"Patients pay monthly for their plan, and that gives them a discount on, like 10% discount, I think, on their treatment costs. And that covers all [other] practices. So if they were to come to us for more specialist*

treatments, like the specialist root canal, implants and cosmetic treatments, their 10% from the other practice covers the whole group."
Dentist, SMDG, Mixed, Wales, Suburban

"You either get your one checkup and your one hygiene in a year, or your 2 checkups, your 2 hygiene [appointments] in a year, and 10% discount on all treatment, except implants and cosmetic work. So, tooth whitening wouldn't be included in that, for instance, or any cosmetic veneers."
Dentist, Independent, Mixed, Wales, Rural

A small minority of dental professionals described their practice as also offering a more comprehensive 'full care' plan, covering all treatment. This was reported only at a handful of independent practices and one small to mid size dental group and were reported to be more costly for patients. In a few of these cases, 'full care' plans were not seen as good value for patients.

"Full care is where there's no cost of any treatment. So you've got your one checkup a year and your one hygiene and also full care, or like 2 checkups, 2 hygiene and full care. And that is like, if you break a tooth and you need a new filling, your filling's all included. The only thing that we would pay would be if there's any lab fees."
Dentist, SMDG, Mixed, Scotland, Rural

"We found that with the full care plan, patients were paying for treatment that we knew they're going to have, and they're also paying for treatment that they may or may not have. And it didn't seem fair that some people were paying quite a lot, just coming in for examination, scaling twice a year, paying the same as somebody who had a mouthful of fillings. So we decided to stop that scheme."
Dentist (owner), Independent, Mixed, Wales, Suburban

Of the dental professionals asked, the majority felt that dental plans offered good value for patients, as treatment worked out cheaper than paying as you go and made costs easier to budget for. This was particularly true for patients requiring more extensive or complex treatment, compared to those with minimal treatment needs.

"I think it's if you pay-as-you-go and pay for two checkups, hygiene appointments a year, I think it works out like £200 more expensive than if you're with the plan. Really, it is good."
Dental nurse, Independent, Mixed, Northern Ireland, Urban

"I find it helps patients with the budgeting. They know their band is X amount per month and that's what they pay. You do get a bit of a discount if you've got multiple people on there."
Dentist (owner), Independent, Private only, Wales, Urban

"I think the plan's excellent value, it spreads the cost of treatment. It's equivalent to the cost of just coming in and having it done, plus you get the discount and you get worldwide insurance."
Specialist (owner), SMDG, Private only, Scotland, Suburban

A small number of dental professionals disagreed, feeling plans over-charged patients or signed them on for treatment they did not really need, including multiple checkups for people with generally good oral health.

"I think [dental plan provider] is shockingly poor value for money... you get access to a certain amount of examinations and hygiene, which if you paid pay-as-you-go, I think would be either the same or just a slight… marginal, maybe single-digit figure discount from what I've calculated."
Dentist, FLDG, Mixed, England, Suburban

"So one of the reasons I've never provided plan is because I inherently disagree with it. It's like anything... the reason you [buy] a membership is because they obviously make more money off you... I've always been a believer in just pay for what you get."
Specialist, Independent, Private only, Wales, Suburban

"I just think patients think we're all greedy and a monthly fee to someone who's already greedy... Let me ask, apart from your gym, where else do you pay a monthly membership to?"
Dentist, Independent, Private only, Northern Ireland, Urban

6.2.2 Most dental plans were introduced during new patient appointments

Most dental professionals reported discussing dental plans during a patient's first consultation, as a way of presenting different payment options. A few dental professionals said they would not discuss dental plan options to patients before they had attended their new patient exam, to make sure they weren't signed up for an option they weren't suitable for.

> *"It's on our website, that we offer [plans]. And on the whole, it tends to be new patients who were offered them, and there's no pressure either way, to be honest. You can do what you like."*
> **Dentist, LDG, Mixed, England, Suburban**

> *"When they first have their checkup and they come back down to reception, [the receptionist] generally has a conversation with them whether they'd like to stay as a pay-as-you-go patient or if they'd like to join [dental plan provider option]. If they want to join [dental plan provider option], they generally join up on the day and we offer the 10% from that point."*
> **Dental therapist, Independent, Private only, Wales, Rural**

> *"At the end of a new patient consultation, I will ask them, 'Do you want to remain as a pay-as-you-go patient, in which case you'll pay for things as they crop up?' or 'Do you want to have a look at the [dental plan provider] options?'… I will normally, having asked whether they want information about dental plan, bring up the plans that we've got and then talk them through the 4 plans that they've got and explain that the care plans include no treatment but checkups and cleans and x-rays with a 10% discount on any treatment required. And we'll talk through the gold and the platinum plans, which cover varying degrees of treatment."*
> **Dentist, Independent, Private only, England, Rural**

A few dental professionals said they preferred to raise plans later in the appointment, once they had judged whether a patient would benefit from signing up to one.

> *"The associate would see them and make the decision as to whether or not that patient would benefit from having that plan in place. And then they'd probably go out to the practice manager to further discuss it and how they enrolled into it."*
> **Specialist, Independent, Private only, England, Suburban**

> *"Sometimes I would chat to new patients about [plans] if I deem that they're quite dentally stable. Practice plans are aimed at patients like that who only really require exams and cleanings to maintain their dental health, they don't have a high treatment need. I would talk to them about a practice plan."*
> **Dentist, Independent, Mixed, Northern Ireland, Suburban**

> *"At their new patient examination, the dentist briefly discusses [plans] because everybody is different, their needs. They always risk assess the patient, whether they need multiple visits in a year, for instance, for hygiene sessions or examination, or someone is extremely low risk, then of course they would need to be seen less frequently. They tailor the plan directly to the patient and then pass information on to our treatment coordinators."*
> **Dental therapist, Independent, Mixed, Scotland, Urban**

Multiple members of staff within practices were reported to be able to discuss dental plans with patients, with many dental professionals suggesting that reception staff, treatment coordinators, or practice managers were primary touchpoints for patients to speak about dental plan options. A few dental professionals said they would refer patients on for more detail, preferring not to discuss the plan options themselves.

> *"I think the practice, if they hit certain targets, they get paid more with [dental plan provider] etc. Obviously, clinicians don't get involved in that, but it's a practice thing. I think it's more for the practice manager and receptionists to try and convert people to it, say, 'Oh, by the way, [dental plan provider] is available, would you like to sign up for it?'. But from a clinician point of view, I don't get involved in that at all."*
> **Dentist, SMDG, Mixed, England, Urban**

> *"I never mentioned the plan, [patients] just ask me. But there's posters within the practice and I think when they see the treatment coordinator that she maybe gives them a leaflet as well about the plan. It's never forced upon anyone."*
> **Dentist, SMDG, Mixed, Scotland, Suburban**

> *"You just have to go back to TCO [treatment coordinator] and the TCO will explain the differences between both of them. And he has chosen the [practice's own] plan later to join the practice."*
> **Dental therapist, SMDG, Private only, Scotland, Suburban**

One dental professional described experiencing pressure relating to converting patients to their dental plan and offering private treatment.

> *"There is an expectation that there is more conversion to the [dental plan]… there's always a bit of pressure to convert, that's the truth in the dental [sector]: convert patients to a plan and do more private treatment."*
> **Specialist, Independent, Mixed, Northern Ireland, Rural**

Dental plans were promoted through a range of practice materials

Many dental professionals reported dental plans being promoted around the practice, for example through leaflets, signage inside the practice, or screens in waiting areas.

> *"We've got leaflets in the waiting room. We've got a big sign up in the waiting room. We also have a TV in the waiting room that says that we offer the plans and then the patients can ask about it when they're in surgery and they can get given a bit more of a detailed breakdown… and we can let you know what category you would fall into."*
> **Dental therapist, Independent, Mixed, Scotland, Suburban**

> *"It would be on our website with the 3-tiered list and the pros and cons and what's included in those offers. It would be verbally discussed over the phone if patients enquire, and it will be discussed in person, and leaflets will be given over the desk if patients come directly for face-to-face discussion of that."*
> **Dentist, Independent, Private only, Wales, Suburban**

A few dental professionals described general encouragement from management to discuss plans with patients, but without setting targets or expectations on staff. This included nudging dentists to discuss the plan in consultations, and one example of a small incentive payment offered to reception staff for each patient signed up to a plan.

> *"I'm rubbish, I rarely offer [the plan] to patients unless they ask for it. And reception, we are supposed to say, if we have a new private patient, mention it at that checkup. I often do, to be fair, especially if I am recommending the hygienist."*
> **Dentist, Independent, Mixed, Wales, Suburban**

> *"[Reception] have a number of plan patients I think they're trying to hit each month signing up. I don't think it's a hard target, I think it's more general encouragement. I think every plan patient a receptionist signs up, they get £5 for it, or something like that."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

6.2.3 Most dental professionals reported that dental plans were straightforward to cancel

Across the sample, most dental professionals said they had limited visibility of whether a patient had cancelled their plan, or the process to do so. When dental professionals were aware of cancellations and the process surrounding cancelling plans, they described little to no friction for patients to do so. Dental professionals believed patients could cancel their plans by calling the practice or logging in online.

> *"They can cancel their plan at any time… They can just change to pay-as-you-go, and they'll still be with us as a private patient. Or if they let us know they won't be coming back to us, then we'll sort of deactivate their record."*
> **Dental therapist, LDG, Private only, Wales, Rural**

> *"They must [cancel], I'm not sure. Not very often, unless they're moving away or something."*
> **Dentist, SMDG, Mixed, Scotland, Suburban**

> *"It's not difficult at all [to cancel]. Not at all. It just happens as soon as they say we're leaving, they can cancel their direct debit straight away. As long as they inform us that they're leaving, that's fine. But I haven't known of any who have actually given up their plan."*
> **Dentist, Independent, Private only, Northern Ireland, Urban**

Where plans were cancelled, the most common reason given was a patient moving away or to another practice, but there were few reported obstacles reported from dental professionals. This included leaving mid-treatment, or when patients had received more or less treatment that they had technically paid for. A few dental professionals said they would consider offering refunds when patients had not received their allocated treatment under the plan before cancelling.

> *"I suppose if they've not been for years but still paying in, we would have to have a chat with them about getting them some money back. But, if they'd been for one checkup instead of two that year, we wouldn't be initially offering any refund."*
> **Dentist, Independent, Private only, Wales, Suburban**

When this discrepancy resulted in patients having more appointments than they had technically paid for on the plan, several dental professionals said they would not seek payment from patients, even when this meant losing out on income.

> *"Well, we suck it up… we're not going to chase patients who've wanted to leave the practice."*
> **Specialist (owner), Independent, Private only, Northern Ireland, Suburban**

> *"You just make the loss, even if on [the dental plan provider] you've done quite a bit of treatment on them, say you've done 3 fillings on them – this is the swings and roundabouts in dentistry - and then the following month they cancel their direct debit."*
> **Dentist (owner), Independent, Private only, Wales, Urban**

However, a small minority of dental professionals discussed seeking payment for appointments patients received through dental plans that they subsequently cancelled. To combat this, a few practices had implemented conditions to their plan to prevent patients from signing up, taking advantage of 'free' or cheaper appointments early on in the plan, before cancelling.

> *"If [the cancellation of a dental plan] happens within 6 months [of them signing up], then they owe us for the full private cost minus what they've paid for the plan… which then we'll either ask them to pay or, I think on a couple rare occasions we've had to involve the debt collectors."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

> *"I know initially, because there wasn't a set term that some patients did try and do it so that they would get their checkup and hygiene and then they cancel their plan and then move elsewhere. So they're actually getting a big saving because they've cancelled it quite quickly, had their treatment… I think that's why they increased it to be three months that you were tied into, and then you were able to opt out just to cover the costs."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

6.3 Monitoring performance and targets

Key findings from 6.3.1-6.3.3 on the presence and impact of targets.



Dental professionals from across practice types were aware of monitoring systems in place at their practice, but often reported they rarely paid attention to them. Many believed this data was visible to practice management.



This monitoring enabled targets to be set, which was heard across practice types, and varied between more operational and more commercial targets. Reports of formal targets varied by practice type with Independent practices less likely to have them, while dental groups more often did.



Some reported targets in their practice related to ensuring dental professionals had full diaries, but there was no reported pressure for diaries to be filled with any particular case type (e.g. private, cosmetic, or NHS). This was the case across different practice types.



Very few dental professionals reported feeling pressured by the presence of monitoring or targets, and none said they felt it affected their clinical decisions-making.

Examples of formal targets in place at dental practices

While the majority of dental professionals reported there were no targets in place at their practice, the following examples were heard from a minority in the sample:

- NHS targets (relating to UDA)
- Private revenue and income targets
- Converting NHS to private patients
- Chair occupancy and operational targets
- Product related targets.

6.3.1 Most practices used software to record practice and clinician activity

Many dental professionals were aware that practice software collected data on a range of practice and clinician activity. This was reported across a wide spread of practice types and was consistently heard from dental professionals across all four nations. For some dental professionals, it was simply used to generate daily, weekly, or monthly income reports, whereas for others, software could be used to record specific measures across their practice, such as treatment activity and chair occupancy rates.

> *"I'm sure they can track what our turnovers are and… I can check my income for the day and stuff like that, it's on this dental software."*
> **Dentist, FLDG, Mixed, Northern Ireland, Urban**

Several dental professionals were unsure about the exact information that was collected but assumed that most activity undertaken within the practice was recorded through the software as part of their practice's general business administration.

> *"There are a couple of different software that the dental practices use, but I don't know what they use to track [performance]."*
> **Dentist, SMDG, Mixed, Northern Ireland, Rural**

> *"The software that they use is [dentistry software], and all of the sites use that. That gives a lot of information, a lot of data. I know they're on that a lot. I don't know what they use business-wise, but that tracks a lot."*
> **Dental therapist, LDG, Private only, Wales, Rural**

Many dental professionals believed that their recorded data was overseen by management at their practice

Most dental professionals who were aware of the recording of their activity believed the data was visible to practice owners or principal dentists, which was often seen as a routine part of practice activity.

> *"Don't get me wrong, I'm sure there is, with any business, background monitoring, but it's not shoved down my throat."*
> **Dentist, Independent, Private only, Scotland, Rural**

However, while this data was widely reported to be collected and visible to senior members of practices, only a few dental professionals described this as a form of performance monitoring.

> *"That's why you use your software, you can work out every minutia using your software, I've got access to that all the time, plus the business manager and your accountant. They can look at gross detail. Then you can pinpoint and run report, you know, chair occupation, revenue per patient… You have to be open and apparent because they're going to be look at this information themselves. You're not hiding anything."*
> **Dentist (owner), Independent, Mixed, England, Suburban**

In a few instances, the recording of clinician activity was shared more widely within the practice, for example through monthly reports or performance charts.

> *"I know they are privy to what the other dentists do… they know how many patients I see, what they're in for, and how much money is generated by me… It's all very transparent. You can all see everybody else's, what they do... the figures are read out at a practice meeting every month, so we're aware, but I don't see it."*
> **Dental hygienist, Independent, Private only, Wales, Rural**

> *"Sometimes they will help but actually, you're down here on a chart and most of your colleagues are up here."*
> **Dentist, FLDG, Mixed, England, Suburban**

However, even when data was known to be collected by the practice, this did not mean dental professionals were looking at it as part of their performance or paying close attention to their activity.

> *"I think it all just goes in the background. That wouldn't really be fed back to us. We would just be fed back maybe about patient satisfaction surveys and things like that."*
> **Dentist, FLDG, Mixed, Northern Ireland, Urban**

Dental professionals widely reported to be unaffected by the features of software in place at practices

Almost all dental professionals reported that they did not feel pressured or directed in their clinical decision-making by the software in place at practices, in relation to both the recording and tracking of their activity, and any way their systems presented treatment options.

> *"I don't get pressurised by [performance data] at all because… if you're self-employed, you always want to be busy and earn more as well. You want to see your numbers go up because you want to see that you've got patients and you haven't got empty spaces. But in private dentistry, it's the norm to have empty spaces, right?"*
> **Dentist, SMDG, Private only, England, Urban**

Only a very small minority of dental professionals reported feeling any pressure related to the tracking and monitoring of their clinical performance, but still felt this did not impact their clinical decision-making.

> *"We have appraisals and if I'm not doing enough private [treatment], it will be highlighted saying, the practice is generally quite low, you need to try and convert… ultimately, I'm not responsible for the monetary value of privates they gain because we don't get a lot out of it. I care about my patients, I care about my treatment, I care about my clinical work."*
> **Dentist, FLDG, Mixed, England, Urban**

6.3.2 Target setting varied by practice type across the sample

Across the sample, whether or not practices set targets for dental professionals varied by practice type. The majority of independent dental professionals in the sample reported that their practice did not set any formal targets.

> *"I have to obviously earn a certain amount every month to pay my bills, and if I didn't earn that at the practice, I would have to get additional work or another job, but that's the only target."*
> **Dentist, Independent, Private only, England, Urban**

> *"Not really financially, no. Obviously, you have your CPD [Continuing Professional Development] requirements and all that, making sure you're up to date and up to speed with that."*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

In contrast, dental professionals working at both large and small to mid size dental groups more frequently reported that they did have targets in place at their practice. There were also a few instances of independent practices setting targets for dental professionals. Scottish small to mid size practices had targets slightly more than other nations.

> *"There's always a talk about targets and there's always a talk about goals and about they've tried to zone the book for procedures that make so much money and things like that. But I don't feel stressed by that on a daily [basis], it's there in the back, and the ideal for any business would be [the owner] wants his dentist to make that money for him and his business. But also, as an individual dentist, you'd be like, yeah, I would like to make that money. So everybody is kind of striving for that, but there's no set stress."*
> **Dentist, SMDG, Mixed, Scotland, Rural**

> *"In our last practice meeting… we were talking about private targets. She was saying that we were doing really well and we are expected to hit our targets by the end of the year."*
> **Dentist, FLDG, Mixed, Wales, Suburban**

6.3.3 When practices did have targets, these varied in nature considerably

The nature of targets referred to by dental professionals varied across the sample, including both operational targets, such as chair occupancy and running cost targets, and business growth targets, such as NHS to private treatment conversion.

Operational targets

A few dental professionals described operational targets around their activity at the practice, such as chair occupancy or ensuring appointment books were full. Targets set to avoid 'white spaces' in calendars and pressure to keep diaries full were mentioned by several dental professionals across multiple practice types.

> *"The biggest thing is maximising the diary. That's the biggest thing that is monitored for sure, is why is there white space in the diary? Why is there a gap? Because there definitely shouldn't be, kind of thing."*
> **Dentist, LDG, Mixed, Scotland, Urban**

> *"I think for the dentist, they want you to hit at least… chair occupancy, more than 95%."*
> **Dentist, SMDG, Mixed, Northern Ireland, Rural**

> *"The practice owner is keen that dentists are not sitting around not treating patients... we might have an email saying you've got white spaces, [asking us to] send them letters, with photos you've taken, to encourage them to book for treatment."*
> **Dentist, Independent, Private only, England, Urban**

> *"Sometimes I feel like a patient requires the treatment, yes, but it doesn't require it for as long as they need it... letting the patient sit for 30 minutes when the patient doesn't necessarily need 30 minutes, I do feel conflicted regarding that."*
> **Dental nurse, SMDG, Mixed, Scotland, Rural**

On the other hand, a similar number of dental professionals across practice type and role described having autonomy over their schedules which meant they did not feel any pressure to schedule their diaries a certain way.

> *"You'll have slow times and busy times throughout the year... So if I have a gap and they'll go, will you see so-and-so's patient? I'm like, yeah, you know, get them in, I've got space, and go from there."*
> **Specialist, Independent, Private only, Wales, Suburban**

> *"It's basically run by how the dentist wants to run their time... there's nothing that says that they have to do any private at all. It is optional and down to the associate of how much they would like to do."*
> **Dental nurse, SMDG, Mixed, Wales, Urban**

> *"The principal was very flexible in allowing me... sufficient time for new patients. So I would manage my own diary in that sense of how time was allocated."*
> **Dentist, Independent, Private only, Wales, Rural**

Management of appointment diaries varied across the sample, but dental professionals most commonly spoke about keeping a fixed daily or weekly slot for emergency or urgent appointments, rather than having specific treatment type targets built into their calendar.

> *"On an 8-hour day shift... an hour and a half I give exclusively for urgent patients. We don't open that until that morning... An hour and a half we give to them every morning, and rest is everything mostly planned."*
> **Dental therapist, Independent, Mixed, England, Urban**

> *"I start at 9, and I'll normally start with a checkup, and then we have an hour allocated to emergencies, every single dentist every morning."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

Business growth targets

A few dental professionals reported targets relating to increasing the number of patients moving from NHS to private treatment. This was mostly spread across independent and the four largest dental groups.

> *"There are targets for the practice. Um, and what's really ridiculous is the targets of which I'm partly responsible for achieving... they call them conversions… and they have to have a certain number of those… It gives the impression that you can monitor something, but you can't. There's no context, it doesn't mean anything."*
> **Specialist, FLDG, Mixed, England, Urban**

Several dental professionals who were familiar with the targets in place said they related to the number of private and cosmetic procedures the practice completed, or targets around the income earned from private procedures. However, this was sometimes reported as hitting minimum income goals to keep the practice running, rather than maximising the profitability of the practice.

> *"There is a target, but in saying that…It's just, I guess, so the practice can keep going. To keep the practice going, we need to be doing that. It's not a case of 'we're here to make money, you must hit this target'…That's never been the case. It's just been targets that means we're doing well and we're keeping going then. I'm not under pressure to hit targets at any time."*
> **Dentist, SMDG, Mixed, Scotland, Suburban**

> *"[I set targets for] everything: finance, how much money they've made. It's how much bleaching, building, ortho cases, Botox, filler, implants – it's easier sometimes to look at revenue and profit margins… it's a business, isn't it?"*
> **Dentist (owner), Independent, Mixed, England, Suburban**

However, while several dental professionals were aware of or had heard of 'KPIs' or 'targets' at their practice, they were not familiar with the specific measures being monitored.

> *"I'm sure they do, but I'm just probably not aware of it just because I'm more of a part-time hygienist for now with them. So I'm not a full-time… There are targets. I'm just not sure what their targets are because when it's discussed, I'm not usually there."*
> **Dental hygienist, SMDG, Mixed, Scotland, Rural**

> *"What the targets are, I have no idea."*
> **Dentist, FLDG, Mixed, Wales, Suburban**

One dental professional linked their tendency to dismiss and feel unaffected by targets to their self-employed status, which meant they felt management at their practice was unable to dictate how they carried out their work.

> *"[FLDG name] has got it upside down. They think they're in charge. They are essentially glorified managers. We're all self-employed… but they treat us like employees. So we have to remind them… They will tell my practice manager to tell me that I'm doing [prices] wrong, and I will tell my practice manager to tell them to piss off. I'm self-employed, I can charge what I like."*
> **Dentist, FLDG, Mixed, Wales, Rural**

No clinicians reported formal targets relating specifically to cosmetic or private treatments. However, some noted more informal expectations to offer cosmetic treatment to patients, which is discussed further in section 6.4. While several dental professionals expressed a degree of discomfort at the presence of targets in their practice, and a small number felt pressure from their performance being monitored, only one dental professional described feeling meaningfully affected by the pressure of meeting targets. They referred to targets in place at their second practice, which was part of a FLDG.

> *"In the [FLDG] practice, they don't force too much on me, as I'm doing only a specialist thing there, so it's not routine dentistry, so they don't target too much on me. But I can feel the pressure, there is a feeling for you to perform and a pressure there… it's not a nice feeling, and you don't have the freedom to do what you want. You don't want pressure on you when you're doing treatment. There is a mental consequence."*
> **Specialist, Independent, Mixed, Northern Ireland, Rural**

A few treatment coordinators reported specific treatment targets

The picture was different for treatment coordinators, one of whom reported a numerical target to offer a clear aligner brand to patients in order to maintain the practice's discount on the product.

> *"There's specific targets I have to hit with [clear aligner brand]. The more you sell [clear aligner brand], you get more of a discount. They haven't really gone into too much detail with me about this, but I need to hit targets with aligners. They want a certain amount of [clear aligner brand] cases to hit their target with [clear aligner brand]."*
> **Treatment coordinator, Independent, Mixed, Wales, Rural**

Separately, a treatment coordinator at an FLDG outlined monthly revenue targets in place at their practice that resulted in the practice encouraging them to offer products to meet that target.

> *"Say we're lacking in a department, a product, say whitening, then I feel pressure to offer it to everybody… as long as I'm ticking a box that I'm offering it, I can answer that question, I'll never get pressure."*
> **Treatment coordinator, FLDG, Mixed, Wales, Rural**

Beyond private and cosmetic income targets, a smaller number of dental professionals reported having targets linked to NHS contractual requirements. Those working in mixed practices described targets associated with meeting their allocated UDA target, or targets based on their share of the practice's overall NHS contract. This was referenced across all nations except Northern Ireland.

> *"NHS wise, there was targets… you've got a certain amount of targets you need to hit. Otherwise, there is possibility of having some clawback with it, which is the same for any NHS practice."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

Only a handful of dental professionals reported having targets in place for both NHS and private treatment.

> *"They'll have a target as to how much income they want to make per month or per quarter. And so in our monthly practice meetings, we'll see where we are year to date. It's split into private revenue and NHS revenue."*
> **Specialist, FLDG, Mixed, Scotland, Suburban**

6.3.4 Several dental professionals with targets described discussions about performance against targets

Related to widespread tracking of clinician activity at practices, several dental professionals reported discussing practice performance against targets with practice management. This was heard from several large dental group-owned practices, but also a number of independent and small to mid size dental groups.

Many of these conversations were had during team meetings with other dental professionals at the practice, in an effort to encourage the whole team to work towards targets. These meetings would vary in frequency, with some happening quarterly, monthly, or even more frequently.

> *"We have every monthly meeting, they have a separate nurses meeting every month, they have a separate clinicians meeting every month…The manager who is responsible for five or six practices will be attending the quarterly meeting, and [they'll] be explaining what needs to be done, what is going well and what needs to be checked a bit."*
> **Dental therapist, SMDG, Private only, Scotland, Suburban**

A few dental professionals mentioned having or hearing about one to one conversations between practice management and dental professionals about their performance against targets. These were sometimes as part of routine appraisals, or to intervene when a dental professional fell behind targets.

> *"[I'd discuss performance] monthly, sometimes weekly, especially if there's something of concern."*
> **Dentist (owner), Independent, Mixed, England, Suburban**

> *"The owner would have a chat if someone was not meeting any sort of targets."*
> **Dentist, SMDG, Mixed, Scotland, Rural**

> *"I think [performance] probably is [monitored] because lot of the dentists will have a mentor… I don't really know what that looks like."*
> **Dental therapist, FLDG, Mixed, England, Urban**

No dental professional reported facing consequences at their current main practice for missing targets. This emerged from a few situations, including dental professionals refusing to engage with any targets and not being aware of targets, but there was no reported consequence for failing to meet them. However, one dental professional reported having left their previous practice following a dispute relating to their performance against targets.

> *"They were quite passive aggressive about [targets]… we're our own dentist and we can do what we want. That was the first practice I'd been in that was overtly controlling over that… You'd obviously challenge it and be like, 'This is how I do it'… ultimately, they terminated my contract… I was not playing ball how they wanted to."*
> **Dentist, Independent, Private only, Scotland, Rural**

Dental professionals reported little change to targets when practices came under new ownership

Most dental professionals who had experienced an ownership change at their practice reported that targets and incentives remained largely unchanged following the transition. Only one dental professional reported the introduction of targets following ownership change, while one said the number of targets was reduced when purchased by a large dental group.

> *"We never had targets before [the ownership changed], ever. No one was really overviewing [sic] it, it was kind of let be."*
> **Dentist, Independent, Mixed, Wales, Suburban**

> *"The previous owners were very financially [focused]. Oh God, they were worse… they were trying to build the practice up to sell… they brought people in, we had sales talks and all sorts of stuff… We had a two-day course on upselling and it didn't come to anything in the end, but that was the idea."*
> **Dentist, LDG, Mixed, Wales, Rural**

A few dental professionals described broader cultural changes following a change in ownership, including changes of treatment emphasis within the practice, approaches to pricing, or the attitudes of dental professionals more widely.

> *"The [owner] who was there previously was old school, very good, would have patched up a filling and say to a wee old lady, £8 will do. And then this new company came in, and they were going out to the desk and some woman got charged £33 and she was like, 'such and such would never charge me that!'... [Patients] do notice the difference because the policies are stricter and the girls that work there have to enforce these policies."*
> **Dental hygienist, SMDG, Mixed, Northern Ireland, Suburban**

> *"There are people in the car park fully changed at 26 minutes past four now and that never used to happen. People were finishing cleaning and helping each other… It's like, 'you're not squeezing another minute out of me'."*
> **Specialist, FLDG, Mixed, England, Suburban**

6.4 Expectations around cosmetic treatment

6.4.1 As with targets, most dental professionals reported no informal expectations to offer private or cosmetic treatments

Within most practices, the majority of dental professionals reported that they were not expected to offer private treatment to NHS patients, nor offer cosmetic options to patients.

> *"I wouldn't say there's any pressure on us to convert NHS treatment into private. There's no real pressure upon me to do a set amount of smile makeovers or anything like that, really."*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

> *"There's no expectation. We're not a cosmetic-based practice, we're a clinical-based practice… the demographics of the area don't warrant it."*
> **Dental hygienist, Independent, Private only, Wales, Rural**

A few dental professionals reported being expected to raise cosmetic treatment options during routine check-ups or consultations. The majority described these expectations as informal rather than explicit requirements or formal targets, and were reported across multiple practice types, nations, and regions.

> *"We're encouraged to sort of mention it at checkups and things if people are happy, if there's anything they want to change, but it's not enforced or anything… I'm not encouraged to try and upsell it or anything."*
> **Dentist, Independent, Mixed, Wales, Suburban**

> *"They emphasise that you should always give all patients all options. So don't think, 'maybe they might not be able to or [are] not interested'. Just lay it all out on the table and then they can decide… It's been said to everyone at team meetings, so it's been conveyed across, but there's no written thing to say, 'do this.'"*
> **Dentist, FLDG, Mixed, England, Urban**

> *"Patients come to us [for cosmetic treatment]. It is ethically remiss of us to not offer patients treatment. However, in our experience as a practice, the vast majority we say, 'if you're concerned with anything about your smiles, you can ask us and we're able to facilitate that'. But we not forcing or coercing anybody. People are increasingly vain and searching out good dentists who are able to provide these things."*
> **Specialist (owner), Independent, Private only, Northern Ireland, Urban**

Only a very small number of dental professionals described these expectations as business-driven, aimed at converting or upselling patients from routine or NHS treatment.

> *"I think there's always an element of, from a business perspective, the cosmetic treatments are making you a lot more money. It would be to try and upsell where you can. I do that to an extent, but I think there's also your own moral compass to work from."*
> **Dentist, SMDG, Mixed, Scotland, Rural**

> *"Most private treatment actually is done at mixed practices, not just all private practices, because what happens is you upsell. Providing NHS services is a bit of a loss leader, but it's got other advantages, like the pension."*
> **Dentist (owner), Independent, Mixed, England, Suburban**

When raised by dental professionals, these expectations were generally described as coming from practice management, although a few dental professionals reported expectations being set by individuals at the practice themselves, for example if they wanted to offer and gain experience in specific treatments.

> *"[Practice management] have amounts they like us to meet each quarter. Sometimes it goes over, sometimes it goes under. If we do our quarterly targets, the staff get a little bonus."*
> **Dentist, SMDG, Mixed, Scotland, Suburban**

> *"Say we've got a dentist that wants to increase their [clear aligner brand] cases, we'll keep an eye on how many [clear aligner brand] cases they're getting and keep a watch on that just to see if there's anything we need to do to try and increase or improve it."*
> **Dentist (owner), SMDG, Private only, England, Rural**

Several dental professionals presumed the uptake of cosmetic treatments was monitored by their practices, including a few who had this discussed with practice management. However, none reported these expectations, nor their possible tracking by practice management, to affect their clinical decisions in any way.

> *"They want us to offer as much as we can to get more private. I don't think they care about what we do, it's just get the money in… They track us… The tracking affecting my conversations? Not really, no."*
> **Specialist, FLDG, Mixed, England, Suburban**

> *"I don't have a stat given to me that this many patients have done this… probably tracked out of interest but it's not data that I see… when we've had meetings it's discussed to try and mention 'Are you happy with the appearance of your smile?' When new patients come, on a questionnaire there's a question that says 'would you like to discuss cosmetic treatment?' If they don't tick it we don't mention it… so we're not nagging people who aren't interested."*
> **Dentist, Independent, Mixed, Wales, Suburban**

6.5 Financial incentives and rewards

6.5.1 Financial incentives were inherent in the self-employed payment model of most associate dentists

Most dentists interviewed worked as self-employed associate dentists, meaning their income was directly linked to the amount of treatment they carried out rather than receiving a fixed salary. Many dentists described how this employment model created inherent financial incentives because earnings depended on the volume and type of treatment provided. This was the case across all four nations and different area types. The exact split in revenue and costs between practices and dental professionals varied, but was typically around a 50:50 arrangement.

> *"I suppose the dentists are incentivised in that they're paid a percentage of the work they do, so the more work they do, the more they get paid."*
> **Dentist (owner), Independent, Mixed, Wales, Suburban**

> *"Obviously if you work harder, see more patients, you earn more money. That's it basically."*
> **Dentist, Independent, Private only, England, Urban**

> *"The more you do, the more you get."*
> **Specialist, Locum, Wales**

> *"Obviously, if we work more or do more, then we earn more. So that's the argument why we shouldn't get a bonus, is because if the practice is making more money, the dentist is making more money anyway."*
> **Dentist, LDG, Mixed, Wales, Rural**

Several dental professionals explicitly said that this payment structure did not shape the clinical decisions they made for patients, only proceeding with clinically appropriate treatments.

> *"We're not selling them things that they don't need or anything, just... Just treating them as humans, treating them as how you would want to be treated there."*
> **Dentist (owner), Independent, Private only, Wales, Urban**

> *"It wouldn't change my clinical decision-making… I have to sleep at night."*
> **Dentist, Independent, Private only, Wales, Suburban**

One dentist drew a distinction between general and cosmetic dentistry, saying the payment model didn't drive their approach to general treatment but did shape how they thought about cosmetic work, including the materials they used and time they would take, which they described as more of a commercially-minded treatment plan.

> *"When it's cosmetic, I've got a different viewpoint. The patient wants this, it's a financial investment because it's what they want, it's not what they need… You think, 'how long will I need to do this? What materials will I need to use to provide the best treatment outcome for that patient?' And you're financially driven by that. General dentistry, no, but definitely when it comes to cosmetic work, then you do. It is a bit more of a business plan."*
> **Dentist, Independent, Private only, Wales, Rural**

Additional financial incentives for dentists beyond this payment model were uncommon

A few dentists explicitly described additional financial incentives, like bonuses, operating within their practice. This included financial bonus for offering specific treatments and rewards for referring patients.

> *"What I have been told is if I do refer someone for an implant and they uptake it, I'll get £50."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

> *"The person that refers the most patients can sometimes get like a dinner paid for them every couple of months."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

However, the majority of instances of financial incentives at practices reported by dental professionals related to other members of staff, who were typically salaried and not under the same self-employed arrangements as dentists. This included examples of financial rewards included bonuses linked to meeting CPD requirements, receptionists registering patients to a dental plan, and maintaining good reviews and high patient satisfaction.

> *"The nurses get the bonus and their bonus is completely dependent on work that the clinicians do."*
> **Specialist, FLDG, Mixed, England, Urban**

> *"I think for every patient a receptionist signs up [to a plan], they get £5 for it."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

Examples of financial incentives offered at dental practices

Only a handful of additional financial incentives were heard across the sample, and were primarily offered to salaried members of staff rather than dental professionals themselves. The below list the examples of additional financial incentives reported by dental professionals:

- Payments for referrals.
- Financial incentive for meeting targets.
- Nurses, treatment coordinators, or receptionists being offered bonuses.

7. Regulatory frameworks

This chapter includes reflections on regulation including:

- The roles of and experiences with specific regulatory bodies
- How dental professionals wanted regulation to change
- Processes and experiences with complaints from patients and raising concerns about others professional conduct

For context, when asked about regulation, many dental professionals raised points that were outside of the scope of this research. This included points on the impact of NHS contracts and how commissioning was structured. This chapter doesn't cover this and instead focuses on regulation by the GDC and nation specific bodies.

Key findings

- Dental professionals widely described the sector as heavily regulated, citing the administrative burden of record keeping and inspection preparation. Most felt the GDC standards translated well into day-to-day practice but were more critical of how complaints and 'Fitness to practise' cases were handled.
- Awareness of nation-specific regulation was lower than awareness of the GDC, although when dental professionals did have reflections, they found the bodies to be complementary rather than duplicative. A small number of dental professionals felt regulation had not kept pace with the sector, citing cosmetic treatment, overseas treatment, and online advertising as areas to strengthen.
- Nearly all practices had a complaints process that was usually handled by the practice manager or owner. Dental professionals were aware of routes to raise a conduct concern within their practice, but fewer were aware of further routes to escalate concerns.

7.1 Reflections on regulations, GDC Standards and nation specific regulators

7.1.1 Generally dental professionals saw the dental sector as highly regulated

The dental sector was described as highly regulated in general by dental professionals from across all four nations. While they recognised the importance of regulation, they described the processes around it as time consuming and resource intensive.

In particular, dental professionals highlighted the administrative burden of day-to-day documentation and record keeping, and of preparing for inspection. This included writing and updating practice policies, maintaining decontamination and equipment logs, evidencing mandatory training such as annual fire and life support certificates, and producing clinical notes to a standard that would withstand later scrutiny.

> *"It's insane, but I understand there's regulation for it, but the level of detail we're going to… you have to produce a little receipt of paper from a machine with the temperature on it from six months ago to say that that day for that 10 minutes, that machine operated at a sufficient temperature."*
> **Specialist, FLDG, Mixed, England, Urban**

Practice owners in particular described the heavy workload associated with 'keeping up' with regulatory bodies. Most of these owners still accepted the oversight as necessary, and described inspection as reassuring.

"It's never-ending. You have to pay a lot for compliance. We're over-regulated. What can I say? But that's the nature of how we work."
Dentist, Independent, Mixed, England, Suburban

"I suppose sometimes we feel we're just so over-regulated."
Dentist, Independent, Mixed, Scotland, Rural

A small group of dental professionals felt regulations were too heavily focused on practice requirements

A small number of dental professionals described regulations as too focused on what was required at the practice level. They said regulations did less to check treatment quality or monitor the impacts of the shift towards private treatment.

"[Inspections] don't look at patients, talk to dentists, or look at quality of work… which is the biggest indicator of quality. If another dentist actually saw the treatment plan, the quality of the treatment provided, the margins of the crown, they'd know what quality we're doing, but nobody does that."
Dentist (owner), Independent, Mixed, Wales, Suburban

A handful of dental professionals reflected that they didn't feel there was enough regulation about commercial ways of working, viewing some practices as too commercial. A few dental professionals worried that this may be leading to costly, and even unnecessary, treatments being carried out.

"I do think there should be more regulation of who's doing what. There's a lot of weekend course implants that should not be done. I do a lot of oral surgery, I don't place implants… but would I throw an implant in because I did a weekend course? No, because I know nearly too much. Whereas I think there's no regulation, especially in that side of things. Every Tom, Dick, and Harry is doing [clear aligner brand]. Every Tom, Dick, and Harry is doing implants. Everyone's a cosmetic dentist. Everyone that's two years out suddenly has a specialism with no specialism behind them. And I think that's the problem with dentistry now."
Dentist, Independent, Mixed, Northern Ireland, Urban

One dental professional argued that inspections specifically should be more focused on quality of treatment being carried out.

7.1.2 Most dental professionals said the GDC Standards translated well into their day-to-day practice

Across all four nations, practice types and professional roles, most dental professionals were familiar with the GDC Standards and described them as shaping their day-to-day practice. Most dental professionals said the Standards translated well into their day-to-day work. Few had any criticism of the content of the Standards themselves, which were widely described as fundamental and underpinning day-to-day clinical practice and interactions with patients.

"They probably are the basis of my working week, because there will always be a GDC principle related to my work, whether it's consent or putting patient interest first or transparency, honesty, treatment planning, being up front about costs, all of it."
Specialist, Independent, Private only, England, Suburban

"Fundamental. The GDC principles and standards, number one is putting patients' interests first, so ultimately everything is driven around that. All the standards are obviously very important, but ultimately everything we do is with the view of putting their interests first. So as far as I'm concerned, everything comes secondary to that."
Specialist, Independent, Mixed, Scotland, Urban

"I think they work fairly well… You have your freedom to do what you're supposed to be doing. You work inside those guidelines that are set by the GDC, you know, the standards they set and it works."
Dentist, Independent, Mixed, Northern Ireland, Rural

Many dental professionals described their awareness of the standards as largely subconscious

Many dental professionals described the Standards as embedded within their routine practice rather than something they actively referred to when making decisions. Several traced this to dental school rather than procedures or protocols at the dental practice they worked at.

> *"It's never talked about but it's always there. Everything we do is according to the standards, they're ingrained in us from day one at dental school, even from interview days when we were still in grammar school. We researched them and knew about them."*
> **Dentist, Independent, Mixed, Northern Ireland, Suburban**

> *"Absolutely, it's quite vital and our practice manager is very on it with the GDC Standards and makes sure that we're compliant and it probably gets brought up daily. We can't do this because that's not GDC, we can't do that... it's part of the daily language."*
> **Dental nurse, LDG, Mixed, Scotland, Rural**

> *"It's always in the back of your head - shouldn't you follow the standards explicitly?"*
> **Dentist, SMDG, Mixed, Northern Ireland, Rural**

Many dental professionals associated the GDC with its handling of complaints and 'Fitness to practise' proceedings

After the Standards, the most visible part of the GDC was its handling of complaints and 'Fitness to practise' proceedings. This was the case for dental professionals across all four nations. A small number of dental professionals described the GDC as only becoming relevant once something had gone wrong.

> *"The GDC doesn't really play a role unless it's a malpractice case."*
> **Dentist, SMDG, Mixed, Northern Ireland, Rural**

Where dental professionals were critical, that criticism was attached to the GDC as an organisation and to how it handles cases, not to the Standards themselves.

> *"There is a lack of support from the GDC... I think the GDC Standards are so easily thrown at associates."*
> **Dental nurse, SMDG, Mixed, Wales, Urban**

A minority of dental professionals described the GDC in terms of fear or punishment. This was usually about the prospect of being referred to the GDC for consideration under its 'Fitness to practise' procedures, rather than about anything they were being asked to do clinically.

> *"I think every dentist will say largely the same thing, which is that the way the GDC works, it's very punitive or feels very punitive. I think lots of dentists do live in fear of the GDC letter coming in at some point. I think it's getting a GDC hearing. Imagine just being the worst case scenario, the worst thing that can happen to a dentist."*
> **Specialist, Independent, Mixed, Scotland, Urban**

> *"Everybody, you know, we're all slightly scared of the GDC."*
> **Specialist, Independent, Private only, Wales, Urban**

A small number of dental professionals argued the seriousness of the process did not match the seriousness of what had triggered it, such as small complaints that could have been handled in-house, or processes deemed bureaucratic and out of touch with practicing dental professionals. In each case the process was seen as the heavier of the two, with investigations running for years, or ending careers, in response to what dental professionals regarded as minor note keeping errors or complaints without merit.

> *"Some of the stories you hear about cases being referred to the GDC seem so trivial, and then it's ruined dentists' lives, and it could happen to any one of us, no matter how careful we are. A complaint can be raised and that can drag on for three or four years."*
> **Dentist, FLDG, Mixed, Northern Ireland, Urban**

"The previous owner of one of the practices, for example. He's retired now and he just didn't take himself off the register… So [the GDC] have written to him to say, you haven't done enough [Continuing Professional Development], we are now investigating your 'Fitness to practise'. He replied to say, well, I'm actually not practicing, so can I take myself off the register? And they said no."
Dentist (owner), SMDG, Private only, England, Rural

"I've never had any experience with them. I don't really want to. But dentists who I've known have had experience with them for trivial things, it's just you're guilty until proven innocent, which I think is wrong."
Dentist, Independent, Private only, Northern Ireland, Urban

Several dental professionals reflected negatively on the cost and process of dealing with the GDC

Several found GDC registration and the 'Fitness to practise' process costly, slow, or both. This covered the annual fee alongside indemnity and the length of time complaints take to resolve.

"I think the GDC charge us a fortune for not very much."
Dental therapist, Independent, Mixed, Scotland, Suburban

"The cost of us, was it £600, nearly £700, a year for us to be registered with the GDC? Which is pretty high, I would say, as a registration goes if to take that off your bottom line in the first place, plus your indemnity that's going to be anywhere between £3,000 and £6,000 a year."
Dentist (owner), SMDG, Private only, England, Rural

"If they thought that there was any sort of risk to other patients, they'd suspend you, which means you wouldn't be able to work during the 'Fitness to practise' procedure. And it can take them years to get to the end of a 'Fitness to practise' procedure."
Specialist, Independent, Private only, Wales, Urban

A small number felt the GDC was too narrowly focused and did not reflect the reality of everyday practice. These aspects were paperwork and note keeping in particular, which dental professionals contrasted with the quality of care actually delivered.

"I think a lot of the GDC Standards are aspirational and not based on real world life. You just don't have enough time to do every single thing."
Dentist, Independent, Mixed, Wales, Suburban

"The GDC don't come and actually seek an unbiased opinion from other colleagues and other people who are there seeing their day-to-day work. Because if you pick up any one of my notes … you will find holes in it everywhere. Because nothing is perfect on a busy day. Nothing. And I just think the GDC needs to get their eyes open and wise up a bit. Go in and get those rogue people and weed them out. But don't go and sweat the small stuff where people have made genuine, innocent mistakes now and again … It's different if a patient comes to harm."
Dentist, Independent, Private only, Northern Ireland, Urban

"There's a lot of paperwork that isn't that necessary that we just have to do because the GDC want us to do it."
Dental nurse, Independent, Mixed, Northern Ireland, Urban

A small number described how concerns about complaints and investigations led to more cautious treatment decisions

A small number of dental professionals described serious career consequences following GDC involvement, either in general terms or from a colleague's case. Some of these dental professionals described the fear of complaints as changing what treatment they offer, declining or referring on cases they would otherwise take themselves.

"Yeah, I mean, everyone follows them technically, but the problem is when you follow things on a technicality, this is where you have problems creep in like dentists practising defensively because they're so rigid in terms of... the standards they set out, if that makes sense. And you lose, I feel, that old school, just treating people for people."
Specialist, Independent, Private only, Wales, Suburban

> *"I know I can do it. but I can't offer it because I know that the 2% chance that it goes wrong, I'm going to be liable and I'm going to have to pay out for the treatment."*
> **Dentist, SMDG, Mixed, Wales, Rural**

Only a few linked complaints and investigations to patient behaviour, describing patients as able to complain easily in pursuit of a refund because clinicians fear escalation.

> *"I think you're put in a bit of a vulnerable position if let's say the patient is targeting you for money or whatever, to prove the only thing you can do is say, I've done all these things right. There's no way to prove that patient is being malicious towards you. I don't know if any professional body actually has any standards that protect you from that, but that's the only thing."*
> **Dentist, SMDG, Mixed, Northern Ireland, Rural**

> *"We always end up refunding patients even when nothing's been done wrong and things like that, because obviously we just don't want a complaint going any further."*
> **Dentist, Independent, Mixed, Wales, Suburban**

A small number of dental professionals perceived the GDC to place greater emphasis on protecting patients than supporting dental professionals

A small number of dental professionals described the GDC as oriented towards patients rather than towards the profession, and complaints processes as weighted in favour of patients.

> *"I would say probably, I can speak for pretty much everyone in the practice, that the general vibe is that the GDC are out to get you rather than support you."*
> **Specialist, FLDG, Mixed, England, Urban**

> *"Yes, but I also feel that the GDC cares more about the patients than they do about their clinicians."*
> **Dentist, FLDG, Mixed, Wales, Suburban**

> *"I think we have always said that we definitely feel like GDC is more for the patients than it is for us. So that if there was ever a time where you were going through a complaint with the GDC, it's so long winded that I feel for the clinician, it's really unfair in how long it takes. I think they could be a lot quicker on that. So I do feel there's a lot in place to protect the patient."*
> **Dental therapist, Independent, Private only, Wales, Rural**

One dental professional wanted the GDC to become less prosecution focused, to make it harder for some complaints to progress, and to have more dentist representation on its board.

> *"A patient can make a spurious complaint against you and there's such a low bar for entry, the GDC will listen to any moaning so-and-so…The GDC used to have a fair number of dentists involved in the board, it's been weighted so heavily the other way, especially as more lawyers have got involved… they became less interested in protecting the public and supporting the profession and more interested in, 'Let's see how many dentists we can drag across the coals who are good.'"*
> **Dentist, Independent, Mixed, Scotland, Rural**

7.1.3 Many dental professionals had little to say about how nation specific regulation sits alongside the GDC Standards

Dental professionals tended to have less to say about nation specific regulators, including the Care Quality Commission, Healthcare Inspectorate Wales, Healthcare Improvement Scotland and the Regulation and Quality Improvement Authority, than they did about the GDC.

Around half said they did not know, were not sure, or had not had cause to engage with the body, with several attributing this to never having been present for an inspection. These dental professionals were from across all four nations.

> *"Within the practice, not entirely sure. All I know is that I'm asked to be compliant with both."*
> **Specialist, Independent, Private only, England, Suburban**

> *"I've heard of them and I know people use them in private practice, but I've never had to deal with them."*
> **Dental therapist, Independent, Mixed, Scotland, Suburban**

Where dental professionals did describe how the nation specific regulation requirements were met, a small number located that work with the practice manager, the owner, the dental group, or the lead nurse rather than with themselves.

> *"Oh, fine. It's just something that we've got to do, something you have to adhere to, and well, you just do it. It's just, it's one of those things in life, the nature of the job. You have to protect your patients, and you have to just do it."*
> **Dental Hygienist, Independent, Private only, Wales, Rural**

> *"The manager will be letting us know if there's something that needs to be updated and we'll be checking that regularly, yes."*
> **Dental therapist, SMDG, Private only, Scotland, Suburban**

Dental professionals who had experienced an inspection gave more detailed accounts than those who had not

A small proportion of dental professionals referred to direct experience of an inspection, and therefore were able to reflect in more detail on engaging with a national regulator. This included describing what inspectors look at, how much notice is given, and how the process felt.

> *"They're better than they used to be. And I just have to always try and remind the [inspector] who's coming to do the inspection, they can have a bad day too and they need to remove their bias because there are a couple of characters that it can be very hit or miss on whether you're going to have a successful inspection or unsuccessful inspection and I don't like that. So even on a bad day people have to be fair and transparent but I have seen both sides of that sadly."*
> **Dentist, Independent, Private only, Northern Ireland, Urban**

> *"We get a practice inspection, every 3 years. We've got like a checklist we need to go through. They come out and they'll make sure we're all up to date with basically everything from PAT testing to our notes to our logs for our decontamination."*
> **Dentist, SMDG, Mixed, Scotland, Rural**

Dental care professionals were somewhat more likely than dentists to say they did not deal with nation specific regulation. Most dental care professionals gave limited or no reflections on the national body, compared with around half of dentists and specialists.

7.1.4 Most dental professionals said nation specific and GDC regulation worked well together

Among those who had a view, most described the GDC Standards and the national requirements as complementary or well-coordinated, with each covering something the other does not. This was reflected by dental professionals from all four nations.

> *"I think they're very complementary, aren't they? Because the GDC is very much from the way I understand the GDC principles predominantly look at making sure the clinical care is safe, effective, and it's done for the right reasons and ethically and morally. Whereas I'd say the CQC are complementary in the sense that they're making sure that those clinical decisions and environmental practice based decisions are actually safe and I think they very much go hand in hand."*
> **Specialist, Independent, Private only, England, Urban**

> *"Oh, they fit in perfectly with the GDC standard. The actual guidelines sit perfectly. The only thing that's out of the GDC standard or forces people to deviate away from the GDC standard is the NHS contract."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

> *"I think they reflect each other, sort of similarly"*
> **Dentist, Independent, Mixed, Northern Ireland, Suburban**

The most common substantive reflection was a clear division between the two bodies, that the GDC regulates the individual clinician, while the national body regulates the practice's premises, the policies and the equipment.

"I feel like the GDC is what I answer to, but I feel like RQIA is what the clinic answers to."
Dentist, Independent, Private only, Northern Ireland, Urban

"They're 2 different bodies. One is more of a regulatory body for the clinician, the GDC, and the other one is more for the practice and the protecting the patients."
Specialist, FLDG, Mixed, England, Urban

A small number described the overlap between frameworks as duplicative or excessive

A small number took the opposite view, describing the two sets of requirements as covering the same ground twice, or as imposing checks that do not improve care.

"There's a lot of overlap. You have NHS England, you have the GDC, the CQC... You could have an inspection by all three... Surely that's a waste of everyone's time."
Dentist, Independent, Mixed, England, Suburban

"I don't think the two align very well at all, actually. For example, the GDC have CPD requirements, and then the CQC have what they think should be done as part of CPD requirements and some of the stuff that they're expecting us to do from my personal perspective, it's just time wasting."
Specialist, SMDG, Mixed, England, Urban

"Some things I think they're going overboard on. They're not imagining life in a practice. They brought a thing in now that you have to have a weekly fire drill. I think in a small practice, you don't need that every week. To me, that's overkill. It's another job we've got to do."
Dentist, Independent, Mixed, Wales, Urban

7.2 Views on the changes needed in regulation

7.2.1 A small number of dental professionals felt regulation hadn't kept pace with how dentistry is changing

There were a range of areas where dental professionals felt the sector was developing more quickly than existing regulation and guidance. The largest of these was cosmetic treatment, followed by treatment received overseas, and then online advertising. Dental professionals from all four nations offered examples of where they felt this was the case.

Several dental professionals felt regulation had not matched the growth in demand for and delivery of cosmetic treatments

Some pointed to the rise in cosmetic treatments specifically. They described dentistry as having moved closer to aesthetic medicine than to healthcare, and felt regulation had not followed.

> *"How do I say this? Less applicable for my work, but in terms of the wide array of treatments that are available, dentistry is very much now more into the realms of plastic surgery."*
> **Specialist, Locum, Private only, Wales**

> *"The problem is that all those 3 bodies are quite reactive rather than proactive… dentistry has turned more aesthetic this past 20, 30 years. And it's that aesthetic part, which is the lucrative end. We have a lot of dentists going into it literally for the point of money. And that's your ethical line that I was talking to you about at the very start, where you have this line of ethics and business."*
> **Specialist (owner), Independent, Mixed, Northern Ireland, Rural**

A small number of dental professionals were concerned that unnecessary dental work was being carried out, describing elaborate treatment plans presented to patients as clinically necessary.

> *"Just from the experience of what some patients have experienced, that at some private practices their treatments are so elaborate and being pushed as clinical."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

A few also raised patients choosing cosmetic treatment before their mouth was stable, with one wanting explicit rules about the order in which treatment is carried out.

> *"Clinically, putting you first does not mean that we should do composite bonding on a wobbly tooth."*
> **Dental nurse, SMDG, Mixed, Wales, Urban**

A handful of dental professionals had concerns about untrained or unregulated practitioners carrying out cosmetic treatments, such as teeth whitening.

> *"I feel there's a little bit of a laxity around provision of non-dental professionals providing treatments. For example, cosmetic whitening, that is done by non-dentists."*
> **Specialist, Independent, Private only, England, Urban**

A small minority of dental professionals were concerned about treating patients who had received treatment in other countries

This included concerns about the growth of dental tourism. In particular, these dental professionals raised concerns about the remit of UK based dentists when it came to treating patients who had received treatment overseas. They questioned how any dispute could be regulated once a patient has moved between providers in different countries. One described knowledge of clinicians declining to help patients in pain, because touching the work would draw them into responsibility for it.

> *"The foreign travel that I said, you know, sort of switching between providers and it's very hard because every dentist is different and some might not clinically agree with treatment that's been carried out and especially when then that's moving country to country, it's very hard to regulate."*
> **Dentist, Independent, Mixed, Northern Ireland, Suburban**

A few dental professionals raised online advertising as an area regulation had not reached

A few dental professionals also identified online advertising and social media as somewhere regulation had not caught up, pointing to claims made for rapid or transformative treatment and to services promoted by people without dental qualifications.

> *"I suppose false advertisement would be the thing there, with all that like turkey taste kind of advertisements... teeth-in-a-day job, where they advertise... you get all your teeth out and then plants in one day."*
> **Dental hygienist, FLDG, Private only, Northern Ireland, Rural**

7.3 Complaints and conduct concerns

7.3.1 Complaints were usually handled in-practice first, with potential for escalation

Every dental professional bar one said their practice had a complaints process. Most described it as owned by the practice manager, with the principal dentist or owner brought in where the complaint was more serious or where the manager was unavailable. This held across nations, practice types and roles.

> *"All complaints go to the practice manager, so she deals with any complaints. She's very strict with all her policies. All of her policies are good."*
> **Dentist, SMDG, Mixed, Scotland, Suburban**

> *"It would be passed on to management and management would deal with it from there."*
> **Dental nurse, Independent, Mixed, Northern Ireland, Rural**

> *"Yes, a standard procedure. Any complaint would usually be dealt with directly by reception and escalated to the practice manager. Practice manager would then discuss it with the practice principal, and then the practice principal would take over dealing with that."*
> **Dentist, Independent, Private only, Wales, Suburban**

Several dental professionals described attempting to resolve complaints informally first

A substantial minority of dental professionals described trying to resolve complaints informally during or shortly after the appointment where possible, before any formal process began. This included opportunities for both patients and dental professionals to give their account to the practice manager or owner. Several framed this as deliberately keeping the matter at the lowest level.

> *"We encourage anything to be brought up straight away with the treating clinician or with the administration staff if that's where the point of friction is. And then we just try to deal with it straight away there and then at the lowest level"*
> **Dentist, Independent, Private only, Northern Ireland, Urban**

> *"We always try to manage this in-house first and we always apologise and then try to resolve it there and then where it's possible. If not, then it'll get passed on to the practise manager."*
> **Dental therapist, Independent, Mixed, Scotland, Urban**

Where this was not possible, patients were typically invited to submit their complaint in writing

Where informal resolution was not possible or not wanted, patients were asked to put the complaint in writing to the practice. Dental professionals commonly described the same two steps from that point: acknowledgement within one to three days, then a full response within a set period, most often ten working days.

> *"So if anyone is to complain via e-mail or telephone, they are then asked, do they want to put their complaint in in writing? If they say no, I just wanted you to be made aware of it, then that's all documented and passed on to the practise manager and the relevant people involved. And if they do want to put it in writing, then that's directed on to the practise manager, the complaints procedure is outlined, I think, in posters around the practice, but also on the website."*
> **Dentist, SMDG, Mixed, Wales, Suburban**

> *"So if a person, if they make a complaint, a lot of the time it would be referred to a practise manager. And then if they haven't sort of came to an agreement verbally, we would ask the patient to put it in writing. and then the practise manager or the professional who it involves would respond within 10 working days, I think."*
> **Dentist, Independent, Mixed, Northern Ireland, Suburban**

A number of dental professionals named a specific route for escalation beyond the practice

A large minority named where an unresolved complaint could go next. The most common route named was an ombudsman or the Parliamentary and Health Service Ombudsman, followed by the GDC, and then the local health board.

> *"If people are unhappy with that response, then they are offered the ability to take that complaint further to the Ombudsman, as you would do in the NHS. It's a very similar process to complaints, but there is one and it is used."*
> **Specialist, Independent, Private only, England, Urban**

A further small group of dental professionals said a complaint would escalate without being able to say where to, and a handful said explicitly that they did not know what happened beyond the practice stage.

A minority of dental professionals could not describe their practice's complaints process

Several dental professionals could not set out how their practice handles complaints, usually knowing that a process existed and where it was displayed, but not what it involved. Most attributed this to never having had a complaint, or to it being someone else's responsibility. This was as common among dentists and specialists as among dental care professionals.

> *"Obviously somebody complains and we have to reply to it for some way or other, but I really don't know the ins and outs of the process. I'm not being funny, but I've been there 13 years, and we've never had a complaint.*"
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

> *"I still forget it. How I know it works is if you've got any issues, we encourage our patients to write an email to the practice manager… And then she normally handles all of it, if I'm honest with you. So I don't really know what the complaint procedure is."*
> **Dentist, FLDG, Mixed, Wales, Suburban**

7.3.2 Many dental professionals had received a complaint from a patient

Many dental professionals said they had personally dealt with a complaint themselves. Among those who hadn't personally had one, there was a sense that it was only a matter of time rather than something to be ruled out.

> *"Thus far I haven't had any, so I'm not too familiar with it, but I'm sure my time is coming… I think most people will have several big complaints in their career."*
> **Specialist, FLDG, Mixed, Scotland, Suburban**

> *"Personally, no, which is very nice, touch wood, that continues. We had a receptionist who was quite grumpy and she got a lot of complaints. I would probably say that's our most common complaint."*
> **Dentist, SMDG, Mixed, Scotland, Rural**

Several dental professionals described complaints centred on the clinical outcome or safety of treatment, including pain, infection, a filling or crown failing, ill-fitting dentures, or a tooth being damaged during treatment.

> *"Fairly recently we had one where the aspirator wasn't working, and the patient swallowed something. So that was a complaint, but that was referred to the dentist who had to contact their indemnity."*
> **Dentist, FLDG, Mixed, Scotland, Urban**

> *"Probably people who are a bit disgruntled and things haven't worked, for example... if you've paid for treatment and then treatment doesn't work."*
> **Specialist, Independent, Private only, England, Urban**

> *"Yes, so it was a lady who had paid for a 60-minute hygiene appointment, and she wanted staining removed from her teeth. But the staining she [wanted] removed was actually an intrinsic stain to her teeth and it couldn't be removed by polishing. I'd taken photos so I could refer back to them and wrote her an e-mail explaining that we removed all the stain that could be removed, but what she actually referred to couldn't be removed by the treatment she'd had."*
> **Dentist, Independent, Private only, England, Urban**

A small number of dental professionals described complaints as specifically cosmetic or aesthetic. Examples included dissatisfaction with the look of a denture, orthodontic aligner treatment, and cosmetic bonding.

> *"I remember that one wasn't happy with the result from bonding... we just refunded her."*
> **Dentist, Independent, Mixed, Wales, Suburban**

> *"He was literally like, I don't care what they look like, just give me teeth for the holiday… two weeks later, we get this massive long email from his wife giving out a massive amount of stink about how they look awful and he's got body dysmorphia and we've made his body dysmorphia even worse because of the state of the dentures we've given him."*
> **Dentist, Independent, Private only, Northern Ireland, Urban**

A few dental professionals reported complaints relating to cost, including higher-than-expected bills, missed-appointment or cancellation fees, price rises, or a request for a refund following an unsatisfactory result.

> *"Yeah, the usual ones, so not happy with the treatment they've had, or prices haven't been discussed and I didn't agree to this or, I wasn't told this or XYZ."*
> **Dentist, SMDG, Mixed, Wales, Rural**

> *"A few times I have heard [that] the patient was unhappy because they just got cancelled and tried to move them to later. And a few times… because of the increase in the prices every six month[s]."*
> **Dental nurse, SMDG, Private only, Scotland, Suburban**

> *"The complaints are from rude patients and people not attending their appointments and then having to deal with the repercussions of that or being struck off. Another one for me was the only one I've had. I've had two queries come in about the price of treatment versus why can't you give me this in the NHS?"*
> **Dentist, Independent, Private only, Northern Ireland, Urban**

A small number of dental professionals linked complaints specifically to a dentist leaving or retiring, which left patients mid-treatment or created a backlog. Similarly, some dental professionals described complaints about NHS availability or eligibility, for example, a patient being told a treatment wasn't available on the NHS, or being unhappy about deregistration.

> *"I've had patients that have come in quite irate. I had one patient that... was told that she could have, I think, a crown or a bridge on the NHS and then the dentist left, so that couldn't be done. So now she was told if you still want to have that treatment done, you'd have to pay a private fee for it."*
> **Dental therapist, LDG, Private only, Wales, Rural**

No practice type stood out as receiving a distinctly different overall volume or profile of complaints, nor were there any consistent nation or area-type differences.

7.3.3 Most dental professionals said they would raise a conduct concern within their practice first

Most of those asked said they would raise a concern within the practice before going anywhere else, primarily with the practice manager or the owner. Several described this as straightforward, pointing to open practice meetings, regular one to one sessions with the manager, or having a good relationship generally with their manager. A smaller group of dental professionals said they would speak to a colleague, or to the person concerned directly, before involving management at all.

> *"Yeah, I feel like actually our practise meeting is a pretty much open forum. I would bring it to that. We have a pretty active specialist chat group. If I had concerns, I could bring it to that group. I don't feel like I couldn't talk to my colleagues about concerns at this practice."*
> **Specialist, Independent, Private only, England, Suburban**

> *"Straight through management."*
> **Dental nurse, Independent, Mixed, Northern Ireland, Rural**

> *"There's quite a few ways that... you're able to raise a concern, because we are a partnership of three practices, because we have the three practice managers, it's quite open that if it's not sort of something within the building, they're very happy for you to go to the other two managers. If it was a concern about your manager, everyone has contact details for each of the managers."*
> **Dental nurse, SMDG, Mixed, Wales, Urban**

Only a handful had actually been through this process. The instances described were mostly low level and clinical: raising a colleague's proposed treatment plan with the practice manager, or speaking to a colleague directly about something they were doing wrong. One described raising the conduct of practice staff with the owner, when feeling hurried by other members of staff.

> *"There was one occasion where I actually had to say to the owner that I'm that close to making a formal complaint because I cannot be pushed [on time]. It's my responsibility if something goes wrong."*
> **Dentist, Independent, Mixed, Scotland, Suburban**

A small number reflected on experiences at practices earlier in their career. These accounts were consistently negative, and in most cases the dental professional either did not raise the concern or found that raising it did not help. Experiences included harassment after raising concerns, an anonymous reporting channel seen as neither anonymous nor respected, and leaving a practice rather than reporting a premises issue that seemed unlikely to be resolved.

> *"If you raise concerns, you get harassed and bullied at the practise level."*
> **Specialist, FLDG, Mixed, England, Urban**

> *"You can do it through a practice manager. We have this anonymous speak up thing. But from what I heard, it's not really respected or used – so probably not actually anonymous."*
> **Dentist, FLDG, Mixed, Scotland, Urban**

A small number of dental professionals were aware of routes to escalate conduct concerns beyond the practice

A small number were aware that a concern could be taken outside the practice if it could not be resolved internally. The GDC was named most often, followed by a nation specific regulator, and then a health board. A few referred to a whistleblowing policy without naming where it led.

> *"If something really concerns me, touch wood I haven't had to, but should it come to that point, I will go to the RQIA. I will whistle-blow."*
> **Dentist, SMDG, Mixed, Northern Ireland, Rural**

> *"Either to the management inside, or to the principal, or the owner of all of these practices. And for the NHS, we can send directly to the CDA, which is the health board, or in the private we can either contact the HIW."*
> **Dentist, SMDG, Private only, Wales, Urban**

A small number described being unwilling to use these routes or doubting they would achieve anything. Several were specific about the GDC, describing it as something to stay away from, as a step that could end another dental professional's career over a judgement they were not certain about, or as a risk to their own livelihood and to the practice's reputation if the case became public.

> *"I wouldn't be confident contacting the GDC about anything. I feel best just to stay away, keep away and try and never be in communication with them."*
> **Dentist, SMDG, Mixed, Scotland, Suburban**

> *"That's possibly part of the problem because as soon as you go into one of them higher bodies, it becomes so formal and you could destroy somebody's livelihood, somebody's career"*
> **Dentist, Independent, Mixed, Northern Ireland, Rural**

Two dental professionals described having no realistic route at all, because the concern would be about the owner, who they were related to.

8. Technical annex

- Research approach
- Sample breakdown
- Dentist and Specialists discussion guide
- DCP discussion guide
- TCO discussion guide

8.1 Research approach

An overview of the research approach is set out below:

Set-up and sampling	Recruitment	Fieldwork	Analysis
• Purposive sampling approach across key characteristics. • Careful quota development to reflect different practice types and roles. • Developing a sample frame from the GDC list of registered dental professionals	• Consecutive random samples contacted, including targeted quotas. • Staged invitation process with detailed screener completed by dental professionals. • Repeat follow-ups to encourage participation	• Development of a structured discussion guide. • Flexible interview slots offered to dental professionals. • Pilot fieldwork phase • Main fieldwork phase	• Grid analysis, filled in by researchers and compared across the full sample. • Interim findings session with the CMA. • Final reporting phase.

8.2 Sample breakdown

The research team took a purposive sampling strategy to ensure breadth, and a range of experiences were included across the **102 interviews,** with **58 dentists, 20 specialist dentists, 20 dental care professionals,** and **four treatment coordinators.**

To protect participant anonymity the sample breakdown by criteria is not reported. However, specific quotas were set for each criteria across samples. The research included a good spread across all of the below criteria.

Criterion	Detail	Sample (across dentists, specialists and DCPs)
Demographics	Gender	*A spread across gender, with a slight weighting towards women due to over-representation of women in DCP roles*
Geography	Nation (England, Scotland, Wales, Northern Ireland)	*A spread across the four nations, in line with target quotas* • 25x England • 25x Scotland • 26x Wales • 26x Northern Ireland

	Location • Urban • Suburban • Rural	*A spread across locations, weighted towards urban settings (45), and avoiding clustering locations.*
Practice type	Practice size • Independent (1–2 practices) • Small to mid sized (3–29 practices) • Large (30+ practices)	*A spread across practice sizes, weighted towards independent practices due to over-representation of independent dental professionals in Northern Ireland.* • 56x Independent practices. • 21x Small to mid size dental groups. • 25x Large dental groups. *No dental professional was recruited from the same practice, although treatment coordinators were recruited via dental professionals.*
	Big Four Dental Practices • MyDentist • BUPA Dental Care • PortmanDentex • Rodericks Dental Partners	*A spread across the four major dental groups* *No participant was recruited from the same practice*
	Patient mix • Mixture of NHS and private • Private only	*A spread across patient mix, weighted towards practices with a mixture of NHS and private patients*
Professional characteristics	Job role • Dentist • Specialist • DCP • TCO	*Reflects the intended role mix, weighted by design towards dentists.* *Following conversations with the CMA, dentists who held 'special interests' and effectively practised as specialists, but were not registered as specialists with the GDC, were included in this research as specialists.*
	Years since qualification • <3 years ago • 3–10 years ago • 11–25 years ago • 26+ years ago	*A spread across career stage*
Experience of changed practice ownership	Moved practice • Changed hands • Moved to independent • Moved to larger dental group	*A spread across those with experience of changed ownership*

8.3 Research materials

Interview guides were designed to focus on dental professionals' most recent cases, ensuring that insights were grounded in concrete, recent examples rather than general opinions. This approach provided a random selection of cases across three case types (clinical non-urgent, clinical urgent, and cosmetic) avoiding any bias from participants choosing cases they deemed particularly relevant.

The discussion guide for DCPs was adapted from the dentists' guide to accommodate the shorter interview length and to focus on areas of particular relevance, such as regulation. Likewise, the TCO guide was further shortened so as to focus on the key areas, such as prices.

All materials were developed in collaboration with the CMA case team.

See below:

- Dentist discussion guide (Page 72-91)
- DCP discussion guide (Page 92-110)
- TCO discussion guide (Page 111-115)

Dentistry professionals research

Discussion guide – Dentists (90 mins)

Note this first section is for internal RR/CMA reference purposes only, to document the aims of the project and this document. The information in this section will not be used as part of discussions with dentistry professionals.

Research objectives

- Explore how dental professionals interact with private consumers when making decisions about clinical care needs, cosmetic treatments, and referrals for specialised dental services.
- Understand what guides dental professionals' interactions with private consumers across different scenarios - for example, clinical versus cosmetic, or urgent versus routine - with a particular focus on how they present treatment options and prices.
- Understand the different scenarios in which dental professionals recommend private treatment options to NHS patients, and what guides these interactions - with a particular focus on how they present treatment options and prices.
- Understand how the existing regulatory framework influences the day-to-day practice of dental professionals when working with private consumers.

About this document

The document is designed to be used flexibly, with researchers probing around relevant areas and excluding any questions that are not relevant to the participant. It is a guide to help steer qualitative depth interviews not a quantitative survey questionnaire, where questions must be asked in a set order and structure. During interviews, researchers will always focus questions on the participant's own area of professional practice, encouraging the dental professional to give examples of how they currently provide care and make decisions when interacting with patients.

Interview flow

1. Introduction 5 mins	• Introduce the project and background • Outline of interview • Verbal consent process
2. Background and professional context 10 mins	• Their role and responsibilities • Practice profile, including ownership history • Working history • Typical case-mix (NHS/private split, treatment types)
3. Decision-making journey 15 mins	• Specific recent case across three types: non-urgent clinical, urgent clinical, cosmetic • Reflections on how approach varies • Treatment options, pricing, consent • Add-ons, referrals, second opinions • NHS-to-private transitions
4. Practice as a business 20 mins *Priority section*	• Attracting and retaining patients • Marketing • Pricing • Dental plans • NHS vs private positioning • Staff training
5. Commercial pressures and practice conduct 20 mins *Priority section*	• Targets and KPIs • Financial incentives • NHS/private interplay • Management systems • Professional tensions • Ownership changes and business models
6. Regulation 15 mins *Priority section*	• GDC standards • Nation specific standards / bodies • Day-to-day role of regulation • Complaints • Whistleblowing
7. Wrap-up and close 5 mins	• Final thoughts • Post-interview consent and incentive procedure • Signpost resources

1. Introduction (5 mins)

Objective: Introduce the respondent to the project, make them feel comfortable, and explain how the interview will be carried out.

Researcher to outline project background:

> The CMA is examining the market for private dental services in the UK: how it functions, how well it works for consumers, and how it might work better for them. As part of this, the CMA is interested in understanding the perspectives of dental professionals.
>
> The organisation I work for, Revealing Reality (an independent research agency), has been commissioned by the CMA to explore the experiences and perspectives of dental professionals, to inform its market study.
>
> Do you have any questions at this point?

Researcher to outline consent:

> There are **no right or wrong answers** in these interviews. We encourage you to be open and honest, and you should feel at ease sharing your thoughts and experiences.
>
> Our role as researchers is entirely **neutral and non-judgmental**. We are here to listen and gather information without any bias.
>
> All reporting will be **aggregated and anonymous**. The CMA does not know who has been approached about taking part in the research, nor who has agreed to take part. We will not reveal your identity to the CMA, except in the very unlikely event that we are required to do so by law. Your colleagues, your employer, your patients, and the GDC will not know that you have participated in the research. We may use quotes and aggregate evidence, but all information will be anonymised in the reports.
>
> Your participation is **entirely voluntary**. You can choose not to answer any questions or end the interview at any time.
>
> I will resend the information sheet and consent form after this interview, giving you the chance to review and provide informed consent for the information you have shared today.
>
> Do you have any further questions at this point?

2. Background and professional context (10 mins)

Objective: Briefly understand the dental professional's working context and recent history to help put into perspective their opinions and any contrasting experiences.

First I'd like to ask some questions about your role?

From your sign-up form, I can see

- you're a [clinical role]
- working as a/an [owner-principal / associate / salaried dentist]
- you've been registered with the GDC for [less than 3 / 3–10 / 11–25 / 26+ years]
- you're working at [named practice]

Is this right?

- How long have you been at [named practice]
    - Do you work at any others? If yes, how long have you been at those?
    - If yes, what proportion of time do you spend at each?
- Can you give me an idea of your current responsibilities?
- Can you briefly describe where your role sits within the structure of the practice?
    - Probe: junior or senior, team leader, owner/principal/associate, part of management,
- How many work at the practice?
    - What other roles? PROBE: Treatment coordinator
- Do you have a specialism or a particular area of clinical interest?
    - If yes: what is it? [Probe examples if needed: orthodontics, oral surgery, endodontics, cosmetic dentistry.]
    - How did you come to focus on that area?
    - Are you registered as a specialist with the GDC? [Note to researcher: GDC maintains 13 specialist title lists; specialist title registration is optional and separate from practising a specialism.]
- [If owner/principal] What are the main challenges of running the practice as a business at the moment?
    - Probe: financial pressures, staffing, NHS contract, competition.

Now I want to ask some questions about the practice.

From your sign-up information, we know:

- you work at [practice name]
- which is a/an [independent (1–2 practices) / small-mid group (3–29) / large group (30+)]
- it sees [a mix of NHS and private / private only] patients
- it's based in a/an [urban / suburban / rural] area of [England / Scotland / Wales / Northern Ireland].
- [If a group was named:] We also have it down as part of [MyDentist / Bupa Dental Care / PortmanDentex / Rodericks Dental Partners].

Is this all right?

Researcher note: For those working at more than one practice, please focus on the practice they work for most often.

- [If part of a group and not already named:] What is the name of the group?
- How many practices are in the group?
- [If mixed NHS/private:] Roughly what proportion of patients are NHS versus private?
- Who owns the practice?
- How long has the current ownership been in place?
- Is practice ownership presented to patients and if so how?
    - Probe: website, signage both inside and outside the practice, brand name, leaflets and printed materials.

- Are there other dental practices nearby?
    - Probe: number, type, and ownership pattern of local competitors.
    - Is there a patient waiting list in this practice?
        - If yes: how long is the waiting list?
    - Do you have a sense of whether this is typical for the local area or not? What, if any, is the need for outreach to attract new patients?
    - What, if anything, differentiates the practice you work at from others in the local area?
- How would you describe the socio-economic make-up of the local area?

- Has the ownership of your current practice changed since you have worked here?
    - If yes: from what to what?
    - What effect, if any, did that have on you?
    - What effect, if any, did it have on patients?
    - Was the change communicated to patients?
        - If yes, how was the change communicated?
- Is your practice part of any networks or affiliated with any other dental services?
    - Probe: formal or informal e.g. specific dental plan providers, payment plan providers, dental insurance providers, product suppliers, referrals for treatment practice doesn't cover.

Have you worked at any other practices before?

- Have you worked across different types of dental business?
    - For example, independent, mid-small group, large group or larger corporate group?
    - If yes: what differences did you notice?

What is your typical case-mix on an average day?

- What do you find yourself doing most?
- What is the balance of patients you see on a typical day between NHS and private patients?
- What types of treatment do you most commonly carry out?
- How do you manage your diary day-to-day? Why do you manage it this way?

Researcher to explain that we have divided cases into three broad types to help structure the discussion, but acknowledge that the participant may categorise cases differently, and that a case may move from one type to another:

Clinical cases - non-urgent care: e.g routine oral health assessments, preventative care, hygiene appointments, scaling, filling, root canal, complex multi-visit care, planned treatment pathways.

Clinical cases - urgent care: e.g dental abscess management, acute pain, trauma, severe pain, infection.

Cosmetic cases – e.g tooth whitening, veneers, composite bonding, orthodontics.

Note to researcher: Make a note of which types of case the dental professional covers, to probe around in the decision-making journeys section.

- Do these broad categories make sense to you?
    - Is there anything you would categorise differently?
- What is the balance between routine and more complex consultations?

3. Decision-making journey (15 mins)

Objective: Understand how dental professionals make decisions when interacting with patients, anchored to specific recent cases. Capture what actually happens in practice rather than what professionals think they typically do.

Note on researcher approach

This section is anchored to the dental professional's **most recent case** across one of the three case types.

The case type that the participant is asked about is rotated across the sample, and pre-allocated in the fieldwork booking sheet.

If a participant does not have a recent case within their pre-allocated case type, they will be asked to reflect on their **most recent case** and the researcher will retrospectively update the tracker and re-allocate case types for later interviews if needed to ensure spread.

Do not ask participants to describe the full case upfront. Instead, get just enough context to orient the discussion, then take the case step by step through the questions below. This keeps the researcher in control of the pace and ensures detail emerges through the probes rather than in an unstructured preamble.

Opening

"In this part of the interview I'd like to focus on specific cases you have seen recently: what actually happened, step by step, rather than what you would generally do."

Case introduction

- Can you think of the most recent [clinical (non-urgent), clinical (urgent), cosmetic] case you have dealt with?
- Can you briefly describe the patient and what they came in for?
    - Probe: were they private pay-as-you-go, private dental plan, or NHS/health service
- How did this patient come to you?
    - Did this patient come to you as a referral from another dental professional? [e.g., especially relevant for specialist dentists]
        - If yes: who referred them, and what was the reason for the referral?
        - Did the patient seem to understand why they had been referred?
        - Do you agree with the referral?
- Was this patient an NHS patient, a private pay-as-you-go patient, or on a dental plan?

1. Decision-making and treatment recommendations

[Note: For routine checks up or cases researcher to skip questions on treatment]

- What treatment options were discussed with the patient?
- What did you recommend to the patient?
    - Was it a clinical or cosmetic course of treatment, or both?
    - Was the recommended treatment under the NHS or private? Or both?
        - How did you make this recommendation?
        - Note: if an NHS patient was being recommended a private treatment, how did this come about and why?
            - Was an NHS option available for the treatment?

        - Note: if an NHS patient was being recommended a private treatment, how easily do you think the patient understood the switching to a private treatment?
    - What was your approach to managing their expectations around treatment?
- What did you consider when deciding what to recommend?
    - The urgency of treatment?
    - Whether the treatment was clinical or cosmetic?
    - The patient's circumstances or characteristics? (e.g., age, financial situation, anxiety or fear over treatment, any other vulnerabilities or needs)
    - The patient's payment arrangement (e.g., private vs NHS, insurance, dental plan?)
    - NHS contractual terms?
- How did you weigh up those factors?
- Were there any options you considered but did not put to the patient?
    - If yes: why not?
- Does the practice have anything in place to guide treatment decisions in cases like this?
    - If yes: what, and did it affect your decision in this case?
    - Note: Probe specifically on guidance on handling an NHS-to-private patient if relevant

2. Communication of treatment options

- What did you tell the patient about their options?
- How did you explain those options?
- Did the patient ask any questions?
    - If yes: what did they ask?
- Did you do anything to check whether the patient had understood?
    - If yes: what?

3. Pricing and cost communication

- Were costs discussed with the patient?
    - If yes: when in the consultation?
    - Was that before or after you explained the treatment options?
    - Probe: what costs were discussed with the patient (e.g. exact prices, estimates, ranges, maximum prices, minimum prices)
- What payment options were discussed with the patient?
    - If private probe on: dental plans, insurance.
    - What informed which options you discussed? Probe: NHS contractual terms.
- [If patient was on a dental plan] Were all costs covered by their plan?
    - If not, why not?
    - If not: Did you do anything to check whether the patient understood whether the costs weren't covered on their plan?
- How were costs communicated?
    - Probe: verbally, written estimate, price list.

- How did the patient respond when costs were discussed?
- Were any costs added during treatment that were not in the original estimate?
    - If yes: how and when were these communicated?
    - If yes: how was consent gained for these?
- What was the reason for those additional costs?
    - Probe: clinical necessity, administrative, materials upgrade, patient request, cosmetic add-on to clinical treatment

4. Patient decision and consent

- When did the patient make a decision about what treatment to proceed with?
    - Were they given time to consider and make a decision?
    - Was the choice of a second opinion discussed with the customer?
        - If yes: what happened?
        - Was there a period of time to take away the information and consider before treatment started?
    - What informed your decision? Probe: NHS contractual terms.
- At what stage was consent to treatment discussed
    - Was this before or after prices were given?
    - What form did it take? [written, verbal, digital etc]

5. Treatment and onward journey

- How did the treatment go for this patient?
- Was any further or onward treatment needed or recommended?
- Did you make any onward referral for the patient?
    - If yes: How did you decide who to refer to?
        - Probe: Private, NHS
    - What informed your decision? Probe: NHS contractual terms.
    - Was the patient involved in the decision of who to be referred to?
    - Were the costs of the referral or recommended further treatment discussed with the patient?
        - How did that discussion go?
- Were any costs introduced after treatment had completed?
    - If yes: What for and how were they discussed?
- Did any changes to the planned treatment occur, if so how is consent gained?

6. Summary and reflections on this case

- How did you feel about this case overall?
- How does this case compare with other types of case of a similar type?
- Is there anything you would do differently if this scenario came up again?

4. ***Priority section:*** Practice as a business (20 mins)

Objective: Understand how the practice operates as a business: how it attracts and retains patients, how pricing decisions are made, and how it presents itself to patients and the public. Many of these topics will have arisen naturally in earlier sections, researchers should use this section to fill gaps rather than covering ground already discussed.

Note on researcher approach

These questions are more business-facing than the journeys section. Some participants - particularly those who are not practice owners or managers - may have limited visibility of business decisions. Note where this is the case. For practice owners and managers, probe more deeply on decision-making and rationale.

Attracting and registering patients

- Is the practice currently accepting new **private** patients?
    - How is this communicated to prospective patients?
    - Probe: website, signage inside and outside the practice, phone.
    - What is the volume of marketing for this?
- Is the practice currently accepting new **NHS** patients?
    - Why / Why not?
    - How is this communicated to prospective patients?
    - Probe: website, signage inside and outside the practice, phone.
    - What is the volume of marketing for this?
    - Has that changed in recent years?
- Does the practice do anything to attract new private patients?
    - If yes: what?
    - Probe: advertising, social media, referral schemes, sign-up offers or conditions.
    - Who decides on this activity?
    - What do you think attracts customers to your practice?
- Are there any conditions attached to registering, enrolling, or joining your practice list as a private or NHS patient?
    - Probe: required to take out a dental plan, required to pay a registration fee, a parent registering as a private patient when enrolling their child.
    - Probe: justifications for these conditions
- How does the practice handle the transfer of patient records when a patient joins from another practice?
    - Are there any particular challenges?
    - Does it differ for patients who were on a dental plan at their previous practice?
    - Do you / your colleagues look at a patient's previous records? Why / why not?

<u>If time allows, please ask:</u>

- Do private patients ever come to you, switching from another practice to your practice?
    - Do you record their reason for joining from another practice?
    - If yes: what do they tend to say are their reasons?

    - Probe: Prices, wider range of treatments, higher quality of care
- Does the practice do anything to retain existing private patients?
    - If yes: what?
    - Probe: reminders, loyalty schemes, relationship management.

Switching, leaving and one-off patients

- What happens if a patient wants to leave the practice?
- Is there any charge for transferring records to another practice?
- Does the practice treat one-off patients – those not registered with the practice?
    - If yes: how is that handled differently from registered patients?
- Are there any circumstances where a patient might find it difficult to leave?
    - For example, if they are mid-treatment or on a payment plan?
    - PROBE: What if they have had more appointments than they had yet paid for in their plan?
- Are non-attending NHS and / or private patients removed from practice lists?
    - If yes, are they notified?

Pricing

For independent practices:

- How are prices for private treatments decided?
    - Who is involved in that decision?
    - Do individual dental professionals have any role in setting prices?
- Are private and NHS treatment prices publicly available?
    - Probe: on the website, displayed in the practice, leaflets, printed materials, available on request.
    - Probe: the prices available (private PAYG, dental plan, NHS)
    - Who decides how and where prices are displayed?
- Is pricing information provided to private patients before their first consultation?
    - If yes: how?
    - Is there a difference in how this is handled for pay-as-you-go patients versus those on a dental plan?
    - Who within the dental team may talk to patients about prices?
        - PROBE: treatment coordinators, receptionists
- Are different prices or deals offered to different types of patient?
    - Probe: NHS versus private patients, dental plan members versus pay-as-you-go, new versus existing patients, anxious patients, patients in pain or experiencing urgency, those who are older or experiencing complex care needs, those with limited financial resilience
    - If yes: who decides this?
    - How is it communicated to patients?

If time allows, please ask:

For corporate/group practices:

- Can you talk me through how pricing for private treatments is decided and communicated in your practice?
    - *Probe as relevant: who is involved, whether prices are publicly available or shared before a first consultation, and whether pricing or offers vary for different types of patients.*

Dental plans

- Does the practice offer a dental payment plan for private patients?
    - If yes: what does it cover?
        - PROBE: Maintenance plans, full cover plans, finance
    - How is it marketed or presented to patients?
    - Do you have any reflections on whether the plan is good value for patients? Why/why not?
    - Do you tailor this to different types of patients in your practice? If so, does your practice have policies on this?
    - What information is included regarding the key treatments and what would be additional to their plan?
    - At what point is it offered?
        - Probe: on registration, during a consultation, when cancelled, at another point.
        - How does this vary based on patient and / or treatment type?
    - Is the plan provided by an external company?
    - If yes, were the terms of the plan negotiated specifically for your practice? continuation as an NHS dental patient ever conditional on purchasing a payment plan?
- How much chair time do dental plan patients take up compared to PAYG/NHS patients in your practice?
    - How well does this work for you?
- Do patients ever cancel their plan?
    - If yes: what tends to prompt that?
    - If yes: How do you respond? Do you ever try to offer them a better deal to avoid cancellation?
    - What happens to their patient registration / enrolment if they cancel?
    - What happens if the patient cancels their plan having had more appointments than they've technically paid for?
    - How about if they have had fewer appointments than they've technically paid for?

Branding and presentation of services

- Who in the practice decides how services are presented to patients?
    - Probe: website, waiting room, during consultations.

    - Does the dental professional themselves have any input into this?
- Does the practice use any particular branding or labelling for its services?
    - Probe: for example "smile treatments", "smile makeovers".
    - If yes: who decides on that branding?
    - Do patients appear to understand what these terms mean?

Complaints

- Does the practice have a complaints process?
    - If yes: what does it involve?
    - Are complaints collated and monitored by the practice?
- What kinds of complaints does the practice tend to receive?
    - Probe if not raised: suspected overtreatment, higher than expected bills, loss of trust, lack of transparency on treatment / costs, inconsistent with treatment plan, treatment plan not followed, no treatment plan, failure to obtain valid consent
- What happens if a complaint cannot be resolved by the practice?
    - Are patients made aware of where they can escalate?
- Have you personally dealt with a complaint?
    - If yes: can you briefly describe what happened and how it was resolved?
        - What was the complaint about? [Researcher note if complaint was clinical or cosmetic procedure]
        - Did you have any difficulties when dealing with the complaint?
- What role, if any, did your indemnity insurance play in the process?

<u>If time allows, please ask:</u>

Staff training

- Can you tell me about any training the practice provides on interacting with patients?
    - *Probe: what it covers, who delivers it, and whether it is offered as a one-off or refreshed over time*

Perception of the dental sector

- Are there any barriers you have come across to setting up a new dental practice?
    - Probe: finances, regulation, staffing, NHS contracts.
- Have you ever wanted to adopt a new clinical technique or technology in your work?
    - If yes: what?
    - If not: Is there a reason for this? Did anything get in the way?

5. ***Priority section:*** Commercial pressures and practice conduct (20 mins)

Objective: Understand the extent to which commercial incentives, business ownership structures (including any change of ownership), and practice-level targets influence how dental professionals interact with patients. Capture both formal and informal pressures.

Note on researcher approach

This has potential to be a sensitive section of the interview. Begin with a broad unprompted question and allow the participant to define what counts as a pressure before introducing any specific topics. Record carefully what is raised spontaneously before any direct probing.

Distinguish throughout between hard influences (formal targets, explicit incentives, written policies) and soft influences (cultural expectations, implicit pressure, peer norms).

Opening

Ask this question and allow a full answer before introducing any of the specific topics below. Note carefully what the participant raises spontaneously.

- Are there any management practices or expectations that affect how you interact with patients?

Formal targets and incentives

- Does the practice set any targets or goals for the practice as a whole / individual dental professionals?
    - If yes: what kind of targets?
        - Probe if not raised: revenue, number of patients seen, chair occupancy, private conversion rate, child NHS patient to private patient, treatment volume, specific treatment types.
    - How are those targets set?
        - Who sets them?
- Is there any expectation about if/how patients should be offered cosmetic treatments?
    - If yes: where does that expectation come from?
    - Is it formal or informal?
- Does the practice track how many patients take up cosmetic treatments?
    - If yes: how is that information shared?
    - Does it affect how you approach those conversations?
- Is performance against those targets monitored?
    - If yes: how?
    - How often is performance discussed?
    - With whom?
- What impact do targets have on you?
    - Probe: career development, progression opportunities, contract terms, job security
- Are there any financial incentives linked to performance?
    - Probe if not raised: bonuses, commission-style arrangements, profit share.

    - If yes: what are they linked to?
    - Do they affect the decisions you make with patients?
- Are there any consequences if targets are not met?
    - If yes: what?
- What role, if any, does the self-employed payment model as an associate dentist play in your clinical decision-making?
    - Does this differ at all when offering cosmetic treatment?

If ownership has changed:

Targets and incentives after ownership change

- Did the targets or incentives change after the ownership change?
    - If yes: in what ways, for better or worse?
    - How did you come to be aware of those changes?
- Did the ownership change how you felt around commercial performance?
    - If yes: how – did anything feel better or worse?

NHS and private interplay

Use only if the participant works in a mixed NHS/private practice and this has not already been covered.

- Is there any expectation about if/how NHS patients should be offered private treatment options?
    - If yes: where does that expectation come from?
    - Is it formal or informal?
- Does the practice track how many NHS patients take up private treatment options?
    - If yes: how is that information shared?
    - Does it affect how you approach those conversations?
- When / if a patient's NHS eligibility ends, what happens to their registration / enrolment at this practice? (Note to interviewer: e.g., might be when they turn 19 in Scotland, or turn 19 and are no longer in FT education in England)
    - Probe: e.g., automatically moved to private
    - Why might this happen?
    - How are associated charges and payment options communicated to the patient?

If ownership has changed:

NHS/private balance after ownership change

- Did the balance between NHS and private work shift after the ownership change?
    - If yes: in what direction?
    - How did the change come about?
- Did expectations around offering private options to NHS patients change?
    - If yes: how?

- Is NHS treatment for any patients at this practice conditional on them also registering as a private patient?
    - For example, is a parent required to enrol as a private patient in order for their child to be treated on the NHS?
    - If yes: why is that the case?
    - Probe: NHS contract terms, practice policy, business decision.

Softer and cultural pressures

- Is there a general expectation in the practice about the balance between NHS and private work?
    - If yes: where does that expectation come from?
    - Is it written down or more of an unspoken norm?
- Do you ever feel any pressure (e.g., from management, colleagues, or the structure of the practice) that affects your clinical decisions?
    - If yes: can you describe what that looks like in practice?
    - Is it something that is discussed openly, or more implicit?
- Has there ever been a situation where you felt a tension between what you thought was clinically right and what the practice expected of you?
    - If yes: can you tell me what happened?
    - How did you handle it?
- Is there anything about how the practice is run that you think affects the experience of patients?
    - Probe: consultation length, appointment availability, treatment options available, information provided to patients on costs / treatments.

If ownership has changed:

Culture and expectations after ownership change

- Did the culture or expectations in the practice change after the ownership change?
    - If yes: in what way?
    - How did you come to be aware of these changes?
- Did you notice any change in how clinical decisions were made or overseen?
- Did the ownership change affect how you felt about your work?
    - If yes: how?

Management systems and oversight

- Does the practice use any software or management systems to track clinical or business performance?
    - If yes: what does it track?
    - Do you have visibility of your own performance data?
    - Does anyone else in the practice have visibility of your performance data?
- Do any of the systems or software you use at the practice shape what treatments or services are offered?

- Probe: e.g., default settings, suggestions

If ownership has changed:

Management systems after ownership change

- Did the management systems or oversight change after the ownership change?
  - If yes: in what way?
  - Were new systems introduced?
- Did the level of oversight or monitoring of your work change?
  - If yes: how did that feel?

If ownership has changed:

The ownership change experience

Use this block to cover aspects of the ownership change that are specific to the experience of the transition itself, rather than comparisons with the current situation.

- How were you told about the ownership change?
  - How much notice were you given?
  - Were you consulted at any stage?
- Were patients informed about the ownership change?
  - If yes: how?
  - Did patients ask questions about it?
- Did the ownership change affect the range of treatments available at the practice?
  - If yes: in what way?
- Did any colleagues leave as a result of the ownership change?
  - If yes: what were their reasons, as far as you know?
- Have you considered leaving as a result of the ownership change?
  - If yes: what has kept you, or what prompted you to stay?

Liability arrangement and experience

- Does liability (refunds) for treatments sit with you or the practice?
- Does this arrangement have any effect on your treatment approaches?
  - If so, in what way.
  - Probe on attitudes to risk taking.

6. ***Priority section:*** Regulation (15 mins)

Objective: Understand how the existing regulatory framework shapes day-to-day practice in reality, not just in principle. Capture both formal awareness of regulatory standards and honest accounts of how regulation is experienced in practice.

Note on researcher approach

Begin with a broad unprompted question before introducing specific regulatory frameworks. Avoid framing that signals what the CMA thinks dentists should be doing, the goal is to understand how regulation is experienced in practice, not to assess compliance.

Whistleblowing and concerns about colleagues are particularly sensitive, approach with care and maintain a neutral tone throughout.

Note what participants raise spontaneously about regulation before introducing the GDC Standards directly.

Note: participants in different nations may also be subject to differing nation-specific regulations:

- **England:** Care Quality Commission (CQC). All practices (NHS and private) must register.
- **Scotland:** Healthcare Improvement Scotland (HIS). Only fully private practices register with HIS. Mixed and NHS practices are overseen through the NHS board system.
- **Wales:** Healthcare Inspectorate Wales (HIW). All practices offering any private treatment must register; HIW inspects NHS and private practices at least once every three years.
- **Northern Ireland:** Regulation and Quality Improvement Authority (RQIA). Practices providing private treatment must register.

Opening

"Now we're going to move on to talk a bit more specifically about regulation and how it impacts your day-to-day work and experiences as a dentist. Before we go through some more specific questions, is there anything specifically you'd like to share around regulation?

Researcher note whether their immediate reflections relate to clinical or consumer regulations

In particular, with regards to pricing, consent, and communication?"

GDC Standards for the Dental Team

- What role, if any, do the GDC's Standards for the Dental Team play in your work?
    - Have you ever interacted with the GDC?

- Do you feel the standards adequately cover the situations you encounter in private practice?
    - *Probe: Any gaps, too much regulation*
    - *Probe: how to ensure private patients can make informed choices about treatments and costs*
- How well do you feel standards have kept pace with modern practice?
    - *Probe: different business models, different patient preferences?*
- Does the practice have any guidance or policies that go beyond the GDC standards?
    - Who sets them? What do they cover?

- Thinking about the wider dental team – hygienists, therapists, nurses, technicians – how does regulation shape how you all work together to see and treat patients?

- Are there areas where responsibilities between roles feel more or less clear?

Nation specific regulation

- Do you have any specific reflections on how dentistry is regulated in [Wales / NI / Scotland / England]
- How familiar are you with [CQC / HIS / NHS Board System / HIW / RQIA] requirements for your practice?
  - *Probe: recent engagement; registration, inspections, evidence requests, displayed certificate.*
- Have you had any direct contact with [CQC / HIS / HIW / RQIA]?
  - *Probe: type of contact, experience, and whether it changed how the practice works.*
- How do these requirements affect your day-to-day work?
  - *Probe: complaints, paperwork, audits, policies/protocols, displayed information, who handles this.*
- How do these requirements sit alongside GDC standards?
  - *Probe: overlap, duplication, gaps.*

Regulation in reality

- How well do regulatory standards translate into day-to-day practice?
  - *Probe: gaps between standards and practice.*
- Have you felt pressure to act in ways that felt inconsistent with your professional obligations?
  - *Probe: what happened and how you responded.*
- Have you had concerns about a colleague's or the practice's conduct?
  - *Probe: whether you raised them and how.*
- What channels are available for raising concerns about practice conduct?
  - *Probe: within the practice, GDC, CQC, professional association; confidence using them; barriers.*

Reflections on regulation

- Does the current regulatory framework work well for private dental patients?
  - *Probe: where it falls short.*
- What, if anything, should change about regulation of the private dental market?
  - *Probe: gaps in coverage or detail; helping patients make informed choices about treatment and cost; supporting best use of the whole dental team.*

7. Wrap-up and close (5 mins)

Objective: Close the interview warmly, ensure any remaining topics are captured, and complete the post-interview consent and incentive procedure.

Final thoughts

- We are coming to the end of the interview. Is there anything we have not covered that you think is important for the CMA to understand about how the private dental market works?
- Is there anything you'd like to see done to address any of the issues we've discussed?
- Is there anything you would like to add to anything you have already said?

Close

Thank you very much for your time today. This has been really valuable.

Researcher to go through consent and incentive process.

If you have any questions about the research or your participation, please do not hesitate to get in touch.

Dentistry professionals research

Discussion guide – DCP (60 mins)

Note this first section is for internal RR/CMA reference purposes only, to document the aims of the project and this document. The information in this section will not be used as part of discussions with dentistry professionals.

Research objectives

- Explore how dental professionals interact with private consumers when making decisions about clinical care needs, cosmetic treatments, and referrals for specialised dental services.
- Understand what guides dental professionals' interactions with private consumers across different scenarios - for example, clinical versus cosmetic, or urgent versus routine - with a particular focus on how they present treatment options and prices.
- Understand the different scenarios in which dental professionals recommend private treatment options to NHS patients, and what guides these interactions - with a particular focus on how they present treatment options and prices.
- Understand how the existing regulatory framework influences the day-to-day practice of dental professionals when working with private consumers.

About this document

The document is designed to be used flexibly, with researchers probing around relevant areas and excluding any questions that are not relevant to the participant. It is a guide to help steer qualitative depth interviews not a quantitative survey questionnaire, where questions must be asked in a set order and structure. During interviews, researchers will always focus questions on the participant's own area of professional practice, encouraging the dental professional to give examples of how they currently provide care and make decisions when interacting with patients.

Interview flow

8. Introduction 5 mins	• Introduce the project and background • Outline of interview • Verbal consent process
9. Background and professional context 10 mins	• Their role and responsibilities • Practice profile, including ownership history • Working history • Typical case-mix (NHS/private split, treatment types)
10. Decision-making journeys 15 mins	• Specific recent cases across three types: non-urgent clinical, urgent clinical, cosmetic • Reflections on how approach varies • Treatment options, pricing, consent • Add-ons, referrals, second opinions • NHS-to-private transitions
11. Practice as a business 10 mins *Priority section*	• Attracting and retaining patients • Marketing • Pricing • Dental plans • NHS vs private positioning

	• Staff training
12. Commercial pressures and practice conduct 10 mins *Priority section*	• Targets and KPIs • Financial incentives • NHS/private interplay • Management systems • Professional tensions • Ownership changes and business models
13. Regulation 10 mins *Priority section*	• GDC standards • Nation specific standards / bodies • Day-to-day role of regulation • Complaints • Whistleblowing
14. Wrap-up and close 5 mins	• Final thoughts • Post-interview consent and incentive procedure • Signpost resources

1. Introduction (5 mins)

Objective: Introduce the respondent to the project, make them feel comfortable, and explain how the interview will be carried out.

Researcher to outline project background:

> The CMA is examining the market for private dental services in the UK: how it functions, how well it works for consumers, and how it might work better for them. As part of this, the CMA is interested in understanding the perspectives of dental professionals.
>
> The organisation I work for, Revealing Reality (an independent research agency), has been commissioned by the CMA to explore the experiences and perspectives of dental professionals, to inform its market study.
>
> Do you have any questions at this point?

Researcher to outline consent:

> There are **no right or wrong answers** in these interviews. We encourage you to be open and honest, and you should feel at ease sharing your thoughts and experiences.
>
> Our role as researchers is entirely **neutral and non-judgmental**. We are here to listen and gather information without any bias.
>
> All reporting will be **aggregated and anonymous**. The CMA does not know who has been approached about taking part in the research, nor who has agreed to take part. We will not reveal your identity to the CMA, except in the very unlikely event that we are required to do so by law. Your colleagues, your employer, your patients, and the GDC will not know that you have participated in the research. We may use quotes and aggregate evidence, but all information will be anonymised in the reports.
>
> Your participation is **entirely voluntary**. You can choose not to answer any questions or end the interview at any time.
>
> I will resend the information sheet and consent form after this interview, giving you the chance to review and provide informed consent for the information you have shared today.
>
> Do you have any further questions at this point?

2. Background and professional context (10 mins)

Objective: Briefly understand the dental professional's working context and recent history to help put into perspective their opinions and any contrasting experiences.

First I'd like to ask some questions about your role?

From your sign-up form, I can see

- you're a [clinical role]
- working as a/an [owner-principal / associate / salaried dentist]
- you've been registered with the GDC for [less than 3 / 3–10 / 11–25 / 26+ years]
- you're working at [named practice]

Is this right?

- How long have you been at [named practice]
    - Do you work at any others? If yes, how long have you been at those?
    - If yes, what proportion of time do you spend at each?
- Can you give me an idea of your current responsibilities?
- Can you briefly describe where your role sits within the structure of the practice?
    - Probe: junior or senior, team leader, owner/principal/associate, part of management.
- Do you have a specialism or a particular area of clinical interest?
    - If yes: what is it? [Probe examples if needed: orthodontics, oral surgery, endodontics, cosmetic dentistry.]
    - How did you come to focus on that area?
    - Are you registered as another DCP role with the GDC?
        - Are you a qualified dentist overseas and working as a DCP in the UK whilst waiting to be registered as a dentist in the UK?
- [If owner/principal] What are the main challenges of running the practice as a business at the moment?
    - Probe: financial pressures, staffing, NHS contract, competition.

Now I want to ask some questions about the practice.

From your sign-up information, we know:

- you work at [practice name]
- which is a/an [independent (1–2 practices) / small-mid group (3–29) / large group (30+)]
- it sees [a mix of NHS and private / private only] patients
- it's based in a/an [urban / suburban / rural] area of [England / Scotland / Wales / Northern Ireland].
- [If a group was named:] We also have it down as part of [MyDentist / Bupa Dental Care / PortmanDentex / Rodericks Dental Partners].

Is this all right?

Researcher note: For those working at more than one practice, please focus on the practice they work for most often.

- [If part of a group and not already named:] What is the name of the group?

- How many practices are in the group?
- [If mixed NHS/private:] Roughly what proportion of patients are NHS versus private?
- Who owns the practice?
- How long has the current ownership been in place?
- Is practice ownership presented to patients and if so how?
    - Probe: website, signage both inside and outside the practice, brand name, leaflets and printed materials.

- Are there other dental practices nearby?
    - Probe: number, type, and ownership pattern of local competitors.
    - Is there a patient waiting list in this practice?
        - If yes: how long is the waiting list?
    - Do you have a sense of whether this is typical for the local area or not? What, if any, is the need for outreach to attract new patients?
    - What, if anything, differentiates the practice you work at from others in the local area?
- How would you describe the socio-economic make-up of the local area?

- Has the ownership of your current practice changed since you have worked here?
    - If yes: from what to what?
    - What effect, if any, did that have on you?
    - What effect, if any, did it have on patients?
    - Was the change communicated to patients?
        - If yes, how was the change communicated?
- Is your practice part of any networks or affiliated with any other dental services?
    - Probe: formal or informal e.g. specific dental plan providers, payment plan providers, dental insurance providers, product suppliers, referrals for treatment practice doesn't cover.

Have you worked at any other practices before?

- Have you worked across different types of dental business?
    - For example, independent, mid-small group, large group or larger corporate group?
    - If yes: what differences did you notice?

What is your typical case-mix on an average day?

- What do you find yourself doing most?
- What is the balance of patients you see on a typical day between NHS and private patients?
- What types of treatment do you most commonly carry out?
- How do you manage your diary day-to-day? Why do you manage it this way?

Researcher to explain that we have divided cases into three broad types to help structure the discussion, but acknowledge that the participant may categorise cases differently, and that a case may move from one type to another.

Note: probe only on case types relevant to the participant's role – hygienists are unlikely to encounter urgent/emergency cases, so skip this type if speaking to a hygienist; dental nurses and therapists may sit across all three types.

Clinical cases - non-urgent care: e.g routine oral health assessments, preventative care, hygiene appointments, scaling, filling, root canal, complex multi-visit care, planned treatment pathways.

Clinical cases - urgent care: e.g dental abscess management, acute pain, trauma, severe pain, infection.

Cosmetic cases – e.g tooth whitening, veneers, composite bonding, orthodontics.

- Do these broad categories make sense to you?
    - Which of these are relevant to your current role?
- What is the balance between routine and more complex consultations?

3. Decision-making journeys (15 mins)

Objective: Understand how dental professionals make decisions when interacting with patients, anchored to specific recent cases. Capture what actually happens in practice rather than what professionals think they typically do.

Note on researcher approach

This section is anchored to the dental professional's **most recent case of a specific type.**

The case type that the participant is asked about is rotated across the sample, and pre-allocated in the fieldwork booking sheet.

If a participant does not have a recent case within their pre-allocated case type, they will be asked to reflect on their **most recent case** and the researcher will retrospectively update the tracker and re-allocate case types for later interviews if needed to ensure spread.

Do not ask participants to describe the full case upfront. Instead, get just enough context to orient the discussion, then take the case step by step through the questions below. This keeps the researcher in control of the pace and ensures detail emerges through the probes rather than in an unstructured preamble.

Researchers will monitor coverage of case types across the sample to ensure all case types receive attention, and will ask about a specific case type if it comes up less across all interviews.

Opening

"In this part of the interview I'd like to focus on a specific case you have seen recently: what actually happened, step by step, rather than what you would generally do."

JOURNEY

*Researcher to ask them to select their **most recent case.***

Researcher to make note of the type of case against the three case types.

Case introduction

- Can you think of the most recent [clinical (non-urgent), clinical (urgent), cosmetic] case you have dealt with?
- Can you briefly describe the patient and what they came in for?
    - Probe: were they private pay-as-you-go (including finance), private dental plan, or NHS/health service
- How did this patient come to you?
    - Did this patient come to you as a referral from another dental professional?
        - If yes: who referred them, and what was the reason for the referral?
        - Did the patient seem to understand why they had been referred?
        - Do you agree with the referral?
- Was this patient an NHS patient, a private pay-as-you-go patient, or on a dental plan?

2. Decision-making and treatment recommendations

[Note: For routine checks up or cases researcher to skip questions on treatment]

In this part of the interview I'd like to focus on specific cases you have seen recently: what actually happened, step by step, rather than what you would generally do. I'm interested in the full picture of the case - the decisions that were made, the options discussed, and how treatment came about. That might mean decisions you made yourself, decisions made by a dentist or colleague, or things that happened collaboratively - all of that is relevant to us.

- What treatment options were discussed with the patient?
- What was recommended to the patient?
    - Was it a clinical or cosmetic course of treatment, or both?
    - Was the recommended treatment under the NHS or private? Or both?
        - How was this recommendation made?
        - Note: if an NHS patient was being recommended a private treatment, how did this come about and why?
            - Was an NHS option available for the treatment?
        - Note: if an NHS patient was being recommended a private treatment, how easily do you think the patient understood the switching to a private treatment?
- Does the practice have anything in place to guide treatment decisions in cases like this?
    - If yes: what, and did it affect your decision in this case?
    - Note: Probe specifically on guidance on handling an NHS-to-private patient if relevant

2. Communication of treatment options

- What did you / where relevant the dentist/ another dental professional tell the patient about their options?
- How did you / they explain those options?
- Did the patient ask any questions?
    - If yes: what did they ask?
- Did you / they do anything to check whether the patient had understood?
    - If yes: what?

3. Pricing and cost communication

- Were costs discussed with the patient?
    - If yes: when in the consultation?
    - Was that before or after treatment options were explained to them?
    - Probe: what costs were discussed with the patient (e.g. exact prices, estimates, ranges, maximum prices, minimum prices)
- What payment options were discussed with the patient?
    - If private probe on: dental plans, insurance.
    - What informed which options you discussed? Probe: NHS contractual terms.
- [If patient was on a dental plan] Were all costs covered by their plan?
    - If not, why not?
    - If not: Did you do anything to check whether the patient understood whether the costs weren't covered on their plan?
- How were costs communicated?

    - Probe: verbally, written estimate, price list.
- How did the patient respond when costs were discussed?
- Were any costs added during treatment that were not in the original estimate?
    - If yes: how and when were these communicated?
    - If yes: Was consent gained for these, and if so, how?
- What was the reason for those additional costs?
    - Probe: clinical necessity, administrative, materials upgrade, patient request, cosmetic add-on to clinical treatment

4. Patient decision and consent

- When did the patient make a decision about what treatment to proceed with?
    - Were they given time to consider and make a decision?
    - Was the choice of a second opinion discussed with the customer?
        - If yes: what happened?
        - Was there a period of time to take away the information and consider before treatment started?
- At what stage was consent to treatment discussed?
    - Was this before or after prices were given?
    - What form did it take? [written, verbal, digital etc]

5. Treatment and onward journey

- How did the treatment go for this patient?
- Was any further or onward treatment needed or recommended?
- Were any onward referrals made for the patient?
    - If yes: How was this decided who to refer to?
        - Probe: Private, NHS
    - Was the patient involved in the decision of who to be referred to?
    - Were the costs of the referral or recommended further treatment discussed with the patient?
        - How did that discussion go?
- Were any costs introduced after treatment had completed?
    - If yes: What for and how were they discussed?
- Did any changes to the planned treatment occur, if so how is consent gained?

6. Summary and reflections on this case

- How did you feel about this case overall?
- How does this case compare with other types of case of a similar type?
- Is there anything you would do differently if this scenario came up again?

4. ***Priority section:*** Practice as a business (10 mins)

Objective: Understand how the practice operates as a business: how it attracts and retains patients, how pricing decisions are made, and how it presents itself to patients and the public. Many of these topics will have arisen naturally in earlier sections, researchers should use this section to fill gaps rather than covering ground already discussed.

Note on researcher approach

These questions are more business-facing than the journeys section. Some participants - particularly those who are not practice owners or managers - may have limited visibility of business decisions. Note where this is the case. For practice owners and managers, probe more deeply on decision-making and rationale.

Attracting and registering patients

- Is the practice currently accepting new **private** patients?
    - How is this communicated to prospective patients?
- Is the practice currently accepting new **NHS** patients?
    - Why / Why not?
    - Has that changed in recent years?
- What does the practice do to attract new private patients?
    - Probe: advertising, social media, referral schemes, sign-up offers
- Who decides on this activity?
- Are there any conditions attached to registering or joining the practice as a private patient?
    - Probe: required to take out a dental plan, registration fee, parent registering privately when enrolling a child
    - Probe: justifications for these conditions
- When private patients switch to your practice from another, what do they tend to say are their reasons?
    - Probe: price, range of treatments, quality of care
- What does the practice do to retain existing private patients?
    - Probe: reminders, loyalty schemes, relationship management
- [Researcher note: if speaking to a nurse or DCP with patient-facing responsibilities, also ask:] When a patient joins from another practice, how are their records handled – and are you involved in that process at all?

Switching, leaving and one-off patients

- What happens if a patient wants to leave the practice?
- Are there any circumstances where a patient might find it difficult to leave the practice or switch to another – for example, if they're mid-treatment, on a payment plan, or subject to any transfer charges?

Pricing

Use only if participant is an owner or has a senior role

- How are prices for private treatments decided?
- How is pricing information made available to patients, before and during their time at the practice?
    - Probe: website, displayed in practice, provided before first consultation, difference between plan and pay-as-you-go patients
    - Probe: the prices available (private PAYG, dental plan, NHS)
    - Are different prices or deals ever offered to different types of patient?
    - Probe: plan members vs. pay-as-you-go, new vs. existing, patients in pain or experiencing urgency, those with limited financial resilience
    - If yes: who decides, and how is it communicated?
    - Who within the dental team may talk to patients about prices?
        - PROBE: treatment coordinators, receptionists

Dental plans

- Does the practice offer a dental payment plan, and how is it presented to patients – when is it offered, and to whom?
    - Probe: whether it is provided by an external company, what it covers, whether it is tailored to different patient types
    - Do you have any reflections on whether the plan is good value for patients? Why/why not?
- What happens if a patient cancels their plan – does that affect their registration or relationship with the practice?
    - Probe: whether the practice tries to retain them, any link between plan membership and continued NHS access
    - What happens if the patient cancels their plan having had more appointments than they've technically paid for?
    - How about if they have had fewer appointments than they've technically paid for?
- How much chair time do dental plan patients take up compared to PAYG/NHS patients in your practice?
    - How well does this work for you?

Complaints

- Does the practice have a complaints process?
    - If yes: what does it involve?
    - Are complaints collated and monitored by the practice?
- What kinds of complaints does the practice tend to receive?
    - Probe if not raised: suspected overtreatment, higher than expected bills, loss of trust, lack of transparency on treatment / costs, inconsistent with treatment plan, treatment plan not followed, no treatment plan, failure to obtain valid consent
- What happens if a complaint cannot be resolved by the practice?
    - Are patients made aware of where they can escalate?
- Have you personally dealt with a complaint?

- If yes: can you briefly describe what happened and how it was resolved?
  - What was the complaint about? [Researcher note if complaint was clinical or cosmetic procedure]
  - Did you have any difficulties when dealing with the complaint?
  - What role, if any, did your indemnity insurance play in the process?

If time allows, please ask:

Staff training

- Can you tell me about any training the practice provides on interacting with patients?
  - *Probe: what it covers, who delivers it, and whether it is offered as a one-off or refreshed over time*

Perception of the dental sector

Use only if participant is an owner or has a senior role

- Are there any barriers you have come across to setting up a new dental practice?
  - Probe: finances, regulation, staffing, NHS contracts.
- Have you ever wanted to adopt a new clinical technique or technology in your work?
  - If yes: what?
  - If not: Is there a reason for this? Did anything get in the way?

5. ***Priority section:*** Commercial pressures and practice conduct (10 mins)

Objective: Understand the extent to which commercial incentives, business ownership structures (including any change of ownership), and practice-level targets influence how dental professionals interact with patients. Capture both formal and informal pressures.

Note on researcher approach

This has potential to be a sensitive section of the interview. Begin with a broad unprompted question and allow the participant to define what counts as a pressure before introducing any specific topics. Record carefully what is raised spontaneously before any direct probing.

Distinguish throughout between hard influences (formal targets, explicit incentives, written policies) and soft influences (cultural expectations, implicit pressure, peer norms).

Opening

Ask this question and allow a full answer before introducing any of the specific topics below. Note carefully what the participant raises spontaneously.

- Are there any management practices or expectations that affect how you interact with patients?

Formal targets and incentives

- Does the practice set any targets or goals for the practice as a whole / individual dental professionals?
    - If yes: what kind of targets?
        - Probe if not raised: revenue, number of patients seen, chair occupancy, private conversion rate, child NHS patient to private patient, treatment volume, specific treatment types, dental plan sign ups, cosmetic treatments.
    - How are those targets set?
        - Who sets them?

- Is performance against those targets monitored?
    - If yes: how?
    - How often is performance discussed?
    - With whom?
- What impact do targets have on you?
    - Probe: career development, progression opportunities, contract terms, job security
- Are there any financial incentives linked to performance?
    - Probe if not raised: bonuses, commission-style arrangements, profit share.
    - If yes: what are they linked to?
    - Do they affect the decisions you make with patients?
- Are there any consequences if targets are not met?
    - If yes: what?

- *If self-employed:* What role, if any, does the self-employed payment model as an associate dentist play in your clinical decision-making?
    - Does this differ at all when offering cosmetic treatment?

If ownership has changed:

Targets and incentives after ownership change

- Did the targets or incentives change after the ownership change?
    - If yes: in what ways, for better or worse?
    - How did you come to be aware of those changes?
- Did the ownership change how you felt around commercial performance?
    - If yes: how – did anything feel better or worse?

NHS and private interplay

Use only if the participant works in a mixed NHS/private practice and this has not already been covered.

- Is there any expectation about if/how NHS patients should be offered private treatment options?
    - If yes: where does that expectation come from?
    - Is it formal or informal?
- Does the practice track how many NHS patients take up private treatment options?
    - If yes: how is that information shared?
    - Does it affect how you approach those conversations?
- When / if a patient's NHS eligibility ends, what happens to their registration / enrolment at this practice? (Note to interviewer: e.g., might be when they turn 19 in Scotland, or turn 19 and are no longer in FT education in England)
    - Probe: e.g., automatically moved to private
    - Why might this happen?
    - How are associated charges and payment options communicated to the patient?

If ownership has changed:

NHS/private balance after ownership change

- Did the balance between NHS and private work shift after the ownership change?
    - If yes: in what direction?
    - How did the change come about?
- Did expectations around offering private options to NHS patients change?
    - If yes: how?
- Is NHS treatment for any patients at this practice conditional on them also registering as a private patient?
    - For example, is a parent required to enrol as a private patient in order for their child to be treated on the NHS?
    - If yes: why is that the case?

- Probe: NHS contract terms, practice policy, business decision.

Softer and cultural pressures

- Is there a general expectation in the practice about the balance between NHS and private work?
  - If yes: where does that expectation come from?
  - Is it written down or more of an unspoken norm?
- Do you ever feel any pressure (e.g., from management, colleagues, or the structure of the practice) that affects how you work?
  - If yes: can you describe what that looks like in practice?
  - Is it something that is discussed openly, or more implicit?
- Has there ever been a situation where you felt a tension between what you thought was clinically right and what the practice expected of you?
  - If yes: can you tell me what happened?
  - How did you handle it?
- Is there anything about how the practice is run that you think affects the experience of patients?
  - Probe: consultation length, appointment availability, treatment options available, information provided to patients on costs / treatments.

If ownership has changed:

Culture and expectations after ownership change

- Did the culture or expectations in the practice change after the ownership change?
  - If yes: in what way?
  - How did you come to be aware of these changes?
- Did you notice any change in how clinical decisions were made or overseen?
- Did the ownership change affect how you felt about your work?
  - If yes: how?

Management systems and oversight

- Does the practice use any software or management systems to track clinical or business performance?
  - If yes: what does it track?
  - Do you have visibility of your own performance data?
  - Does anyone else in the practice have visibility of your performance data?
- Do any of the systems or software you use at the practice shape what treatments or services are offered?
  - Probe: e.g., default settings, suggestions

If ownership has changed:

Management systems after ownership change

- Did the management systems or oversight change after the ownership change?
    - If yes: in what way?
    - Were new systems introduced?
- Did the level of oversight or monitoring of your work change?
    - If yes: how did that feel?

If ownership has changed:

The ownership change experience

Use this block to cover aspects of the ownership change that are specific to the experience of the transition itself, rather than comparisons with the current situation.

- How were you told about the ownership change?
    - How much notice were you given?
    - Were you consulted at any stage?
- Were patients informed about the ownership change?
    - If yes: how?
    - Did patients ask questions about it?
- Did the ownership change affect the range of treatments available at the practice?
    - If yes: in what way?
- Did any colleagues leave as a result of the ownership change?
    - If yes: what were their reasons, as far as you know?
- Have you considered leaving as a result of the ownership change?
    - If yes: what has kept you, or what prompted you to stay?

Liability arrangement and experience

- Does liability (refunds) for treatments sit with you or the practice?

6. ***Priority section:*** Regulation (10 mins)

Objective: Understand how the existing regulatory framework shapes day-to-day practice in reality, not just in principle. Capture both formal awareness of regulatory standards and honest accounts of how regulation is experienced in practice.

Note on researcher approach

Begin with a broad unprompted question before introducing specific regulatory frameworks. Avoid framing that signals what the CMA thinks dentists should be doing, the goal is to understand how regulation is experienced in practice, not to assess compliance.

Whistleblowing and concerns about colleagues are particularly sensitive, approach with care and maintain a neutral tone throughout.

Note what participants raise spontaneously about regulation before introducing the GDC Standards directly.

Note: participants in different nations may also be subject to differing nation-specific regulations:

- **England:** Care Quality Commission (CQC). All practices (NHS and private) must register.
- **Scotland:** Healthcare Improvement Scotland (HIS). Only fully private practices register with HIS. Mixed and NHS practices are overseen through the NHS board system.
- **Wales:** Healthcare Inspectorate Wales (HIW). All practices offering any private treatment must register; HIW inspects NHS and private practices at least once every three years.
- **Northern Ireland:** Regulation and Quality Improvement Authority (RQIA). Practices providing private treatment must register.

Opening

"Now we're going to move on to talk a bit more specifically about regulation and how it impacts your day-to-day work and experiences as a dentist. Before we go through some more specific questions, is there anything specifically you'd like to share around regulation?"

Researcher note: for DCPs, we are really interested in any views on the extent to which the current standards may or not restrict the scope of their roles, so probe around this topic in particular

Researcher note whether their immediate reflections relate to clinical or consumer regulations

GDC Standards for the Dental Team

Introduce the GDC Standards directly only after the unprompted opening. Note what the participant raised spontaneously before this point.

- What role, if any, do the GDC's Standards for the Dental Team play in your work?
    - Have you ever interacted with the GDC?

- Do you feel the standards adequately cover the situations you encounter in private practice?
    - *Probe: Any gaps, too much regulation*
    - *Probe: how to ensure private patients can make informed choices about treatments and costs*
- How well do you feel standards have kept pace with modern practice?
    - *Probe: different business models, different patient preferences?*
- Does the practice have any guidance or policies that go beyond the GDC standards?
    - Who sets them? What do they cover?

- Thinking about the wider dental team – hygienists, therapists, nurses, technicians – how does regulation shape how you all work together to see and treat patients?
    - Are there areas where responsibilities between roles feel more or less clear?

Nation specific regulation

- How familiar are you with [CQC / HIS / NHS Board System / HIW / RQIA] requirements for your practice?
    - *Probe: recent engagement; registration, inspections, evidence requests, displayed certificate*.
- Have you had any direct contact with [CQC / HIS / HIW / RQIA]?
    - *Probe: type of contact, experience, and whether it changed how the practice works*.
- How do these requirements affect your day-to-day work?
    - *Probe: complaints, paperwork, audits, policies/protocols, displayed information, who handles this.*
- How do these requirements sit alongside GDC standards?
    - *Probe: overlap, duplication, gaps.*

Regulation in reality

- How well do regulatory standards translate into day-to-day practice?
    - *Probe: gaps between standards and practice.*
- Have you felt pressure to act in ways that felt inconsistent with your professional obligations?
    - *Probe: what happened and how you responded.*
- Have you had concerns about a colleague's or the practice's conduct?
    - *Probe: whether you raised them and how.*
- What channels are available for raising concerns about practice conduct?
    - *Probe: within the practice, GDC, CQC, professional association; confidence using them; barriers.*

Reflections on regulation

- Does the current regulatory framework work well for private dental patients?
    - *Probe: where it falls short.*
- What, if anything, should change about regulation of the private dental market?
    - *Probe: gaps in coverage or detail; helping patients make informed choices about treatment and cost; supporting best use of the whole dental team.*

7. Wrap-up and close (5 mins)

Objective: Close the interview warmly, ensure any remaining topics are captured, and complete the post-interview consent and incentive procedure.

Final thoughts

- We are coming to the end of the interview. Is there anything we have not covered that you think is important for the CMA to understand about how the private dental market works?
- Is there anything you'd like to see done to address any of the issues we've discussed?
- Is there anything you would like to add to anything you have already said?

Close

Thank you very much for your time today. This has been really valuable.

Researcher to go through consent and incentive process.

If you have any questions about the research or your participation, please do not hesitate to get in touch.

Dentistry professionals research

Discussion guide – TCO (30 mins)

Note this first section is for internal RR/CMA reference purposes only, to document the aims of the project and this document. The information in this section will not be used as part of discussions with dentistry professionals.

Research objectives

- Explore how dental professionals interact with private consumers when making decisions about clinical care needs, cosmetic treatments, and referrals for specialised dental services.
- Understand what guides dental professionals' interactions with private consumers across different scenarios - for example, clinical versus cosmetic, or urgent versus routine - with a particular focus on how they present treatment options and prices.
- Understand the different scenarios in which dental professionals recommend private treatment options to NHS patients, and what guides these interactions - with a particular focus on how they present treatment options and prices.
- Understand how the existing regulatory framework influences the day-to-day practice of dental professionals when working with private consumers.

About this document

The document is designed to be used flexibly, with researchers probing around relevant areas and excluding any questions that are not relevant to the participant. It is a guide to help steer qualitative depth interviews not a quantitative survey questionnaire, where questions must be asked in a set order and structure. During interviews, researchers will always focus questions on the participant's own area of professional practice, encouraging the dental professional to give examples of how they currently provide care and make decisions when interacting with patients.

1. Introduction (5 mins)

Objective: Introduce the respondent to the project, make them feel comfortable, and explain how the interview will be carried out.

Researcher to outline project background:

> The CMA is examining the market for private dental services in the UK: how it functions, how well it works for consumers, and how it might work better for them. As part of this, the CMA is interested in understanding the perspectives of dental professionals.
>
> The organisation I work for, Revealing Reality (an independent research agency), has been commissioned by the CMA to explore the experiences and perspectives of dental professionals, to inform its market study.
>
> Do you have any questions at this point?

Researcher to outline consent:

> There are **no right or wrong answers** in these interviews. We encourage you to be open and honest, and you should feel at ease sharing your thoughts and experiences.
>
> Our role as researchers is entirely **neutral and non-judgmental**. We are here to listen and gather information without any bias.
>
> All reporting will be **aggregated and anonymous**. The CMA does not know who has been approached about taking part in the research, nor who has agreed to take part. We will not reveal your identity to the CMA, except in the very unlikely event that we are required to do so by law. Your colleagues, your employer, your patients, and the GDC will not know that you have participated in the research. We may use quotes and aggregate evidence, but all information will be anonymised in the reports.
>
> Your participation is **entirely voluntary**. You can choose not to answer any questions or end the interview at any time.
>
> I will resend the information sheet and consent form after this interview, giving you the chance to review and provide informed consent for the information you have shared today.
>
> Do you have any further questions at this point?

2. Background and professional context (10 mins)

Objective: Briefly understand the dental professional's working context and recent history to help put into perspective their opinions and any contrasting experiences.

First I'd like to ask some questions about your role?

From your sign-up form, I can see

- you're a TCO?
- working as a/an [owner-principal / associate / salaried dentist]
- you've been registered with the GDC for [less than 3 / 3–10 / 11–25 / 26+ years]
- you're working at [named practice]

Is this right?

- How long have you been at [named practice]
- How long have you been a TCO?
- Are you salaried / self employed?
- Is TCO all of your role or alongside a clinical role?
    - Do you work at any others? If yes, how long have you been at those?
    - If yes, what proportion of time do you spend at each?
- Can you give me an idea of your current responsibilities?
- What is your typical case mix?
    - Do you work with a specific 'type' of patient or case more?
    - Do you work with private and NHS?
- Can you briefly describe where your role sits within the structure of the practice?
    - Probe: junior or senior, team leader, owner/principal/associate, part of management.

3. Decision-making journeys (15 mins)

Objective: Understand how dental professionals make decisions when interacting with patients, anchored to specific recent cases. Capture what actually happens in practice rather than what professionals think they typically do.

Note on researcher approach

This section is anchored to the dental professional's **most recent case of a specific type.**

The case type that the participant is asked about is rotated across the sample, and pre-allocated in the fieldwork booking sheet.

If a participant does not have a recent case within their pre-allocated case type, they will be asked to reflect on their **most recent case** and the researcher will retrospectively update the tracker and re-allocate case types for later interviews if needed to ensure spread.

Do not ask participants to describe the full case upfront. Instead, get just enough context to orient the discussion, then take the case step by step through the questions below. This keeps the researcher in

control of the pace and ensures detail emerges through the probes rather than in an unstructured preamble.

Researchers will monitor coverage of case types across the sample to ensure all case types receive attention, and will ask about a specific case type if it comes up less across all interviews.

Opening

"In this part of the interview I'd like to focus on a specific case you have seen recently: what actually happened, step by step, rather than what you would generally do."

JOURNEY

Researcher to ask them to select their ***most recent case.***

Researcher to make note of the type of case against the three case types.

Case

- Talk me through most recent case
- Who were they
  - Types of patient
- What treatment
- Who had they spoken to before / after
- How did you and them come to be in contact
  - They contact you?
  - You contact them?
- What are steps
- When / who treatment plan
- When / who consent
- When costs / prices / payment options

6. ***Priority section:*** Targets

- Are there any management practices or expectations that affect how you interact with patients?
- Does the practice set any targets or goals for the TCOs?
- Is your performance measured against these?
- Are there any financial incentives? Yes – what?
- Do they impact you? Decisions you make?
- Do you feel under pressure?

6. ***Priority section:*** Regulation

Objective: Understand how the existing regulatory framework shapes day-to-day practice in reality, not just in principle. Capture both formal awareness of regulatory standards and honest accounts of how regulation is experienced in practice.

Note on researcher approach

Begin with a broad unprompted question before introducing specific regulatory frameworks. Avoid framing that signals what the CMA thinks dentists should be doing, the goal is to understand how regulation is experienced in practice, not to assess compliance.

Whistleblowing and concerns about colleagues are particularly sensitive, approach with care and maintain a neutral tone throughout.

Note what participants raise spontaneously about regulation before introducing the GDC Standards directly.

Note: participants in different nations may also be subject to differing nation-specific regulations:

- **England:** Care Quality Commission (CQC). All practices (NHS and private) must register.
- **Scotland:** Healthcare Improvement Scotland (HIS). Only fully private practices register with HIS. Mixed and NHS practices are overseen through the NHS board system.
- **Wales:** Healthcare Inspectorate Wales (HIW). All practices offering any private treatment must register; HIW inspects NHS and private practices at least once every three years.
- **Northern Ireland:** Regulation and Quality Improvement Authority (RQIA). Practices providing private treatment must register.

Opening

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Researcher note: for DCPs, we are really interested in any views on the extent to which the current standards may or not restrict the scope of their roles, so probe around this topic in particular

Researcher note whether their immediate reflections relate to clinical or consumer regulations

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- Have you felt pressure to act in ways that felt inconsistent with your professional obligations?

7. Wrap-up and close (5 mins)

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