Welsh Government Consultation Document

Consultation on the reform of NHS General Dental services in Wales

Consultation on proposals to reform the way NHS dentistry is delivered through General Dental Service contracts in Wales.

Overview

We want your views on proposals to make changes to how dental services are provided through the General Dental Service in Wales. This is the first step in reforming the whole NHS dental system in Wales.

How to respond

Please complete the online survey that is available on the consultation web page or print the downloadable version of the survey and email or post it to the addresses below.

Further information and related documents

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

Contact details

For further information:

Email: HSS-PrimaryCareMailbox@gov.wales
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Primary and Community Care Division –
Dental Policy Branch,
Welsh Government,
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This document is also available in Welsh

UK General Data Protection Regulation (UK GDPR)

The Welsh Government will be data controller for any personal data you provide as part of your response to the consultation. Welsh Ministers have statutory powers they will rely on to process this personal data which will enable them to make informed decisions about how they exercise their public functions. Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about or planning future consultations. Where the Welsh Government undertakes further analysis of consultation responses then this work may be commissioned to be conducted by an accredited third party (e.g. a research organisation or a consultancy company). Any such work will only be undertaken under contract. Welsh Government's standard terms and conditions for such contracts set out strict requirements for the processing and safekeeping of personal data.

To show that the consultation was carried out properly, the Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. If you do not want your name or address published, please tell us this in writing when you send your response. We will then redact them before publishing.

You should also be aware of our responsibilities under Freedom of Information legislation. If your details are published as part of the consultation response, then these published reports will be retained indefinitely. Any of your data held otherwise by Welsh Government will be kept for no more than three years. Your rights Under the data protection legislation, you have the right:

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• to (in certain circumstances) data portability
• to lodge a complaint with the Information Commissioner's Office (ICO) who is our independent regulator for data protection.

For further details about the information the Welsh Government holds and its use, or if you want to exercise your rights under the UK GDPR, please see contact details below:

Data Protection Officer: Welsh Government Cathays Park CARDIFF CF10 3NQ e-mail: Data.ProtectionOfficer@gov.wales

The contact details for the Information Commissioner's Office are: Wycliffe House Water Lane Wilmslow Cheshire SK9 5AF Tel: 01625 545 745 or 0303 123 1113 Website: https://ico.org.uk/

Consultation on proposals to reform NHS General Dental services in Wales

Ministerial Foreword

A Healthier Wales sets out a vision of transformation in Wales using a 'whole system approach' which is focussed on health and well-being, and on preventing illness. The Oral Health & Dental Services response outlines how oral health and dental services in Wales will continue to develop in line with the changing needs of the population and how it will contribute to the plan.

Our vision for dentistry builds on the philosophy of Prudent Healthcare and we recognise that system change is required. Our focus is on transformation, innovation, and delivery to meet need. The values and design principles described in the plan will assist us implement change in dentistry. By investing in the teams who deliver dentalcare, offering strong national leadership and continuous engagement it will be possible to see change happen relatively quickly across Wales. We want to:

- 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.

A key part of achieving this vision is the reform of the NHS General Dental Services contract. Creating a contract that incentivises prevention and the provision of dental treatment on a risk and needs basis whilst at the same time providing a fair and attractive remuneration offer for the dental profession.

Tripartite negotiations took place from September 2023 to October 2024 between, Welsh Government, NHS, and the Welsh General Dental Practice Committee to design and develop a new GDS contract. In negotiations, there are aspects that all parties agree on, while other points may be less acceptable or contentious.

It is now time to set out these proposals for wider feedback from both the public and the dental profession. I would encourage all those with an interest in NHS dentistry in Wales to consider the proposals here carefully and to respond to this consultation at the earliest opportunity.

Jeremy Miles
Cabinet Secretary for Health and Social Care

DETAILS OF THE CONSULTATION

Consultation on proposals to reform the way NHS dentistry is delivered through General Dental Service contracts in Wales.

This consultation sets out the detail of the Welsh Government's proposals to reform the NHS General Dental Services (GDS) contract in Wales and the potential affects for patients and dentists arising from the changes.

The key changes proposed are:

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

This consultation outlines the proposed changes to NHS dental services in Wales due to contractual updates. It highlights the details of how these changes will affect service provision. However, it also notes that not all aspects of the laws and regulations related to dental services need to be amended to implement these changes.

This consultation document has been prepared by the Welsh Government and applies to Wales only.

Who will this consultation be of most interest to?

The proposed changes will be particularly relevant to service users, health boards, persons who provide or may wish to apply to provide NHS dental services, persons who assist in the provision of dental services or may wish to apply to assist in the provision of such services, and representative bodies including patient representative groups. The consultation questions are detailed at page 27.

Welsh Language Duties

The core principles established in the new GDS contract seeks to support equity of access for all patients, this includes ensuring that practices and patients in rural areas are supported. This is in alignment with the overarching intention of the Welsh language strategy in terms of promoting sustainable communities and in respect of "creating the social conditions where Welsh speakers can stay in Welsh-speaking communities or return to those communities".

The six Welsh Language duties in the current regulations will be carried through to the provisionally titled National Health Service (Dental Services) (Wales) Regulations

2026 and will support the national Welsh language strategy's commitment towards ''supporting people to use Welsh socially, at work, and when accessing services''

The Welsh Language Impact Assessment will be amended and updated in response to the outcome of the consultation exercise relating to the reform of general dental services contract which includes specific questions related to the Welsh language.

Introduction

The Welsh Government is committed to reforming the provision of NHS dental services in Wales and this consultation sets out our intentions to reform the NHS General Dental Services (GDS) contract to improve prevention, access, and quality and to ensure the service is sustainable for the long term.

Contract reform has been ongoing for a number of years in the GDS with various pilots trialled since 2017. These proposals bring the learning from those pilots together with input from the dental profession's representatives to set out a new contracting model for Wales.

This consultation outlines the proposed policy changes required to achieve the reforms. They will be implemented by legislation and directions, which will involve the following:

- Revoking the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006
- Revoking the National Health Service (Dental Charges) Regulations 2005
- The making of new versions of the above regulations and supporting directions

The Current System

The current GDS contract was introduced in 2006 although it is often still referred to as the 'new contract'. It changed individual 'fee for item' payment claims to an agreed annual contract value with stable monthly payments. The contract measurement used since 2006, the Unit of Dental Activity (UDA), has origins in treatment activity provided before the new contract.

Each contract holder has an annual contract value which, when divided by its UDA rate, generates the number of UDAs the practice needs to deliver each year. The contract value is then paid in twelve instalments with a reconciliation exercise at the end of the financial year. If a practice has delivered the requisite number of UDAs no further action is required however if there is under delivery the practice can be required to pay funds back to the health board which has the term "clawback."

UDAs are claimed in four bands of care attracting 1, 1.2, 3 or 12 UDAs. Individual practice UDA values are usually based on activity prior to 2006, and the value varies from practice to practice and even within a practice itself. There has been attempts to address this inequality by setting a minimum UDA value, but there is still a variance meaning that some performers carry out NHS treatment for less money than others despite doing the same work, which is perceived to be unfair.

Rationale for Change

Tooth decay and gum disease are largely preventable by reducing the frequency of sugar intake, maintaining good oral hygiene through daily tooth brushing, and using fluoridated toothpaste. We also know that reducing tooth decay in a child's primary dentition (baby teeth) often prevents them getting problems later in life. The UDA as a measure does not overtly incentivise nor reward increasing access, quality, or most importantly prevention. The proposals set out in this document clearly show how prevention and access for children are incentivised from a financial perspective.

The current system UDAs are allocated into bands, but this causes issues. For example, a band 2 course of treatment covers an examination, radiographs (x-rays), gum treatment, extractions, and fillings. This can result in a dental practitioner being paid the same for providing multiple items as a performer who only does one single treatment. This creates a perverse incentive and often results in practices being reluctant to accept patients with elevated levels of disease which means that those that need treatment the most, struggle to access NHS dentistry.

Many dental practices in Wales, similar to the rest of the UK, also offer private dentistry, in the past the percentage of private dentistry provided by NHS contract holders was modest compared to their NHS income stream. However, this has steadily grown over the decades with a possible rapid acceleration during and post Covid. The fees generated from similar private work often significantly exceed NHS fees which has the potential to incentivise practices to focus more on private dentistry than delivery of their NHS contract.

The UDA model also restricts urgent access to patients. Although a practice will often see people that have attended the practice previously, they are only responsible for a patient during an open course of treatment. Patients who do not have an existing relationship with a dental practice find it difficult to access the urgent treatment they need. These proposals ensure that every NHS contract must provide urgent care for their existing patient group and any new patients that present through the Health Boards (LHB) urgent dental system.

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. No other part of the NHS health care system prioritises well patients over those with active disease. This is a fundamental flaw in the UDA based dental contract system and is an inefficient use of resources. The proposals contained within this consultation introduce changes to ensure recall is extended to deliver the NICE guidelines.

The current contract pays NHS contractors monthly, based on the average value of their annual contact. If dentists do not deliver the level of dentistry that is required in

their agreement with the Health Board; the practice has to return that money to the Health Board, known as “clawback.” However, the contract is heavily weighted in favour of the contract holder meaning that health boards have difficulty reinvesting any financial underperformance and are limited in their ability to unilaterally reduce a contract value until there have been two financial breaches. This means that the money is “locked” in the practice for at least two years which will adversely affect access and creates an inefficient use of public funds.

Since 2022, dental practices have been offered a variation to the traditional UDA contract, using new metrics to monitor activity. These include a new patient and urgent care metrics to address access pressure points, as well as a prevention metric introduced during the early contract reform stages. Over 80% of practices have now adopted this offer. The variation aims to reduce the negative effects of the UDA contract, incentivise new patients, promote prevention, and reduce unnecessary recalls. While it has improved access for some patients, many of the issues with the UDA contract cannot be fully resolved through this variation alone, and a new contract is needed for more substantial changes.

The change is also driven and supported by the profession. There is clear unfairness in the UDA model and The British Dental Association reports that dental teams are demotivated by the current system and demand change.

Intended effect and beneficial outcomes

For patients we want to:

- ensure that every patient receives individualised advice and treatment where necessary for preventing tooth decay and gum disease
- increase patient accountability for their own oral health
- widen access so that there is greater capacity to provide treatment to those with disease
- ensure that all treatment required to maintain oral health is available
- change the way people with good oral health access services
- establish new pathways that enable people with elevated levels of oral disease to receive treatment
- improve the quality of dental services delivered
- ensure there is always capacity for new patients to get access for both urgent and routine care

For dentists we want to:

- Reduce administrative burden
- Introduce a fairer and more transparent remuneration system
- Encourage dentists to commit more of their time to providing NHS services
- Enable skill mixing and making full use of the dental team
- Have clearer contractual controls to manage underperformance

Policy, legislative framework, and regulation

The proposed changes to the core services that contractors (and LHBs) will be required to provide will be given effect via regulations made under the National Health Services (Wales) Act 2006 ("the 2006 Act").

The legislative framework for dental services in Wales is principally set out in Part 5 (sections 56 to 70) of the 2006 Act.

There are currently two main sets of regulations in this area. These are described below:

- The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006. These are the principal regulations, and they provide for the arrangements for NHS dental treatment in Wales.
- The National Health Service (Dental Charges) Regulations 2005. These regulations set out the patient charges associated with NHS dental treatment and the arrangements for those exempted from paying the patient charge

These regulations are underpinned by the General Dental Services Statement of Financial Entitlements which came into force on 24 April 2009, and which is amended via directions periodically.

The reforms will require the revoking and remaking with changes the above regulations and directions under a set of two new sets of regulations provisionally entitled

- The National Health Services (General Dental Services Contracts) (Wales) Regulations 2026
- The National Health Service (Dental Charges) (Wales) Regulations 2026

The Legislative Process

The regulations will be made under the Senedd's negative procedure for making subordinate legislation (in accordance with section 203(4) of the 2006 Act)

Closer inspection of changes proposed and the expected benefits

This section sets out the detail of the changes that will result from the proposed reforms. There are elements that will be of interest just to dentists and some that directly affect the public. We have tried to separate these out where possible and the questions posed are also slightly different for these groups.

Issue 1 – Contract Segmentation

Each GDS contract has an agreed annual contract value (ACV). The reform variation arrangements introduced the concept of segmenting the ACV to direct how the funding is used; in particular, ensuring capacity for new patients requiring both urgent

and routine care and a specific payment for prevention. Proposed segmentation for the new contract is as follows:

(a) 10% is allocated for urgent treatment for new patients – definitive treatment is mandated and in cases where definitive treatment is not possible it is expected that the patient is offered an additional appointment to complete the definitive urgent treatment. Practices must provide appointment slots at time required by the health board on a rolling six monthly basis. All patients will be supplied via the health board's urgent access arrangements and the urgent fee is paid even if the patient fails to attend.

(b) 10% is allocated for new patient assessment – all new patients will be supplied by the health board from the Dental Access Portal with specific exceptions e.g. children where their parents are already NHS patients at the practice

(c) 70% will be available to provide care packages

(d) 5% is allocated for a prevention payment – This will require full compliance with Delivering Better Oral Health (DBOH), Fluoride application as per current variation requirements, prevention conversation and the provision of a tailored care plan based on risk and need

(e) 5% is allocated for local/national priorities – This will be specified annually, usually through negotiation, and could include elements such as Audit / Quality Improvement activity, Annual self-assessment, high needs areas/retention.

The percentage assigned to contract segments can be varied by the health board depending on population needs and practice profile, for example access for new patients may be changed from 10% in a particular location.

Issue 2 – The Remuneration Model

The remuneration model for NHS dentistry was the topic on which most time was spent during the negotiation process. All parties were united in their opinion that the current Unit of Dental Activity (UDA) needed to be replaced with a fairer and more transparent payment mechanism.

Fee for item (FFI) was the method of payment for NHS dentistry from its inception in 1948 until induction of the UDA contract in 2006. FFI is theoretically the most transparent payment mechanism as there is complete visibility and linkage between work done and payment. It is also the system of remuneration for private dentistry, so even though it has not been used in NHS dentistry for nearly 20 years there is still an attachment to it in many quarters of the profession. However, FFI incentivises or rewards treatment, leading to overprescription with disincentivising of prevention. With a policy focus on prevention through a risk-based approach, this means that FFI cannot be considered a viable or effective solution for achieving sustainable improvement in oral health. With the policy aim for focussing on prevention by

introducing a risk-based approach FFI could therefore never really be considered a viable or effective option.

After considering the advantages and disadvantages of the current variation arrangements, and a comprehensive review of alternative weighted capitation schemes, all parties agreed on a care package model that provides payment for a range of common dental treatments based on complexity and time required, the fees proposed are set out below. Annex 2 provides the details of what is proposed to be included under each care package.

Fee Scale Adults

	Care Package	**Unit Price**
1	Urgent	£75
2	Patient assessment	£49
3	Simple Caries	£65
4	Extended Restorative	£124
5	Perio	£187
6	Anterior RCT	£164
7	Posterior RCT	£329
8	Crown/Bridge	£253
9	Denture	£156
10	Very High Needs Stabilisation	£135
11	3-month recall	£180
12	6-month recall	£90
13	9-month recall	£67.50
14	12-month recall	£45

Fee Scale Children (Higher values to incentivise child access, ongoing monitoring, and preventative support)

15	Initial Assessment under 1 years	£80
16	Initial Assessment 1-4 years	£75
17	Initial Assessment 5-12 years	£70
18	Initial Assessment 13-17 years	£60
19	6-month recall	£110

Should a child need active interventive treatment they would transfer into a care package with the same payment applicable for an adult.

A maximum threshold will be placed on the number of high value treatments (numbers 7 and 8 in the fee scale table). No more than 10% of the 70% of annual contract value (ACV) allocated to the care packages segment can be delivered through the provision of these care packages. This will ensure focus of delivery towards the greatest volume of patient with the highest need. Local flexibilities may apply for high needs areas or practices with a historic trend of needing to deliver a disproportionate volume of this type of treatment. This would need to be with prior agreement of the local health board. The provision of these items, and any threshold, should be managed equally across the entire contract year. Also, the cost of any

dental appliances / laboratory items will be paid for separately; this is covered under the patient charge section later in this document.

No changes are proposed to the way in which contract payments are made. They will continue to be made in twelve monthly instalments. Practices will need to deliver the value of the contract with an end of year reconciliation based on the value of the care packages that have been delivered during the year. This will not eliminate clawback for underperformance against contact.

Issue 3 – End of Year Reconciliation

Currently the end of year reconciliation can take 3-4 months. Practices have 62 days after 31st March to submit claim forms related to treatment provided in the previous fiscal year, which means health boards cannot even begin the reconciliation process until June. This often leads to practices having to wait until July to find out whether any financial recoveries are applicable.

We are proposing to reduce the 62 days limit to 20 days, with the health board having 28 days to then provide an end of year position to the contract holder. Currently over 90% of practices are submitting within 7 days of completion, so this will not increase administrative burden.

Issue 4 – Repair and Replacement

Under the current contract where a restoration/appliance fails within 12 months the contractor must repair or replace the failed item. No patient charge is levied on the patient however the contractor can claim the UDAs associated with the item being repaired/replaced.

Under the new contract we are proposing that the contractor will be responsible for the repair/replacement, without attracting additional payment, for any treatment that fails within a period of 12 months for urgent treatment, and 24 months for treatment provided under a care package.

We recognise that this will require defining to identify scenarios where a free repair and replacement is not appropriate. This will be worked on during the consultation period but will not change the premise of the proposal.

Issue 5 – Parental and Sickness Leave Arrangements

The current Statement of Financial Entitlement (SFE) provides for payments related to seniority/paternity/adoptive/sick leave. Payments are calculated based on performer's Net Pensionable Earnings (NPE) or Net Pensionable Earnings Equivalent (NPEE) and is paid weekly. No changes to the criteria for entitlement are proposed.

In 2017, the maximum payment was capped in England at £1,660 for a dental performer and £3,630 for an orthodontic performer. This cap was not introduced in Wales, but we propose to implement it in the new contract. This change will only

affect the minority of extremely high earners and any savings made by this change can then be re-invested in NHS dental services.

Shared Parental Leave

The concept of shared parental leave (SPL) has been around for many years and is widely available particularly in public sector employment including the NHS. However, the current SFE does not make provision for shared parental leave in primary care dentistry.

We propose making provision for SPL in the SFE for the new dental contract, basing it around the time periods and payment levels for maternity pay.

Issue 6 – Urgent Care

We know that the availability of urgent care is highly valued by the public. Urgent care is not very well defined in the current regulations and under the UDA model is poorly remunerated in terms of the need to provide definitive treatment. The following is proposed:

- Urgent appointments should include a global oral health assessment (including soft tissue) and onward referral where appropriate.
- Urgent care should provide relief from pain and/or prevent significant deterioration of a particular problem, with an onward referral if required. This care should normally be done in a way that provides, where possible, a long-term solution. Where appropriate, and with the patient's consent, urgent care should consist of permanent definitive treatment, including restorations. When definitive treatment is contraindicated or not possible, justification for any treatment or care provided will be recorded in the patient's clinical record.
- For patients that do not currently have an existing relationship with the practice, the patient should be made aware of their responsibilities and requirement to seek further care to resolve the urgent issue or prevent a recurrence. For example, if further routine treatment is needed, they should be advised to register on the Dental Access Portal.
- For the contractor to be paid for any missed new urgent appointments, the practice must demonstrate that they made adequate efforts to ensure the patient's attendance. Evidence of these efforts must be retained and available for audit. A working group has been formed to create guidance on how practices should manage new urgent patients who fail to attend their appointments.
- Practices will need to be open and available for urgent care Mon-Fri 9am-5pm.

Issue 7 – High Needs patients

Patients who present to a practice with exceedingly high needs (defined as requiring ten or more interventions e.g. fillings/extractions, which include endodontic (root canal) treatment) will be referred into a separate pathway. Health Boards will have

the freedom to deliver this pathway via the Community Dental Service or establish commissioned arrangements with dental practices.

While waiting for the referral to be fulfilled the GDS fee structure provides for a stabilisation course of treatment that will prepare the patient for future treatment. Once the referral is completed and the patient is dentally fit, they then can re-enter the GDS system via the Dental Access Portal (DAP).

Issue 8 – Mandatory Services

The contractor will be responsible for ensuring that all level 1 treatment is carried out within the care package. Level 1 treatment guidance has been developed by the different specialities and any referrals made that do not meet the threshold to exceed level 1 will be returned to the practice.

Issue 9 – Failure to Attend

Patients' who break appointments (failure to attend or late cancellations) incurs both a cost and loss of time to the dental practice. In the current contract the contract holder bears this financial risk. The move to funding new urgent patients who fail to attend shifts some of this risk onto the NHS, but it is difficult to go any further given the requirement for proper stewardship of public funds.

There is a need to define good practice in terms of decreasing the failure to attend rate and, as mentioned earlier, there is ongoing work to develop national guidance in this area.

From a regulatory point of view the following terms are proposed to support practices in managing DNAs:

- For new patients allocated via DAP/health boards - failure to attend for initial assessment twice will result in them being returned to the DAP (bottom of the list).

- For patients receiving ongoing treatment (care package) - failure to attend for 2 consecutive appointments, or 3 within their treatment plan (care package), will result in them being returned to DAP (bottom of the list). A percentage of the care package fee will be paid for incomplete delivery depending on how much treatment has been provided.

- Patient responsibilities and consequences of DNA to be clearly displayed in practice, on websites and in patient information leaflets.

Issue 10 - Accelerated Cluster Development / Professional Collaboratives

A cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better coordinated to promote the wellbeing of individuals and communities.

Whilst working on a cluster footprint has been the norm for GPs for many years dentistry has not fully engaged, nor has it been funded to do so. To enable dental teams to form professional collaboratives we are proposing to make participation in professional collaboratives a contractual requirement.

This will require a dentist working under the contract to attend four meetings per year. Meeting attendance will be funded at £1,000 per annum and will be top sliced from the ACV.

Failure to meet requirements (4 meetings) will result in financial sanction or contractual breach.

Issue 11 – Contract Management

Financial sanctions at the end of a financial year are detrimental to both the practice and access to NHS dental services. The next dental contract must give commissioners the appropriate levers to reduce sanctions to minimal levels so that all the dental budgets can be used in full. Proposals are as follows:

Mid-Year – expected delivery will be 40%. NHS dental care is currently delivered unevenly across the year. The UDA contract requires 30% delivery at mid-year which results in a disproportionate amount of activity being delivered in the second half of the year. This change seeks to redress that imbalance. If a practice cannot demonstrate achievement to this level, then the health board can unilaterally implement a mid-year financial adjustment. This will enable funding to be reallocated in-year.

Full year activity achieved below 95% - the Health Board will apply a financial recovery. The Health Board reserves the right to recover the full underperformance, up to 100%, where a contract has underperformed in the previous financial year.

If a practice underperforms in two consecutive years, the Health Board can unilaterally impose a permanent reduction. The regulations will need to prescribe the process which is likely to be the use of breach notices.

Activity achieved between 95% to 100% - the Health Board may allow the contract holder to carry forward this underperformance into the next financial year or apply a financial recovery. When carried forward any underperformance must be delivered within the first two months of the new financial year.

Activity 100% to 105% - the Health Board may apply a carry forward to the following financial year, with no contract value increase. The Health Board reserves the right to financially award the practice instead of applying a carry forward.

Activity achieved in excess of 105% - no adjustment will be made; activity will be lost.

Variations and Terminations – notice period to be 6 months, an increase from the current 3 months.

Issue 12 – Seniority Payments

In Wales, performers who turned 55 can apply for seniority payments from the Welsh Government. Applications must be sent to NHS Wales Shared Services Partnership (NWSSP).

Seniority payments are paid at 21.72% of the performer's Net Pensionable Earnings (NPE) or Net Pensionable Earnings Equivalent (NPEE). Seniority payments are taxable and fully pensionable. The maximum monthly seniority payment a performer can claim is £662.

Seniority payments were removed from the SFE in England in 2011.

Applications for seniority payments in Wales are surprisingly low. We suspect this is because it has been assumed they were removed at the same time as England.

There is an argument to be made that this payment is age discriminatory, particularly towards newly graduated dentists who will take some time to increase their speed of work to what could be considered average.

WG/NHS proposed that the provision for seniority payments is removed from the SFE in the new dental contract so that the funding can be invested in patient care.

Issue 13 – Patient Charge Revenue (PCR)

Across the UK dental patients pay a contribution towards their NHS dental care. Patient charges were first introduced in 1951 and have remained in place ever since. They provide an important contribution by increasing the budget available to fund NHS dental care by over £20m.

Moving from four treatment bands under a UDA system to the 19-care package model proposed for the new dental contract requires a change to the way PCR is determined. It also provides an opportunity to modernise the way in which it is collected.

<u>Collection of the Patient Charge Revenue (PCR)</u>

The current system requires dental practices to handle patient charge collection, leading to administrative burdens and financial challenges from bad debt and bank fees. The proposal introduces an online payment system where patients receive an invoice via text or email after treatment and can pay online. This system aims to reduce administrative burden for practices as it will be handled by the NHS Business Services Authority. It also helps to clarify that Patient Charge Revenue (PCR) funds go to health boards and the Welsh Government—not directly to dental practices—while clearly distinguishing between private and NHS dental services.

<u>Determining the charges</u>

There are no proposals to change the existing criteria that exempts people from paying the patient charge. These can be found here NHS dental charges and exemptions | GOV.WALES

Under the UDA model the patient charge represented around 65% of the cost of Band 1 and 2, 70% of Band 3 and 80% of urgent treatment. It also means that someone having a single filling pays the same Band 2 charge as someone who has three fillings and root canal treatment. There are two areas where changes are proposed

Dental Appliances

The current system underfunds Band 3 dental treatments involving appliances like dentures, crowns, or bridges, as the UDA payment often doesn't cover the costs and time required. To address this, the proposal suggests separating the patient charge for the dental appliance from the treatment charge.

Under the new system:

- **Dental practices** will receive direct payment for appliances, which must be charged at cost—no profit allowed.
- **Patients** will have the option to choose the type of appliance based on what they're willing to pay, a choice currently unavailable unless the entire treatment is privately funded.
- **Exempt patients** will have a set tariff for appliances with a maximum limit, and the cost will count toward the contractor's ACV, ensuring they aren't disadvantaged and practices can meet targets with less overall activity.

Since only about **4% of all treatments** involve a dental appliance, this change will minimally impact the majority of NHS dental care recipients.

Treatment Charges

The proposal suggests that patients receiving NHS dental treatment would cover 50–60% of their care package costs. This approach is similar to the model used in Scotland and Northern Ireland, where patients pay 80% of treatment costs, with a maximum payment of £384, including dental appliances. The goal is to make patient charges more closely reflect the actual treatment costs.

Under this system, some patients may pay slightly more for routine checkups and urgent care while others could pay significantly less for common treatments like single fillings, extractions, and single crowns.

Below are some scenarios to illustrate the charges patients would pay depending on the treatment they receive based on a 55% contribution.

Examples where patients may pay slightly more:

- Check up for existing patients - £24.75, current charge is £20
- New patient assessment - £26.95, current charge is £20
- Urgent treatment - £41.25, current charge is £26.80

We would note that the charges for a check up and new patient assessment remain below the charges for similar treatment in England (£27.40).

Examples where patients would pay slightly less:

- Up to four fillings/extractions - £35.75, current charge is £60
- Single crown - £239.15 (including laboratory fee), current charge is £260
- Full acrylic dentures - £225.80 (including laboratory fee), current charge is £260
- 2 Unit Bridge - £233.15 (including laboratory fee), current charge is £260

The examples provided above are the most common outcomes for patients that need active dental treatment. Therefore, the proposals mean that for people who need treatment they would pay less than under the current UDA patient charge model

Examples where there is a substantial difference:

Under the UDA contract root canal treatment is provided as a Band 2 item. The payment made to the dentist associated with this type of treatment is not reflective of the time needed to undertake the procedure. Given our aim is to ensure a fairer remuneration, the care-package model proposed addresses this by offering a higher fee for root canal treatment than offered under the UDA model. This also means that the patient charge associated with such procedures also increases.

- Root canal on a front tooth - £90.20, current charge £60
- Root canal on a back tooth - £180.95, current charge £60

In rare cases (less than 1%), a patient may need both a root canal treatment and a crown on the same molar tooth, which under this methodology would generate a patient charge of £420.10. To avoid charges exceeding those in other areas of the UK, the maximum charge is capped at £384, including the dental appliance. In this case, the patient would pay the dental practice for the crown (dental appliance) and would pay the balance of £384 to the Health Board.

Issue 14 – Patient Flow

NHS care is based on the principle that good healthcare should be available to all, with access based on clinical need. That principle, of putting patients first, remains at its core. NHS care has changed from one of diagnosis and treatment of disease towards an increasing role in both prevention and improving population health.

A major challenge under the UDA contract was the lack of a mechanism to ensure access to NHS dental services for everyone that needed them. Additionally, a sizeable portion of the NHS dental budget was spent on check-ups for individuals based on demand, not on clinical or risk factors.

A substantive new dental contract, the introduction of the Dental Access Portal (DAP) and a clear mandate for reform provides an opportunity to clarify the relationship patients have with a dental practice and ensure that this is based on their oral health risk and need. This will enable the funding available for NHS dentistry to be allocated to those who need it the most.

Contrary to popular belief, individuals who continue to access NHS dental services at the same practice are not ‘registered’ with that practice. It is only once a patient enters a care plan that they establish a ‘formal’ relationship with that practice. Once the treatment plan is completed, the formal relationship between practice and patient ends. The same applies for patients that visit a dental practice for the sole purpose of a check-up.

Registration was only in place from 1990-2006 and, at no time before or after this period, have patients been registered to a practice. The main purpose of NHS dental registration during this period was to ensure timely access to urgent dental care and to provide a regular income stream to the contract holder. The positive outcomes associated with registration has largely been addressed in the new contract proposal with the ongoing recall care packages.

With the implementation of the new contract, the DAP will serve as the primary gateway to access NHS dentistry in Wales, providing reassurance that patients are within an NHS system. Once a patient has signed up to the DAP, they will be assigned a practice in their local area. The individual will be invited for a ‘check-up’ and then, based on clinical need, will either be put back onto the DAP to await their next ‘check-up’ or receive a care package within their assigned practice.

The principal change we are proposing here is that patients that are assessed to require a recall interval of 18 months or more will return to DAP after their assessment. This benefits the practices as it reduces the administrative need to contact recall patients, supports patients as they will have the security of being within the NHS system, and allows Health Boards to monitor demand for services.

Then, depending on a patient’s recall status and the capacity within the Health Board area at any given time, the patient may be appointed to a different practice in their area once recalled from the DAP. Dental practices will no longer hold any waiting lists as patients will be directed to the DAP.

Being allocated to a different clinic can be beneficial. Receiving care from different practices ensures that patients are seen by peers, thereby enhancing clinical governance. This approach aligns with the wider healthcare system, where patients see multiple health care professionals to address their clinical needs.

The care packages outlined earlier in this document ensure that those who require active treatment of disease, or on-going monitoring, can access services from the same practice at more regular intervals (3, 6, 12 months) until their care plan is complete. So, for those that clinically require regular access, or an urgent need arises, nothing really changes.

We know that tooth decay and periodontal disease are preventable. Patients who return to the DAP are in the lowest risk category and are able to maintain their oral health through self-care practises. The implementation of the DAP provides an opportunity to break the false narrative that six monthly “check-ups” are necessary for everyone. Instead, it aligns dentistry with the wider health care system to provide acute and chronic care based on individual need. Under the new contract, we maintain best practice by maintaining the provision of assessments, in line with national guidelines, to ensure patients are not developing chronic conditions. These assessments can be performed by any member of the dental team, promoting a skills mix within practices.

Patients with longer recall intervals (18+ months) will undergo a ‘Patient Assessment’ on their next appointment, regardless of whether they have attended the practice previously. This is a contractual mechanism designed to optimise resource allocation and ensure continued access. It does not reflect an individual’s status as an NHS patient.

We recognise the risk that patients on 18-24 months recall might wait longer than their assigned recall. However, we also need to consider that patients who have had a course of treatment and have been stabilised and maintained are safe to be placed back into the DAP. This is a far better outcome than people with active oral disease not being able to gain access. It is also important to highlight that 10% of the new contract value will be set aside for new patient assessment, so there will always be capacity for a flow of patients from DAP into NHS dental services, regardless of their clinical risk.

We also recognise that patients with good oral health may require urgent treatment for an acute issue and that being assigned to DAP rather than a practice may appear that access to urgent care will be more difficult. We would reassure patients that if after receiving an assessment, being assigned 18-24 month recall and being placed back on DAP, they will be entitled to receive urgent care from the same practice for 24 months. Once the acute issue has been resolved they will then be recalled for an assessment in-line with their original recall status.

Ultimately, we want to inform the public that having frequent check-ups as a healthy patient does not guarantee that no problems will occur until their next appointment, it's only a base line assessment on the day. We understand that the public’s main concern is accessing urgent care, and this provision will remain. Patients who are considered low risk should feel positive about their oral health and reassured knowing that they do not have to attend the dental clinic unnecessarily.

A flow diagram is provided at Annex 1 to visualise these proposed arrangements.

Regulatory Impact Assessment & Equality Impact Assessment

We have prepared a Regulatory Impact Assessment (RIA) and an Equality Impact Assessment (EIA) to accompany this consultation. The RIA provides an assessment of the costs, benefits and risks associated with the proposed policy changes. The

EIA has considered the main impacts of the policy delivery to those with protected characteristics.

The analysis within the RIA found that the proposed reforms to the GDS contract delivers significant benefits. These benefits include improved patient outcomes, better resource allocation, reduced long-term costs for health boards and social services, improved workforce resilience, and overall economic and societal gains. The RIA demonstrates that the proposed changes will deliver a more modern, agile, and patient centred provision of NHS dental services in Wales.

The analysis within the EIA found that the proposed reforms to the GDS supports the ambition set out in *A Healthier Wales* to deliver a high quality of care and achieve more equal health outcomes for everyone in Wales. There is a strong and consistent association between socioeconomic status and the prevalence and severity of oral diseases and conditions. This is significant when considering the impacts on those with protected characteristics, who are more likely to be living in deprived areas.

By transitioning to a risk and needs-based approach, the new contract seeks to break down barriers for those who have historically struggled to access NHS dental care. This includes increasing capacity for new patients and the provision of treatment. Significantly, the proposals explicitly incentivise access to children by providing higher values to care packages, ensuring comprehensive preventive support and promoting better oral health outcomes. The Welsh Government does not anticipate any negative impacts on those with protected characteristics.

The responses to this consultation will inform future iterations of these impact assessments.

Engagement and Consultation Process

- ***Consultation Process***

A twelve-week consultation is being launched to provide an opportunity to comment on these proposals.

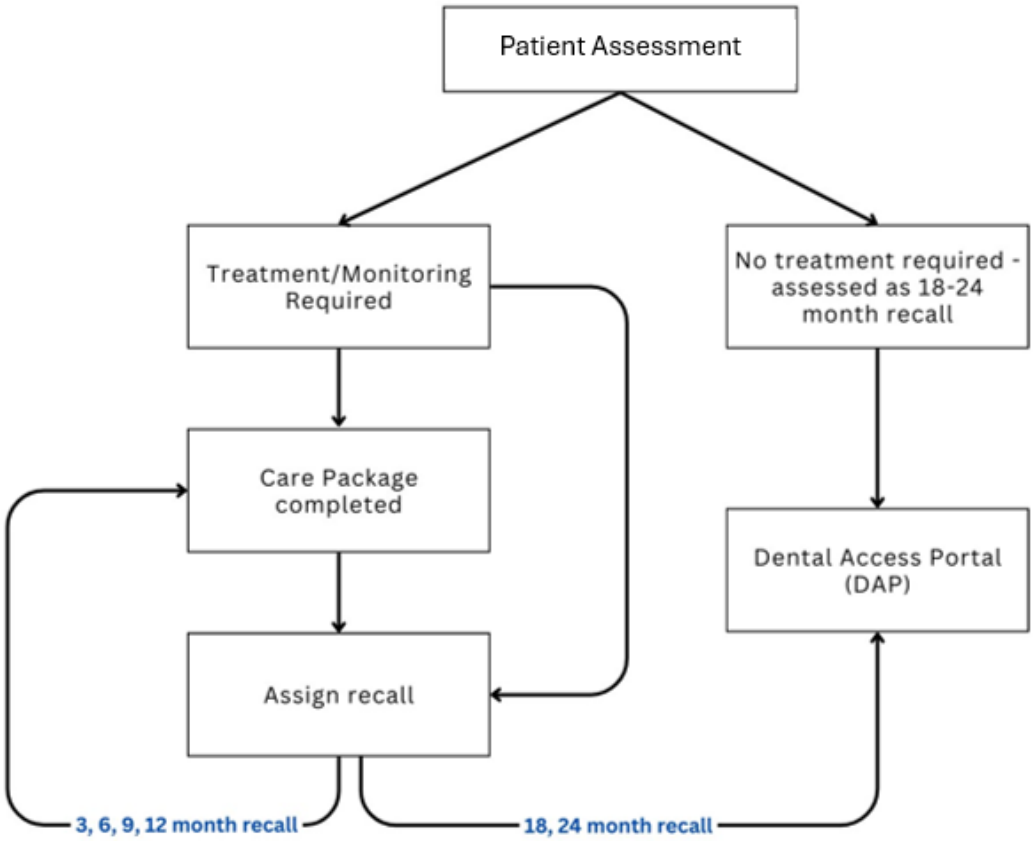
Any responses received as part of this consultation will be given careful consideration and a summary of the responses received will be published on our website.

- ***Groups affected***

The proposals will be relevant to all persons who currently provide or intend to provide NHS Dental services in Wales, and to those who assist or intent to assist in the provision of such services, Local Health Boards, and members of the public.

Annex 1 – Proposed Patient Flow Diagram

The diagram below sets out the new patient journey under the proposed new model.



Annex 2 – Care Package Descriptions

1. Urgent Care

- Urgent appointments should include a global oral health assessment (including soft tissue) and onward referral where appropriate.
- Urgent care should provide relief from pain and/or prevent significant deterioration of a particular problem, with an onward referral if required. This care should normally be done in a way that provides, where possible, a long-term solution. Where appropriate, and with the patient's consent, urgent care should consist of permanent definitive treatment, including restorations. When definitive treatment is contraindicated or not possible, justification for any treatment or care provided will be recorded in the patient's clinical record.
- For patients that do not currently have an existing relationship with the practice, the patient should be made aware of their responsibilities and requirement to seek further care to resolve the urgent issue or prevent a recurrence. For example, if further routine treatment is needed, they should be advised to register on the Dental Access Portal.

2. New Patient Assessment

- To include full clinical assessment (including soft tissue) and intraoral radiography
- Prevention to include diet advice and Oral Hygiene instruction (based on clinical exam), risk factor management including smoking/alcohol/sugar reduction etc advice.
- Topical fluoride application, high concentration fluoride toothpaste prescription and fissure sealants (for enamel caries) as appropriate.
- If treatment or monitoring is needed this will then be provided under a care package

3. Simple Caries Care Package

- To include plastic restorations or extractions for 1-4 teeth
    - Composite 3-3 and posterior smooth surface and class I
    - Alternatives to Amalgam 4-8 Class II
- Excludes endodontics (root canal treatment)

4. Extended Restorative Care Package

- To include plastic restorations or extractions for 5-8 teeth
    - Composite 3-3 and posterior smooth surface and class I
    - Alternatives to Amalgam 4-8 Class II
- Excludes endodontics (root canal treatment)

5. **Perio Package**

- Entry assessed on engagement from assessment but patient must achieve minimum of 30% plaque score by 3rd OHE visit)
- To include
    - plaque score and tailored OHI
    - 6ppc
    - RPRF
    - Pocket debridement

6. **Anterior (Front Tooth) Root Canal Care Package**

- Includes a maximum of 2 endodontic procedures including plastic restorations 3-3

7. **Posterior (back tooth) Root Canal Care Package**

- Includes a maximum of 2 posterior endodontic procedures (4-6)
- Includes cuspal coverage
- Excluding lab cost of any dental appliance required

8. **Crown and Bridge Care Package**

- Maximum 3 unit
- Includes:
    - Crown and bridge retainer
    - Study models, planning or articulation
    - Posts and or core
- Excludes laboratory fees for the dental appliance

9. **Denture Care Package**

- Upper and lower dentures included
- Excludes laboratory fees for the dental appliance

10. **Very High Needs Stabilisation**

- To include GIC stabilisation before referral process
    - Defined as requiring ten or more interventions e.g. fillings/extractions, which include endodontic (root canal) treatment
    - Patient is then referred to the Health Board for treatment to become dentally fit in the community dental service or separate commissioned service

11-14. Recall Care Packages

- 3-month recall provides for 4 assessments in a rolling 12-month period.
- 6-month recall provides for 2 assessments in a rolling 12-month period
- 9-month recall provides for 2 assessments in a rolling 18-month period
- 12-month recall provides for an annual assessment.
    - Assessment to include everything under care package 2 as clinically required.

15-19 Assessment and Recall Care packages for Children

- Assessment to include everything under care package 2 as clinically required
- 6-month recall provides for 2 assessments in a rolling 12-month period

GDS Contract Reform Consultation Questions

Contents

Section One: About you (Profiling)

Questions 1 – 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	☐

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	☐
Dental Care Profession	☐
Social care	☐
Local government	☐
Commercial	☐
Media	☐

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

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

Section Two: Approach to Reform

1) Approach to Reform Opinion Poll (optional)

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

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

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

Section Three: Improving Access to Routine Services

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

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

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

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

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

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

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

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

Part Four: Improving Access to Urgent Services

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

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

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

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

Section Five: Payment for NHS Dental Services

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

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

Section Six: Technical Contract Specific Considerations

1) Technical Contract Specific Considerations Opinion Poll

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

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

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

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

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

Section Seven: Understanding Impacts

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

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

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

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

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

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

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

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