BDA CYMRU RESPONSE

17 June 2025

General dental services (GDS) contract reform consultation questions

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Cymru Wales

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This response is written under the auspices of the Welsh General Dental Practice Committee, (WGDPC) which is the recognised trade union negotiation entity.

The WGDPC has representation from the BDA Board (Principle Executive Committee), the five Welsh Local Dental Committees (LDCs), the Chair of the Welsh Committee for Community Dentistry, (WCCD) and the Chair of BDA Welsh Council.

We are the voice of dentists and dental students in the UK. We bring dentists together, support our members through advice and education, and represent their interests.

As the trade union and professional body, we represent all fields of dentistry including general practice, community dental services, the armed forces, hospitals, academia, public health and research.

Opening Remarks

These reforms have been accurately described by the Cabinet Secretary for Health and Social Care as NHS dentistry's "biggest change in nearly 20 years."

Given the scale of change the choices made in the design of this consultation have created barriers to meaningful feedback from both the profession and the public, and risk undermining the conclusions that could rationally be drawn from it.

This includes leading questions, and encouraging black and white answers on nuanced issues, that taken together rule out meaningful feedback.

Given the reductionist approach taken, we have felt compelled to set out additional concerns about the consultation in detail at the close of this formal submission.

Section 1: about you (profiling) (1 to 5 and 7a 7b 8 not applicable)

Questions 1 to 4 are optional, but answers support us to understand experiences across different demographic groups.

1) What is your age? (optional)

Under 16	☐
16 to 24	☐
25 to 34	☐
35 to 44	☐
45 to 54	☐
55 to 65	☐
Over 65	☐

2) Which gender description most closely matches how you identify? (optional)

Male	☐
Female	☐
Non-binary	☐
Prefer not to say	☐
Prefer to self-describe (please utilise space below)	☐

3) Is the gender you identify with the same as your sex registered at birth? (optional)

Yes	☐
No	☐
Prefer not to say	☐

4) What is your ethnic group? (optional)

White - includes British, Northern Irish, Irish, Gypsy, Irish Traveller, Roma or any other white background	☐
Mixed or multiple ethnic groups - includes white and black Caribbean, white and black African, white and Asian or any other mixed or multiple background	☐
Asian or British Asian - includes Indian, Pakistani, Bangladeshi, Chinese or any other Asian background	☐

Black, black British, Caribbean, African or any other black background	☐
Other - includes Arab or any other ethnic group	☐

5) Which health board region are you located in?

Aneurin Bevan University Health Board	☐
Cardiff and Vale University Health Board	☐
Cwm Taf Morgannwg University Health Board	☐
Hywel Dda University Health Board	☐
Powys Teaching Health Board	☐
Betsi Cadwaladr University Health Board	☐
Swansea Bay University Health Board	☐

6) In what capacity are you responding to this survey?

An individual sharing my personal views and experiences such as a patient, carer or member of the public (move to 8)	☐
On behalf another individual (move to 7a)	☐
A dental professional (move to 7b)	☐
A non-dental member of health or care workforce sharing my professional views	☐
On behalf of an organisation (move to 7c)	☒

7a) If you answered 'on behalf of another individual' on question 6, on whose behalf are you answering?

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

7b) If you answered 'a dental profession' on question 6, what is your profession?

Dentist	☐
Dental nurse	☐
Dental hygienist	☐
Dental therapist	☐
Hospital specialist	☐

Other (please utilise space below)	☐

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

Charity or third sector	☐
Trade Union	☒
NHS health board	☐
Dental Care Profession	☐
Social care	☐
Local government	☐
Commercial	☐
Media	☐

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

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

Section 2: approach to reform

1) Approach to reform opinion poll (optional)

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

- Access for urgent care patients—who are typically those in greatest need—is generally quite good in Wales via the NHS111 system. With that in mind, the original question may not have been the most appropriate or relevant to the context. And respondents will interpret it in different ways.
- The reforms won't help access for all as capacity has shrunk and will shrink further. Total Expenditure on NHS dentistry has reduced.

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

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

Section 3: improving access to routine services

1) Improving access to routine services opinion poll (optional)

Statement See comments below in addition to check box response	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
There should be a process that prioritises dental appointments to those with the greatest clinical need	☐	☐	☐	☒	☐
NHS funding should prioritise children, even if it means fewer people can be seen overall	☐	☒	☐	☐	☐
There should be an equitable mechanism that supports people to gain access to routine NHS dental care	☐	☐	☐	☒	☐
Patients who do not attend their routine appointments with a dental practice on multiple occasions, without contacting the practice, should be moved to another practice	☐	☒	☐	☐	☐
As tooth decay and gum disease are largely preventable, the new dental contract should have a focus on prevention	☐	☐	☐	☒	☐
Patients that can, should take responsibility for looking after their own oral health	☐	☐	☐	☐X	☐
The proposed renumeration packages are an improvement compared to the units of dental activity (UDA) system of payment (profession only)	☐	☒	☐	☒	☐

- If the contract is truly based on assessed need, it cannot simultaneously function as a preventative model. In its current form, this contract seems to reflect a rationing approach rather than one focused on proactive or preventative care.
- Framing the issue as a choice between treating children or adults creates a false dichotomy. The Government should focus on ensuring equitable access to dental care for all age groups through appropriate funding and contractual arrangements which are sustainable and attractive to the profession.
- There should be sufficient funding for everyone who needs it. The DAP alone won't succeed in doing this.

- Patients who miss appointments should not be treated as a single, uniform group and should instead be considered case by case. Simply transferring these patients elsewhere is unlikely to resolve the issue – it just redirects the challenge without addressing it. Such patients may be vulnerable. Children should not be included as they could be '*was not brought'* and a possible safeguarding issue that would need a proactive response. If there is no plausible reason for DNA they could be returned to the DAP waiting list.
- The contract as proposed places minimal emphasis on prevention. Communications from the Welsh Government have consistently focused on access based on clinical need for treatment, rather than genuine preventative care. Dentists already play a vital role in supporting patients to maintain their oral health, which is why continuity of care is so essential. Unfortunately, the DAP risks undermining this continuity for many patients, potentially weakening preventative efforts rather than strengthening them.
- The question on the care package model is a double question. While care packages represent an improvement over the UDA system in terms of structure and approach, the current level of remuneration remains inadequate to support effective, sustainable delivery. Hence both disagree and agree responses.

2) Assuming timely urgent care is available, how often would you expect the receive a dental check-up?

Context: current guidelines suggest adults with good oral health can go up to 24 months between routine check-ups.

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

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

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

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

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

Part 4: improving access to urgent services

1) Improving access to routine services opinion poll (optional)

Statement	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
I am aware of how I access urgent NHS dental care	☐	☐	☐	☐	☐
If I need urgent NHS dental care, I am confident that I will be able to get it	☐	☐	☐	☐	☐
Access to urgent NHS care is more important to me than access to routine NHS care	☐	☐	☐	☐	☐

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

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

Section 5: payment for NHS dental services

1) Payment process for NHS dental services opinion poll (optional)

Statement	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
The money you pay for dental care should be collected through an online system, rather than at the dental practice	☐	☐	☐	☐	☐
When I receive NHS dental treatment, I understand how much I pay towards it	☐	☐	☐	☐	☐
I understand that when I pay for NHS dental treatment that money is ultimately paid to the health board not the practice	▫	▢	▢	▫	▢
It is made clear to me when I pay for a combination of NHS and private dental care	☐	☐	☐	☐	☐
I am happy to make a contribution to my NHS dental treatment providing it is re-invested in dental services to improve access for others	☐	☐	☐	☐	☐

Section 6: technical contract specific considerations

1) Technical contract specific considerations opinion poll

Statement	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	N/A
The contract holder should have overall responsibility to ensure that all level one routine dentistry is provided ensuring that patients are not referred for simple routine dentistry	☐	☐	☐	☒	☐	☐
The new care package payment model represents a fair remuneration for the services provided	☐	☒	☐	☐	☐	☐
The new payment model improves fairness and transparency compared to the previous UDA model	☐	☐	☐	☒	☐	☐
The care package model supports fair payment for associate dentists and the wider dental team	☐	☒	☐	☐	☐	☐
It is appropriate that there is a maximum threshold placed on high-value treatments (e.g. posterior RCT and crown/bridge)	☐	☒	☐	☐	☐	☐
I feel that the new GDS contract will allow me to be able deliver my whole contract and reduce clawback?	☐	☒	☐	☐	☐	☐
The new payment model will support the financial stability of my practice?	☒	☐	☐	☐	☐	☐

A maximum threshold undermines the goal of all Level 1 dentistry being done without referral. Once you meet that threshold you must then refer surely?

The care package model is poorly remunerated so it cannot support fair payment of associates as it stands.

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

No	☐
Yes (please provide further detail in the space below	☒
Yes, we consider the care packages in the new fee scale are undervalued – specifically as given below are the values that have been calculated based on current costs to run a dental chair on a breakeven basis.	

1	Urgent	£105.00
2	New patient assessment	£105.00
3	Simple Caries	£125.00
4	Extended Restorative	£240.00
5	Perio	£330.00
6	Anterior RCT	£320.00
6.a	Pre-molar RCT	£340.00
7	Posterior RCT	£630.00
8	Crown/Bridge	£485.00
9	Denture (excluding lab cost*)	£300.00
10	Very High Needs Stabilisation	£300.00
11	3 month recall (Flat fee)	£65.00
15	Initial Assessment under 1 years	£115.00
16	Initial Assessment 1–4 years	£115.00
17	Initial Assessment 5–12 years	£115.00
18	Initial Assessment 13–17 years	£115.00
19	6-month recall	£160.00

While care packages represent an improvement over the UDA system in terms of structure and approach, the current level of proposed remuneration remains inadequate to support effective, sustainable delivery.
Our alternative figures are based on the conservative calculation of costs to run a dental chair on breakeven basis. The NHS can no longer expect private dentistry to cross-subsidise NHS work.
For simplicity and equity, the IA charge should be the same in each age group – children shouldn't have to compete for access/ treatment because some are worth more than others

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

Don't know	☐
Agree	☐
Neither agree nor disagree	☐
Disagree (please provide further detail in space below)	☒

There are fundamental issues with these definitions, that serve to undermine the whole package of reforms. Before we even consider 'high needs' status, there is no agreed formal definition of what is meant by an 'intervention'. Based on informal prior usage of the term we know that not all interventions are equal, so this definition does not allow for professional judgement. We reject the definition of a very high needs patient should include at least one RCT. This is not only over-prescriptive to stipulate at least one RCT but also at odds with the likely clinical scenarios.

Section 7: understanding impacts

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

This consultation overlooks a number of significant issues. In particular, the absence of a pilot or transition phase, minimal emphasis on prevention, and a lack of support for occupational health, CPD fees, and protected study time for dentists. A big omission is the impact this will have on patients choosing to move to private care as a result of these changes, and the loss of capacity this will cause for NHS patients. Additionally, this consultation fails to address how the contract will evolve each year under the reform agenda, or the implications on earnings. Finally, BDA Cymru continue to call for the tie to uplift to be removed. Further information on each of these points can be found below:

A. Lack of pilot phase

This is an untested model which requires a *transition period* to ensure it is fit for purpose. We understand the Government will not entertain a pilot period however, we emphasise that this is the preferred option for dentists, and given the high level of risk involved, is in the best interests of the patients we serve. Whether or not a pilot is adopted, this will require several transition years where there are *built in tolerances* for risk reduction until there are sufficient data to ensure its operational success.

B. Preventative contract

The preamble in the consultation document is misleading as there is very little in this contract that supports prevention; certainly nothing beyond fluoride varnish application. The lack of ambition in this regard is regrettable.

This is patently a treatment contract – the funding allocation is for treating disease according to need. Risk does not really figure in this model, nor does use of skills mix for OHE. Indeed, the Government has stipulated access to the dental service should be according to need.

C. Occupational Health Support

The HEIW Workforce Plan recognises there is limited access to occupational health services and to health and wellbeing support within the occupational health provision by Welsh Government. Primary care should have the same level of support of health board delivered health and wellbeing service as employees. The GDS contract should include the ability to access these services. There must be a comprehensive provision made available to all GDPs, DCPs and support staff that work in a practice that holds an NHS contract. This should include *Canopi* for confidential mental health support.

D. Protected learning time

The contract should make provision for financial support for 5 days of CPD per annum, plus time for peer review plus clinical audit for all GDPs to fulfil all requirements of the GDC, HEIW and QE. The contract for Optometry has a scale of fees for CPD – dentists have been offered nothing in this contract. There should be proportionate awards for CPD made in the fee structure.

E. Equality Impact Adjustment

The proposed cap on weekly earnings has been recognised within the equality impact assessment as being more likely to have disbenefit for female dentists. This issue has been ignored and no adjustment made in the proposal. This needs to be addressed with an appropriate adjustment.

F. Impact of patients seeking private dental care on NHS capacity

There is a growing opinion amongst the profession that this new contract model with the very unpopular use of the DAP for green patients is a deliberate ploy to actively encourage such patients who can afford it to move to private arrangements with their practice by March 2026.

It takes a ratio of approximately 1 private patient to replace 3 NHS patients. That means for every patient who converts to a private care plan there will be a loss of capacity for two NHS patients. We foresee this 2026 contract could be the tipping point whereby future retendering will stop being effective as capacity is swallowed up more and more by private conversions.

G. Annual Contract Variations and Removing the Tie to Annual Contract Uplift

The annual negotiations on changes in the GDS contract in future might include Government wanting to alter the value of each element of the care packages, for example. This has already been demonstrated within contract variation whereby the values of different patient types have been reduced.

Our position is that ongoing reforms to the contract should be negotiated without the tie to the uplift and furthermore, any reforms that incur any sort of cost should have those costs properly modelled and agreed upon.

Although Primary Care Reform is intended to improve the quality of care by driving innovation it also brings risks and disbenefits to the contractors. A significant disbenefit is the chronic and damaging erosion of GDPs' pensionable income or 'pay' for short.

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

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

The proposals will have a negative effect on the Welsh language provision because patients who have chosen a Welsh- speaking dentist based on language preference could stand to lose their dentist if they are returned to the DAP in between treatments.

The highest levels of Welsh Speakers occur in places like West Wales and North Wales which currently have the lowest numbers of NHS dentists per 10,000 of the population. The best solution is to make the contract attractive enough that dental team members who are Welsh speakers will want to do NHS work in places that are predominantly Welsh speaking and so can meet the needs of their patients. Currently the opposite is true in West Wales and North Wales. These areas have had large numbers of contract hand backs in the last three years, so Welsh speakers are more likely to be receiving dental care privately as a result.

3) We would like to know your views on the impact that the parameters of practice might have on groups with protected characteristics.

Protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

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

Sex - The proposed cap on weekly earnings has been recognised within the equality impact assessment as being more likely to have disbenefit for female dentists. This issue has been ignored by Government and no adjustment made in the proposal. This needs to be addressed with an appropriate adjustment.

Age- elderly patients often rely on public transport to get to their appointments. Those patients may be indirectly discriminated against by being removed from their local practice and sent elsewhere.

Disability- patients with disabilities may have chosen a practice that they are comfortable attending (be that due to physical access considerations or a level of understanding about a patient's disability). A new practice will not necessarily be aware of a DAP patient's disability and may therefore not book the additional time or accessible surgeries required.

Gender reassignment- explaining this to a new practice every time they are sent back to the DAP could be triggering for some transgender patients.

Marriage and civil partnership- it is unclear if the agreement to see children of NHS patients amounts to indirect discrimination on these grounds based upon what is counted as a parent for the purposes of patient selection.

Ethnic minority patients - indirect discrimination is possible as patients may require translation services. If they are removed from practices for looking after their oral health, a new practice might not be aware of their additional language needs and might not book the additional time needed.

Religion and belief- some patients might be indirectly discriminated against if they have a relationship with an existing practice who is aware of their religious needs. For example, a practice may know that a given patient has asked not to be given appointments on a certain day of the week depending upon their religious observance or during religious fasting times. If that same patient is moved to a new practice and is sent an appointment, they would then face the inconvenience of calling the practice to rearrange their appointment.

Sexual orientation- this has some impact on oral health in terms of sexual practices which a patient may have disclosed to a dentist they know and trust, but they might be uncomfortable 'coming out' over and over again when they are returned to the DAP. The resulting loss of

vital clinical information (gay men are disproportionately prone to HIV, for example) could impact upon the quality of their care.

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

Executive Summary

General Dentistry in Wales stands at a critical juncture. The Welsh Government is right to pursue change and to call time on a failing system. It is to be commended for moving on the reform agenda with more purpose than the Westminster Government.

The proposed 2026 General Dental Services (GDS) contract model is well-intentioned in its stated aims and objectives of improving access, prevention, workforce well-being, and value for money. We support these in principle; however, their realisation falls significantly short in the model's current form.

As the professional body and trade union representing dentists across Wales, BDA Cymru has engaged deeply with the service reform process, including through formal negotiations, extensive member consultation, and rigorous analysis. Our conclusion is unequivocal: the proposed model, if implemented without substantial revision, risks accelerating the collapse of NHS dental provision in Wales.

The contract as drafted is not a product of consensus. It is not a negotiated agreement. At best it contains a few ideas that found accord but contains many that did not. It is a model that imposes new burdens on a workforce already stretched to breaking point, while failing to address the core structural issues that have driven hundreds of dentists out of the Welsh NHS in recent years.

The BDA Cymru May 2025 survey, with over 200 respondents, reveals overwhelming opposition to key elements of the contract as modelled, including the proposed operation of the Dental Access Portal (DAP), creating a revolving door for patients, dubious changes to patient recall intervals, and the erosion of the family dental practice. The planned use of the DAP will ruin patients' continuity of care and will risk turning practices into impersonal treatment factories. The intention to refer very high-needs patients to a Community Dental Service (CDS) that is already overburdened and under-resourced is universally rejected by dentists in the GDS and CDS.

The proposed model contract aims to impose a 24-month professional liability on routine treatment and a 12-month liability on urgent treatment both of which are likely to have unintended consequences on patient treatment by driving defensive dentistry.

The model proposes draconian mandatory attendance at cluster collaborative meetings on the pain of breach of contract; and expects practices to absorb rising costs – including government-imposed hikes in employment costs - without commensurate uplift. It abolishes seniority payments, caps financial entitlements in ways that disproportionately affect women, and offers no meaningful support for occupational health or protected learning time.

The absence of a pilot phase, the lack of clarity on patient flows, and the failure to provide accessible materials that spell out the impact on patients and enable meaningful engagement of the consultation for the public all point to a rushed and opaque process.

We call for a fundamental rethink. Without urgent revisions this contract will not only fail to meet its objectives, but it will actively worsen patient access, staff morale, and oral health

outcomes across the dental landscape in Wales. Patients will not be well-served in the currently proposed configuration of the DAP or the referral pathway of very high-needs patients.

However, there is no need to throw the baby out with the bathwater. We support in principle some elements - such as care packages, urgent care commissioning, and centralised patient charge collection. These must be properly funded, piloted, and implemented with safeguards.

The members of WGDPC remain willing to work in social partnership with the Government and NHS Wales to develop the elements of the model into a workable solution. We urge the Welsh Government to delay full implementation in 2026, introduce a substantial transition period to allow proper testing, and return to the negotiating table in good faith. Let's take a step back and give everyone the chance to properly plan for the change we can all agree is needed for the future success of NHS dentistry in Wales.

Response to the Government Objectives

Government Policy Goals

The health minister states the new 2026 GDS contract will help to achieve the following policy goals:

- Improve population health, oral health, and well-being through a greater focus on prevention.
- Improve access, experience, and quality of dental care for individuals and families.
- Enrich the well-being, capability, and engagement of the dental workforce; and
- Increase the value achieved from funding of dental services and programmes through improvement, innovation, use of best practice, and eliminating waste.

Regrettably, none of these goals can be enabled by the new contract as it is drafted with multiple professional strictures and within the current restricted levels of funding allocated to general dentistry. The new tighter contractual controls and strictures being proposed by Government are likely to have unintended consequences in the way care is provided as a result.

It is difficult to see how this contract model can improve the wellbeing and engagement of dentists when it raises the spectre of reduced professional autonomy, another version of a treatment treadmill, plus a revolving door for patients.

The lack of ambition by Welsh Government to make this a moment of true renewal of NHS dentistry is deeply disappointing.

The profession's reaction

Dentists responding to the **BDA Cymru May Survey** overwhelmingly disagreed that the new contract model would deliver against these policy goals:

Over 75% of respondents did not agree the aims and proposals in the consultation are clear
Over 90% disagree the new contract will improve population health
Over 85% disagree the proposed system will enable a greater focus on prevention
Over 75% disagree the new contract will improve access to dental care
Over 90% disagree the proposed system will improve the quality of dental care
Over 95% disagree the new contract will enrich the well-being, capability, and engagement of the dental workforce

The Consultation Process

The False Dichotomy Argument

The Government has adopted a narrative in its consultation which uses the false dichotomy argument in several instances.

We are supposed to believe that there is no option to extend the period beyond 2026 before launching the new reformed GDS contract. The rationale for this unseemly haste is not cogent. Instead, we are given the false choice of either accepting the new model for immediate implementation next year, or we must revert to UDAs.

This threat to return to UDAs needs to be challenged as that discredited system does not meet the policy aims of the Government nor of the profession. Only 20% of respondents in our survey said they would like to work under UDAs going forward, given the current choices. We need to work to a position where the new model offer is clear, equitable, trialled and attractive enough that even those 20% could be won over to work in it.

If the Government were to revert to UDAs next year, then even the small wins seen in contract variation of opening up the service to 'new' patients without previous access would be lost. That runs counter to any policy argument from Government so seems like an empty threat. Unless of course the Government insists on using the DAP to control patient flows anyway, and practices are remunerated via UDAs. This would be the death knell for NHS dentistry.

Ideally there should be a proper period to trial the new contract. At the very least there needs to be a transition period of three years with risks reduced to the minimum and a moratorium called on those aspects we have highlighted as problematic.

The False Narrative Argument

The consultation document insinuates that many practices have been recycling patients with little to no dental disease every 6 months to generate the UDAs required to meet their contractual obligations. "*Despite NICE guidelines on recall intervals many practices have traditionally recycled patients with no / little dental disease every 6 months to generate the UDAs required to meet their contractual obligations*." This makes no sense given that there are 80% of NHS practices within contract variation which don't generate UDAs in this way. The contract variation model already does not recall green patients more frequently than once a year as there is no additional funding.

This false narrative also runs counter to the findings by Miller Research in 2023 which describes patients experiencing extended recall periods, especially those with good oral health. *The dentist said: "see you in two years – as you look after your teeth you shouldn't need to come before then." This participant felt this reflected poorly on access to NHS dentistry: "I don't think the service is as good as it was."* None of those patients were happy about two year recall intervals: *not one participant across all seven groups supported two years as an appropriate recall interval: "so much could happen in two years, that is bonkers."*

Recent NHS dentistry data shows that three quarters of patients seen in the last year had treatment needs and were managed with appropriate recall intervals. Of the quarter of patients who were disease free, there was no financial incentive within the contract to recall them within the year. Furthermore, it can only be a small number of remaining UDA contracts where 6 monthly recalls of healthy patients may even possibly occur, but there is no evidence of that in practice.

The narrative that there is all this wasted capacity is thus mythology. Therefore, any increased capacity from extending the recall period to 18 months or 24 months will be minimal and have very limited impact on numbers of patients who can be treated, particularly if they are higher-needs patients each requiring significantly more chair time.

Consultation in name only

The content of the consultation document has been written in a technical style that is not easy to follow for the lay audience. Some of it is difficult to follow in any case because there are inconsistencies, ambiguity and contradictions in the model.

We argued that there should be two distinct versions – a fully technical detailed version with the supporting evidence for the profession, and another one which is a plain version for the public in order to provide a simple overview of the impacts and changes of the new contract model and what these will mean for patients. Furthermore, when we enquired about an easy read version, to accommodate those with a learning disability, we were informed that the decision had been made not to supply this.

We also find many of the consultation questions leading in their construction. Our members say these questions do not allow feedback to be provided that is representative of the sentiment of the profession towards the model contract under consultation. We raised these issues directly in a letter to Mr Miles MS, but his reply dismissed our concerns.

Responding to the BDA Cymru May Survey:

Over 75% of dentists did not expect issues raised by them in the consultation will be acted upon by the Welsh Government.

Around 85% of dentists did not agree that the questions were balanced, nor provided the background for them to give an informed response

Meanwhile, many practices, supported by their LDCs, have put out patient information leaflets to give a clear explanation of what the changes will mean. The universal experience of dentists is that their patients were completely unaware of the new contract when discussing the changes with them. We have produced guidance for Llais and other patient interest groups on the key aspects of the model.

Support in Principle for Aspects of the Model Contract

Below are listed those aspects of the contract model that we support in principle following hard fought negotiations. Even within each of these aspects there are elements we are still at odds with and thus reject.

#1. & # 2. Care packages (and segmentation)

We accept in principle the different types of care packages. Care packages can define the care to be provided and allow that care to be remunerated appropriately. If operated properly they could facilitate the design of high-quality care and supporting data collection for contract management.

Use of care packages designed from evidence, best practice and clinical guidelines could assure quality. The care packages should include prevention and self-care advice. Data on entry into a treatment care package is itself disease risk data and this can assist in maximising clinical time while optimising data collection.

The new GDS contract model attempts to address the differentials in treatment costs through the care packages, which have the *potential* to ameliorate the problem of inadequate remuneration for high needs (red) patients.

We accept in principle the care packages for children. Older children will spend time with a mixed dentition of deciduous and permanent dentition until by about 13 years of age they will have lost all their primary teeth and will need care for their adult teeth. Care packages for

children have been developed recognising this move into the mixed dentition toward the permanent dentition.

 # 3. Year End Reconciliation

We support in principle the aim to be submitted within 35 working days (7 weeks) after 31 March. This assumes the period matches that of LHBs' turnaround times. Given that year-end processes are needed to reconcile activity with payments made it is reasonable to speed up the year-end reconciliation for all completed treatment.

 # 6. Urgent Care of New Patients

We accept in principle the commissioning of protected urgent dental care capacity which ensures capacity, and which remunerates the practice for making those slots available. Remuneration on a sessional basis can reduce the financial risk to the practice associated with providing this care while ensuring Health Boards have capacity to place patients into urgent dental care slots.

We reject the 12-month period repair or replace of urgent treatment. We propose instead a programme of audit with education for outliers. If this clause is brought in it will likely drive defensive dentistry (i.e. extractions rather than higher risk restorations).

We reject that access to walk-ins is prevented/highly restricted with emergency slots only be filled by the health board. This is likely to prove wasteful if there are unfilled appointments.

We reject the expectation that all practices will be able to offer urgent care 9 to 5 five days a week as this discriminates against small practices that do not currently have these opening hours. For such practices this requirement is likely to be discriminatory due to impacting caring responsibilities. The opening hours should be proportionate to the size of the contract. Smaller contracts should have the option of reduced hours of availability.

 # 7. Very high needs (blue) patients

We reject the definition of a very high needs patient should include at least one RCT. This is not only over-prescriptive but also at odds with the likely clinical scenarios.

We accept in principle the separate care pathway for this category of patient. Once classified as such upon examination they need to be dealt with mostly outside the GDS contract envelope of care. These patients need a package of stabilisation within the GDS before referral. Once they are stabilised, they should be referred to a PDS-based very high needs referral care pathway for a full course of care and treatment to become dentally fit. These PDS contracts can be offered to larger general dental practices with both capacity and capability to deliver them.

We reject the referral pathway to the CDS for these patients. The CDS has no capacity – see next section.

 # 13. Centralise collection of patient charge revenue

We accept the proposal to collect patient charges centrally by local health boards. This will relieve practices from the time and costs of administrating the collection of PCR. There will be a bedding in period, but it is not evident whether this mechanism will be operational by April 2026.

Rejected Aspects of the Model Contract

The following elements of the model contract are not acceptable in their current form and need revision:

 # 2 Pricing of care packages

We reject the current pricing of the packages. See also Section 6 Q2. We consider that the model pricing does not reflect the true costs of operating a dental chair despite the nominal hourly rate increasing from £120 under the UDA system to £135 in this model. This is reflected in the feedback from the May survey.

For simplicity and equity, the fee should be the same for all children as they shouldn't have to compete for access/ treatment because some are worth more than others.

We are concerned to learn from officials that if some of the packages are deemed 'too generous' the remuneration model will be adjusted down.

High value treatments will likely lead to increased administration, rationing of the high value treatments, and potential waiting lists which would sit with the practice.

We question the logic of practices being liable for urgent care for patients they have seen in the last two years. If they are dentally fit and returned to the DAP, then surely that is their position. If such patients need urgent care, should they not go via NHS111 like other patients on the DAP? This seems very muddled.

 # 4. Repair and Replace

We reject the 12-month period repair or replace of urgent treatment. We propose instead a programme of audit with education for outliers. If this clause is brought in it will likely drive defensive dentistry (i.e. extractions rather than high risk restorations).

We reject the 24-month liability on routine treatment. The values associated with the care packages are insufficient to balance this risk. This period is far too long and doesn't recognise the many issues that could arise from patient's lack of self-care, especially if they are on 24 months recall. A 24-month liability on routine treatment could lead to reduced practice of higher risk but less invasive treatments and resorting to extractions over complex restorations / RCTs, or lower risk but more invasive treatments, e.g. crown instead of large filling.

 # 7. Referral of very high needs patients to the CDS

We reject very high needs patients being referred to the CDS. Over the past decade, the CDS in Wales has evolved to focus primarily on providing care for children and adults with special needs - patients who would never be able to access dental care within the GDS.

The proposal to send very-high-needs patients to the CDS has been met by universal dismay across the profession. These patients need to be referred to a PDS-based very-high-needs referral care pathway for a full course of care and treatment to become dentally fit.

If this plan is not reversed, and an alternative PDS contract devised to operate in the GDS for these very high needs patients, then it is likely to result in trade union intervention on behalf of members.

 # 9. Failure to Attend

We reject the DNA rules. Patients who do not attend for NHS appointments cause a loss of NHS capacity and a financial risk to the practice. The higher the proportion of NHS care offered by a practice the higher the potential risk to its sustainability caused by such factors.

Historically, practices were able to manage this risk by charging patients for missed appointments but the decision that this must be discontinued for all NHS patients left the practices holding all these risks.

For new patients allocated via the DAP - failure to attend for an appointment should result in them being returned to the DAP if they have no mitigating factors and receiving feedback that they can no longer be allocated to that practice.

For patients receiving ongoing treatment (care package) - failure to attend for one or more appointments within their treatment plan (care package) should result in them being referred to the Dental Access Portal at the practice's discretion. Any costs incurred should be fully recoupable.

 # 14. Patient Flow - Dental Access Portal

We reject the proposed use of the DAP. The DAP system has usefulness in operating as a centralised waiting list for each LHB and is being used in that way currently. However, we do not agree that it can successfully be used to create extra capacity for new patients by making it the primary control mechanism for patient flows.

There is little evidence to support the assertion that the DAP will improve access for those patients who struggle to access care. In this model, increasing access is predicated upon the supposition of increasing capacity being generated by very low risk patients being returned to the DAP. The putative numbers will barely make a dent in the problem. Green patients will be sent to the DAP, and likely will be at the back of the queue for much longer than two years given the scale of numbers of patients already signed up.

Moreover, the proposed use of the DAP will damage continuity of care for many patients, which in turn will be detrimental to disease prevention and improving oral health. It will also create an unnecessary clinical and administrative burden of duplicating patient histories and additional radiographs etc. if a patient is sent to a different practice from the DAP. It would be much simpler to extend recall times to two years, if that is the aim of the model, so that continuity of care isn't broken. The DAP is the proverbial sledgehammer in this scenario.

 # 10. Mandatory Attendance of Cluster Collaboratives

We reject the proposed mandatory requirement to attend four meetings. We reject the clause where missing attendance causes a breach of contract. We only accept the loss of fees for meetings missed.

We reject the fee structure offered of £250 to dental contractors for each collaborative working meeting as it is inferior to that offered to Optometry (£277) and Community Pharmacy £295 per meeting. And these are figures for 2025 not 2026!

An acceptable fee to reflect the cost of back-filling for time lost is a minimum of £360, at current rates, which is less than the £400 current Guild rates for half a day.

 # 11. Contract Management Mid-year contract value reduction

We reject the proposed ability of LHBs to impose a mid-year contract value reduction. At the very least this needs a moratorium for the first three years of operating the new contract.

We reject the extension from 3 months to 6 months of variations and terminations of the contract. This could lead to various troubles for the practice including with patient flow and an increased risk of clawback if a practice is handing back their contract due to lack of workforce. This clause alone will very likely tip the balance for many dentists not wishing to be entangled with this level of risk in an unproven contract.

 # 12 Seniority payments

We reject the abolition of these payments. These payments were top-sliced pre-2006, so CVs were reduced by having lower fees. This top-slicing has perpetuated ever since so that most practitioners must contribute to the 'fund' for over 30 years before being able to claim them back. At the very least there needs to be a grandfathering period of a minimum of five years**.** It is not acceptable for these payments to fall off a cliff and leave dentists who were close to claim them in the lurch.

Recommendations

Governance

Commission an Independent Review of Dental Contract Reform Governance: Evaluate the process, transparency, and stakeholder engagement of the reform programme to ensure future reforms are truly co-produced and evidence based.

Fiscal policy

Increase NHS Dental Funding: Address inflation, rising staff costs, and infrastructure needs to ensure practices can sustainably deliver NHS care.

Establish a National Dental Infrastructure Fund: Create a capital investment scheme to support practice expansion, digital upgrades, and equipment renewal—especially in rural and underserved areas.

Separate Contract Reform Negotiations from Annual GDS Uplift: Ensure that contract reforms and changes are negotiated independently of annual financial uplifts

Pilot and Transition Period

Delay Full Implementation: Introduce a transition period to test and refine the contract model. There should be a moratorium on several of the contractual strictures for three years to allow this transition and to maintain the trust of the profession. OR …

Create a Dedicated Pilot Programme for the New Contract: Trial the full contract model in a small number of practices across different health boards before national rollout, with independent evaluation.

Patient Flows

Revise the operation of the Dental Access Portal (DAP): Reconsider or significantly revise the operation of the DAP to preserve continuity of care and avoid disrupting patient-dentist relationships.

Protect Continuity of Care: Avoid removing healthy patients to the DAP and ensure practices can maintain long-term relationships with their patients. Consider incentivising extended recall periods for green patients instead.

Do not use the CDS for Referrals for Very High Needs Patients: Develop a dedicated PDS-based pathway in the GDS sphere instead of overburdening the already stretched Community Dental Service.

Contract Model

Fair Pricing of Care Packages: Ensure care packages reflect the true cost of treatment, especially for high-needs patients, and avoid underfunding complex care.

Implement a Risk-Adjusted Capitation Model: Ensure funding reflects the complexity and oral health needs of patient populations, particularly in areas of high deprivation.

Revise DNA (Did Not Attend) Policy: Allow practices to claim for missed appointments or introduce a fairer system to manage patient non-attendance.

Contract Management

Introduce a Fair and Transparent Appeals Process for Contract Disputes: Establish an independent body to adjudicate disputes between practices and health boards over contract performance, clawback, and targets.

Develop and Engage the Workforce

Support the Dental Workforce: Provide access to occupational health services, ensure protected learning time, mandate CPD fee allowances, and work to restore pay levels to improve morale and retention.

Ensure Parity of Meeting Fees Across Primary Care Professions: Ensure cluster collaborative meeting payments for dentists are commensurate with loss of earnings for attendance.

Reinstate Seniority Payments and support equity for female dentists: Protect experienced clinicians' career commitment to the NHS by restoring seniority payments and support gender equity in dental earnings and enhancing maternity provisions.

Improve workforce and patient data

Mandate Data Transparency on GDS and CDS Capacity and Waiting Times: Require health boards to publish regular data on GDS and CDS staffing as FTEs and head counts separating out dentists in training; publish data on waiting lists as well as treatment data and provide referral outcomes to inform planning and accountability.

List of concerns about the survey design for the Welsh Government "Reform of NHS general dental services" response process including submitting online

General comments about Questionnaire design

- It is bad form to have sections numbered and questions numbered this way. Each question should have a unique number and each section a unique letter. That is very basic design.
- There are questions to the public and other questions to the profession. These are very muddled and should be made clearer which is for which.
- Several questions are double questions – they are asking opinions on two distinct aspects but allowing only a single response.
- Many of the questions cannot be satisfactorily answered with a simple yes or no or even a Likert scale.
- Many answers require context. There should be text boxes against each section. Text has been added into our written response and would ask this to be evaluated as part of our response.
- Many aspects of the contract are not covered at all by the questions so as a result most of our feedback on the entirety of the proposals has been included in the free text box at the end.

- It seems as if all the important issues are being swept under the carpet by omitting to address them in the main part of the questionnaire.
- The radio buttons as not exclusive so you can (accidentally) check more than one box. Also, some of the radio buttons are nonfunctioning.

More detailed critique of questionnaire design follows below:

1. Lack of Clear Definitions and Context

Terms like “remuneration packages,” “UDA system,” “endodontic treatment,” and “high needs patients” are not explained clearly.

This excludes members of the public who may not be familiar with clinical or contractual terminology, limiting their ability to give informed responses.

2. Professional Bias

Several questions appear to be targeted more at professionals (e.g. dentists, practice managers) without clearly separating them from general public questions.

No guidance is provided on which questions are appropriate for which audience—leading to potential confusion or skipped questions.

3. Overuse of Technical and Compound Questions

Many questions contain multiple ideas or qualifiers, making it harder to interpret them or respond accurately (e.g. “10 or more interventions, including endodontic treatment”).

This can lead to response fatigue or misunderstanding.

4. Limited Response Flexibility

Most questions are multiple-choice only, with limited space for nuanced or contextual responses.

Free-text boxes (where they exist) often do not follow the questions that need them.

5. Loaded or Leading Phrasing

Some questions are worded in a way that leads the respondent toward a specific view

(e.g. implying improved access is inherently preferable without addressing quality of care).

This introduces bias into the data collection.

6. Length and Repetitiveness

The survey is long and visually dense, particularly on a mobile device, which may discourage completion or reduce the quality of later answers.

Some questions seem duplicative or closely related, adding unnecessary burden.

7. Poor Accessibility and Inclusivity

No mention of language support, easy-read versions, or alternate formats for disabled or neurodivergent users.

The survey may not comply with accessibility standards for digital public engagement.

8. No Progress Indicator or Summary

The online survey doesn’t show how many questions are left or give an overall view of topics covered, which can be disorienting for users.

A summary page before submission might help users reflect or revise.

9. Ambiguity in Target Audience

There is no clear distinction between clinical and public opinion sections, making it hard for people to know what is relevant to them.

May lead to professionals answering from a personal rather than clinical perspective—or vice versa.