Logo, company name

Description automatically generated

BDA Template Response

to

Welsh Government’s Consultation

on the

Reformed GDS Contract Model

**9 June 2025**

**Instructions**

*Use this model reply by copying and pasting*

*any sections and text which apply / reflect your view*

***N.B****. The most effective response will capture your own experiences from the frontline.*

*Add to the copy, spelling out what these changes will mean for you, your team, and the community you serve.*

Submit your answers to Questions and free text responses

via the portal which you access here:[Respond online | GOV.WALES](https://www.gov.wales/node/67381/respond-online)

*Suggestions for answering individual questions*

Answer any questions you see as relevant to practitioners.

As a guide:

Section 1 Q 1-7 are about you

Section 2 Q1 (rest are for patients)

Section 3 Q1 (rest are for patients)

Section 4 – all for patients

Section 5 – all for patients

Section 6 – Q 1-3

Section 7 Text suggestions:

Q1 – There are a great many issues not considered in the consultation including lack of pilot phase or transition phase; the preventative aspect in almost non-existent; there is no occupational health support, no CPD fees; no protected study time. A big omission is the impact this will have on patients wanting to move to private care and the loss of capacity this will cause for NHS patients. There is nothing to cover how the contract will change every year under the reform agenda. There is no consideration for how this will impact earnings. And we want the tie to uplift removed. All of these are covered in greater detail below. [*add in sections 5 A to G below*]

Q2 - The best solution is to make the NHS contract attractive enough that dental team members who are Welsh speakers will want to do NHS work in places that are Welsh speaking predominantly and so can meet the needs of their patients. Currently the opposite is true - West Wales and North Wales, which are predominantly Welsh speaking, have the lowest numbers of NHS dentists per 10,000 of the population. Moreover, they 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 in those areas. (It is likely there will be native Welsh speakers providing this private care.)

Q3 - 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 swept under the carpet and no adjustment made in the proposal. This needs to be addressed with an appropriate adjustment.

Q4 - Post the whole main text into the free text box for the last question in the questionnaire.

*[See next pages for full text which you can use and amend as you wish]*

**Section 7. Q4**

***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.

***Include any responses which apply or modify as you wish***

I disagree strongly the aims and proposals in the consultation are clear

I disagree strongly the new contract will improve population health

I disagree strongly the proposed system will enable a greater focus on prevention

I disagree strongly the new contract will improve access to dental care

I disagree strongly the proposed system will improve the quality of dental care

I disagree strongly the new contract will enrich the well-being, capability, and engagement of the dental workforce

I do not expect issues raised by them in the consultation will be acted upon by the Welsh Government.

I do not agree that the questions were balanced, nor provided the background for them to give an informed response

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.

**Support in Principle for Aspects of the Model Contract**

***Include any sections and text which apply / reflect your view***

Below are listed those aspects of the contract model that I support in principle with caveats where I don’t agree:

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

**I 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.

**I 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***

**I 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***

**I 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.

**I reject the 12-month period repair or replace** of urgent treatment. I 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).

**I 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.

**I 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***

**I 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.

**I 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.

**I 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***

**I 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.

**Missing Aspects of the Model Contract**

***Include any sections and text which apply / reflect your view***

1. ***Lack of pilot phase***

This is an untested model which requires a *transition period* to ensure it is fit for purpose. I understand the Government will not entertain a pilot period although I still believe that is the preferred option. 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.

1. ***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. Lly Gruffydd MS has challenged this disregard for including risk in the Senedd:

1. ***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.

1. ***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](https://www.optometrywales.org.uk/wp-content/uploads/2025/03/20250307-Letter-NHS-Associated-Fees-en.pdf) – dentists have been offered nothing in this contract. There should be proportionate awards for CPD made in the fee structure.

1. ***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 swept under the carpet and no adjustment made in the proposal. This needs to be addressed with an appropriate adjustment.

1. ***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. I 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.

1. ***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.

**Rejected Aspects of the Model Contract**

***Include any sections and text which apply / reflect your view***

***# 2 Pricing of care packages***

**I reject the current pricing of the packages.** I 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.

I am 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.

I 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***

**I reject the 12-month period repair or replace** of urgent treatment. I 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).

**I 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. 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***

**I 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***

**I 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](https://www.nature.com/articles/sj.bdj.2014.766) 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 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***

**I 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, I 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***

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

**I 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)](https://www.optometrywales.org.uk/wp-content/uploads/2025/03/20250307-Letter-NHS-Associated-Fees-en.pdf) and [Community Pharmacy £295](https://www.drugtariff.nhsbsa.nhs.uk/#/00886336-DC/DC00885833/Part%20VIIB%20-%20Collaborative%20Working%20Scheme%20(Wales)) 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](https://www.bda.org/about-us/guild-rate-and-expenses/) for half a day.

***# 11. Contract Management Mid-year contract value reduction***

**I 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.

**I 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***

**I 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**

***Include any which apply / reflect your view***

**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 including 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 and provide referral outcomes to inform planning and accountability.

VERSION CONTROL

V1.1 9 June 2025