Explanatory Memorandum to The National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026

This Explanatory Memorandum has been prepared by Primary Care Division of Health, Social Care & Early Years Group and is laid before Senedd Cymru in conjunction with the above subordinate legislation and in accordance with Standing Order 27.1.

Cabinet Secretary's Declaration

In my view, this Explanatory Memorandum gives a fair and reasonable view of the expected impact of The National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026. I am satisfied that the benefits justify the likely costs.

Jeremy Miles MS
Cabinet Secretary for Health and Social Care
11 February 2026

PART 1

1. Description

These Regulations revoke the National Health Service (General Dental Services contracts) (Wales) Regulations 2006[1] and amend the National Health Service (Dental Charges) (Wales) Regulations 2006 and the National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006. These Regulations set out the conditions, requirements and arrangements for a contract between health boards and General Dental Service providers, Including remuneration fees and how contracts will be managed. They also make provision for a new scheme of patient charges.

2. Matters of special interest to the Legislation, Justice and Constitution Committee

None.

3. Legislative background

The Welsh Ministers make these Regulations in exercise of the powers conferred by sections 2, 56(5) and (6), 57, 58, 59, 60(2), 61, 62, 63(1), 66(1) and (4), 125(1), 126(5) and 203(9) and (10) of the National Health Service (Wales) Act 2006.

These Regulations are subject to the Senedd Annulment Procedure.

These Regulations come into force on 11 March 2026, except for regulations 42 and 43 which come into force on 1 April 2026.

4. Purpose and intended effect of the legislation

The Welsh Government is undertaking a reform of the General Dental Services contract to enhance patient care by improving access, prevention, quality, and contract monitoring. This reform aims to transition to a risk and needs-based approach to care delivery from April 2026, fundamentally changing how dental services are delivered and accessed. Alongside this reform the way that patient charges are calculated will change for services provided under General Dental Services contracts and certain services under Personal Dental Services agreements.

[1] S.I. 2006/490 (W.59).

Contract Framework and Key Components

These Regulations establish the components of the GDS Contract which include:

- The conditions which must be met by a GDS contractor before a Local Health Board may enter into a contract with it;
- Terms relating to contract duration and general dental services to be provided;
- Dispute resolution;
- Prescribing and dispensing of medicines;
- Variation, termination and cancellation of contracts;
- The conditions to be met by those who perform services or are employed or engaged by the contractor;
- Patient registration and removal, list closures and assignments;
- Patient records, the provision of information and rights of entry; and
- Complaints.

The Segmented Care Model

The new contract requires contractors to provide mandatory services which are segmented into distinct categories:

- Urgent access for new patients (7% of contract value) - providing urgent care within 72 hours through a Local Health Board programme or rota arrangement;
- Recall appointments (3% of contract value) - for patients requiring recall appointments between 18 and 24 months since the most recent appointment based on risk assessment in accordance with NICE guidance;
- New patient assessments (10% of contract value) - allocated through the Dental Access Portal (DAP);
- Care packages (70% of contract value) - providing needs-based treatment through defined bundles of dental services based on assessed clinical need and risk;
- Prevention services (5% of contract value) - embedding preventative care and self-care support;
- National Priorities (5% of contract value) - addressing priorities set by Welsh Ministers through directions; and
- Urgent care for active patients - provided in addition to the above proportions as required.

Access Standards and Patient-Facing Arrangements

The contract includes clear access standards to improve patient access to NHS dental services:

- Urgent Access: New patients requiring urgent care must be provided with an appointment within 72 hours through the Local Health Board's urgent care programme or rota arrangement.
- Dental Access Portal (DAP): A centralised online dental appointment allocation system administered by Digital Health and Care Wales enables new patients to register for NHS dental services and be allocated to practices for new patient assessments.
- Active Patient Status: Patients who have received a course of treatment within the previous 36 months are considered 'active patients' and remain with their practice for ongoing care.
- De-listing Arrangements: Patients who fail to attend appointments or who have not attended for 36 months may be de-listed and returned to the Dental Access Portal, freeing up capacity for patients who genuinely require care.

Assurance and Performance Management Framework

The contract includes a robust assurance framework to ensure contractors deliver the required level of services:

- Mid-year Delivery Reports: Local Health Boards must provide contractors with a mid-year delivery report (by the end of the seventh month of the contract) setting out the percentage of services delivered against each mandatory service category. Where delivery falls below 40%, the Local Health Board may implement a mid-year financial adjustment.
- Annual Delivery Reports: Local Health Boards must provide an annual delivery report (within 20 days of the end of the contract year) detailing overall performance against each mandatory service category.
- Performance Thresholds and Financial Adjustments:
- Below 95%: The Local Health Board may reduce payments for the next financial year and/or apply financial recovery up to 100% of the value of underperformance.
- 100-105%: The Local Health Board must either reduce the required quantity of services for the next year or remunerate the practice for extra work.
- Over 105%: The Local Health Board must not increase required services or remunerate the practice for the value of the extra work carried out, unless there was a prior written agreement, dated at least 60 days before the end of the financial year.

- Appeal Rights: Contractors may appeal mid-year financial adjustments and annual financial adjustments/recovery through the NHS dispute resolution procedure.

Data, Records and Information Requirements

The contract requires contractors to maintain comprehensive electronic patient records and provide information to Local Health Boards:

- Electronic Recordkeeping: Patient records must be stored in electronic form, with physical records (such as handwritten notes and study casts) stored appropriately and indexed to the electronic record.
- Information to Local Health Boards: Contractors must provide details of patients, services provided, NHS charges payable and paid, and exemption details within 2 months of completing or ending a course of treatment.
- Confidentiality Lead: Contractors must nominate a person with responsibility for practices and procedures relating to the confidentiality of personal data and produce an internal privacy policy.
- Prescription Requirements: Prescribers must issue prescription forms for listed drugs, medicines or appliances in accordance with the requirements set out in the contract terms.

Transitional and Consequential Provisions

Part 6 of the Regulations makes transitional provisions. An existing contract under the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 has effect on and after 1 April 2026 as if it were a contract entered into under these Regulations. This ensures continuity of service provision whilst transitioning to the new contract framework.

The Regulations also make amendments to the National Health Service (Dental Charges) (Wales) Regulations 2006 in order to change the way patient charges are calculated, moving from the current UDA Band 1-3 structure to a care package-based charging model.

These Regulations also make amendments to the National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006 in order to align the way mandatory services and patient charges are provided for in those regulations.

Regulation 42 revokes the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 with effect from 1 April 2026.

Patient Information and Welsh Language Requirements

The contract requires contractors to provide comprehensive information to patients and comply with Welsh language duties:

Patient Information: Contractors must display prominently in practice premises and on their website (if they have one):

- A written statement relating to their commitment to quality assurance
- Information about NHS Charges as supplied by the Local Health Board
- Information about the procedure for notifying concerns
- Details of how to access the practice's privacy policy

Contractors must also compile a patient information leaflet (as specified in Schedule 4) which includes details of the practice, practitioners, services available, surgery hours, how to access urgent care, NHS 111 Wales contact details, the Dental Access Portal web address, patient rights and responsibilities, and de-listing arrangements.

Where a contractor assesses a patient and determines that a care package is required and delivery is over more than one appointment, The contractor must issue the patient with a treatment plan using the form supplied by the Local Health Board. The treatment plan must clearly set out the patient's name, the contractor's name, and the details of the locations where the course of treatment is intended to be provided, together with a contact telephone number for the contractor during normal surgery hours. It must also include details of the services considered necessary at that time, having regard to the reason for, and the risk allocation of, the care package. Where applicable, the treatment plan must set out any proposals for private services as an alternative to services provided under the contract, including full details of the costs to the patient. If the patient chooses to accept private services in place of all or part of the contracted services, the contractor must ensure that the patient signs the treatment plan to confirm their understanding and acceptance of the private services. Where clinical reasons require changes to the services included, the contractor must provide the patient with a revised treatment plan that meets the same requirements.

Welsh Language: Where contractors provide dental services through the medium of Welsh, they must notify the Local Health Board. Contractors must make available Welsh language versions of documents and forms for patients, and where new signs or notices are displayed, the text must be in English and Welsh. Contractors must encourage Welsh-speaking staff to wear identification

badges and to establish and record patients' Welsh or English language preferences.

Dispute Resolution and Appeals

The Regulations provide for comprehensive dispute resolution procedures:

Pre-Contract Disputes: If, in the course of negotiations intending to lead to a contract, the prospective contracting parties are unable to agree on a particular term, either party may refer the dispute to the Welsh Ministers for consideration and determination, provided both parties have first made every reasonable effort to communicate and co-operate to resolve it.

Contract Disputes: In the case of any dispute arising out of or in connection with the contract, the contractor and the Local Health Board must make every reasonable effort to communicate and co-operate with each other with a view to resolving the dispute before referring it for determination. Where the contract is an NHS contract (i.e., where the contractor is a health service body), disputes are referred to the Welsh Ministers in accordance with section 7(6) of the 2006 Act and determined through the NHS dispute resolution procedure. Where the contract is not an NHS contract, disputes may be referred to the Welsh Ministers by the contractor, or with the contractor's written agreement, by the Local Health Board, and are determined through the NHS dispute resolution procedure to which the parties agree to be bound.

Appeals: Contractors have specific appeal rights in relation to:

- Mid-year financial adjustments (where delivery falls below 40%)
- Annual financial adjustments or recovery (where delivery falls below 95%)
- Decisions regarding proportions of mandatory services imposed by the Local Health Board.

Appeals are determined in accordance with the dispute resolution procedure applicable to the contract. Where the contract is an NHS contract, this is the NHS dispute resolution procedure under section 7 of the 2006 Act. Where the contract is not an NHS contract, the parties agree to use the NHS dispute resolution procedure, with the Welsh Ministers appointing an adjudicator to consider and decide the matter.

5. Consultation

Formal consultation

On 27 March 2025, the Cabinet Secretary for Health and Social Care opened a 12-week consultation on proposals to reform the NHS General Dental Service (GDS) contract in Wales. This consultation sought feedback on the different elements of the proposed reform. The consultation closed on 19 June 2025.

In April 2025, the Welsh Government commissioned Miller Research to independently analyse the responses to the consultation.

This report provides a brief background to the consultation before outlining the approach to analysing consultation responses and presenting findings.

The consultation set out the detail of the Welsh Government's proposals to reform the NHS General Dental Services contract in Wales and the potential effects for patients and dental teams arising from the changes. The key changes proposed were:

- 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.

The consultation documentation highlighted the details of how these modifications would change service provision.

Overall, 6425 responses were received to the General Dental Services contract reform consultation. This comprised of 6335 standard responses and 90 non-standard responses. Responses which provided a response to the consultation through the standard form attached to the consultation document were classified as standard responses and responses which were not set out in this format were classified as non-standard responses.

Following review of the consultation response received, taking account of the public and professional opinions received, officials made amendments to the proposals for reform of the general services contract. These were agreed by the Cabinet Secretary for Health and Social Care on 16th September with an oral statement and written statement made by the Cabinet Secretary for Health and Social Care on 23 September, fully outlining the Welsh Governments response to the consultation and next steps in reforming the dental contract. The changes made at this stage are summarised as follows:

- Dispensing with the proposal to transfer patients assigned 18-24 month recall to the Dental Access Portal (DAP) and replacing with a capitation payment for practices to provide recall appointments for this cohort of patients.
- Increasing the general fee rate from £135 per hour to £150 per hour.
- Not progressing the proposals to cap parental leave payments.
- Not progressing the proposal to phase out seniority payments.
- Maintaining the principle of a high needs pathway but committing to working with the NHS and dental profession over the autumn to develop the detail around operationalising the pathway and the referral criteria.
- Increasing the annual contract value top slice to £1,200 to fund participation in Accelerated Cluster Development.
- Setting the patient charge at 50% of care package value (instead of 55%) for those that are required to pay towards their dental care.
- Delaying the implementation of an online PCR collection system until April 2027.

The consultation documents and a summary of the responses are available at: Reform of NHS general dental services | GOV.WALES

PART 2 – REGULATORY IMPACT ASSESSMENT

6. Options

NHS dental services in Wales comprise the General Dental Services (GDS) and the Community Dental Service (CDS), as well as hospital dental services (HDS). The GDS constitutes the largest element of overall services. Under the current GDS contract, introduced in 2006, high-street dental practices hold an annual contract with their local Health Board, measured through Units of Dental Activity (UDAs). The UDA payment model is based on activity (treatment delivered) and has never incentivised preventive care or self-care support. However, both the Welsh Government (WG) and key stakeholders, including the British Dental Association (BDA) and NHS representatives, have long acknowledged that measuring delivery solely through UDAs fails to focus resources on those patients who have the greatest oral health needs. To address this situation, the Welsh Government considered the following two options:

Option 1 – Do Nothing, i.e., continue with the current contract:

By continuing with the existing contract, there would be no need to update legislation, and practices could maintain their current administrative and clinical processes. These elements provide familiarity and minimal disruption, which could be viewed as advantages. Yet, “doing nothing” would leave unaddressed the fundamental shortcomings of an activity-based approach that does not incentivise prevention or align with the Welsh Government’s Programme for Government commitment to modernise primary care dentistry.

Retaining the UDA framework risks perpetuating inequalities in access to dental care, especially for high-need or vulnerable patient groups. This is contrary to a key aim of the Welsh Government’s agenda, which places strong emphasis on preventative healthcare and improved oral health outcomes. Moreover, dissatisfaction with the UDA model is widespread among dental professionals, and failing to reform runs the risk of hindering recruitment, retention, and morale in the sector. Since the contract variation was introduced in 2022 there has been a marked shift towards increased prevention activity, with over 80% of dental contracts now operating on a non-UDA model, although the UDA remains the current funding mechanism.

Considering these factors, continuing with the status quo cannot deliver the necessary reforms to align primary care dentistry with the Welsh Government’s ambition for a healthier population, nor does it reflect the near-universal consensus among stakeholders that the UDA system is no longer fit for purpose. Option 1 is therefore discounted, and the focus of this Regulatory Impact Assessment will turn to Option 2, which seeks to revise the current framework

within existing legislative powers to meet the need for accessible, preventive, and high-quality dental services in Wales.

Option 2 - Revise the current framework within existing powers by updating the existing secondary legislation:

This approach involves modernising the regulatory basis of the GDS without overhauling primary legislation. Instead, the existing secondary legislation will be updated to embed prevention-focused, needs-led principles in NHS dentistry. Under this new framework, the outdated and discredited UDA model will be replaced by a more transparent system that aligns with the Welsh Government's Programme for Government priorities—improving access, focusing on higher-need patients, reducing inequalities, and embedding prudent healthcare. Notably, this option leverages the momentum gained through the 2023–24 tripartite negotiations with the BDA and NHS representatives, ensuring the reforms are developed in partnership with the profession.

Critically, Option 2 maintains the essential structure of primary care dentistry while allowing for the swift implementation of improvements. By revising the secondary legislation rather than introducing new primary legislation, the Welsh Government can rapidly roll out reforms such as new performance metrics, clearer pathways for high need patients, and a care package model that rewards appropriate clinical interventions over pure activity. This approach also introduces a fairer mechanism for remuneration, reduces administrative burdens for dental practices, and supports transparency for both providers and patients, all of which are essential components for delivering high-quality, sustainable NHS dental services in Wales.

These legislative changes will align dental provision more closely with the overarching vision of A Healthier Wales, ensuring that prevention and risk-based care become the norm in NHS dentistry. Ultimately, by updating the secondary legislation, the Welsh Government aims to meet its commitment to widen access, strengthen prevention, and improve oral health outcomes, particularly for the groups that need it most, while minimising disruption for practices already operating under the existing framework.

7. Costs and benefits

Welsh Government Costs:

Dentists enter a contract for services with their local Health Board and are funded based on the volume of activity they achieve. The reform will not alter the overall remuneration dentists receive—rather, it modifies the activity required to meet the contract, while retaining the same total annual contract value (ACV). The Welsh Government will continue to fund Health Boards through existing allocations, which for this year are approximately £188 million (including the annual uplift). In addition to this allocation, Health Boards receive patient charge revenue, which amounted to £21 million in the last financial year.

Alongside these costs, there will be additional legal costs to meet the legislative timetable and costs to administer the public consultation; these are anticipated to be in the region of £100,000 for one year only.

Public Sector costs:

The implementation and enforcement of these Regulations will not constitute additional costs for Local Authorities. There will be minimal or no impact on the justice system and no additional costs to Police Forces in Wales.

Cost to individuals

Under the proposed reforms, NHS dental charges in Wales would shift away from the current UDA Band 1–3 structure (and urgent band) toward a care package model. Currently, most patients pay between £20 and £260 for these treatments. The new proposal seeks to standardise patient charges to 50% of each care package's cost, which compares favourably with the Scottish Government's dental charge rate of around 80%. However, for procedures involving dental appliances or laboratory items (such as crowns, bridges, and dentures), a separate, contribution would be charged directly to the patient, ensuring transparent and predictable costs. Details of the current rates and the proposed fee scale can be found in Annex A of the published RIA and more detail on this and the PCR proposals can be found in the overarching consultation document.

Additionally, the shift to a more risk-based approach may mean that low-risk patients traditionally attending six-monthly check-ups are recalled less frequently (in line with the 2004 NICE guidelines). While these patients can opt for private care if they prefer more frequent check-ups, it is not expected to be widespread. In line with NHS principles, patients with chronic conditions will be placed into care packages, acute conditions will be addressed through the NHS111 pathways but those with no chronic oral disease will be directed to maintain their health through self-care strategies and patient-initiated recall within NICE guidance.

Furthermore, the new patient-centred model aims to prioritise those with higher clinical needs, many of whom are exempt from charges, potentially reducing the overall amount of Patient Charge Revenue (PCR) generated from routine care. However, this reduction is not anticipated to be significant enough to materially affect PCR. The reforms also introduce clearer guidance for handling missed appointments (DNAs), where failure to attend for two consecutive appointments, or three within their treatment plan (care package), will result in them being returned to DAP (bottom of the list). 50% of the care package fee will be paid for incomplete delivery. This measure frees up capacity for patients who require care most urgently and further helps to safeguard resources.

Cost to Health Boards:

Under the proposed legislative changes, PCR collection would move from individual dental practices to the NHS Business Services Authority (BSA). By standardising patient contributions at 50% of care package costs and separating out the costs of dental appliances Health Boards may see a moderate increase in aggregate PCR. Although a subset of low-risk patients will be seen less frequently, the expectation is that by focussing activity on those patients who need treatment will ultimately drive a net growth in PCR, helping to support ongoing improvements in NHS dental services across Wales.

Cost to Dentists / Dental Practices:

Although the new GDS contract reform introduces a care package model with a stronger emphasis on prevention and self-care, the ACV for each practice remains unchanged, ensuring contractors continue to receive the same overall level of funding. In practical terms, dentists will provide an equivalent volume of services, now measured in a more transparent, risk-based, manner. Under this model, specific treatments have assigned values, and dentists must deliver these treatments up to an agreed level, thereby fulfilling their contract value. Critically, by aligning payment more closely with clinically necessary interventions and calculating fees at an hourly rate of approximately £150 (compared to £120 under the previous UDA model), the new approach more accurately accounts for the actual time required for different treatments rather than clustering them into narrow bands. Certain treatment costs, such as the cost of dentures, will also be removed from the practice's core contractual responsibility, reducing financial risk and complexity. This model will remove the different values of a UDA between practices making the remuneration system fairer for all.

The introduction of clearer protocols for managing missed appointments (DNAs) also reduces the financial loss and wasted clinical time associated with no-shows; repeated DNAs by new or ongoing patients will result in their return to the Dental Access Portal (DAP), thereby freeing up capacity for patients who are genuinely seeking care. Additional factors, such as a shorter deadline for final reconciliation and clearer segmentation of contract activity (e.g., dedicating 10% to urgent care, 10% to patient assessments) further support workload planning.

Overall, this approach aims to maintain practice income, streamline administrative processes, and improve patient outcomes through targeted prevention and enhanced access for those with higher needs.

Benefits:

Improved Patient Outcomes

By incorporating a risk-based approach and prioritising prevention, the new dental contract has the potential to enhance access for high-need and vulnerable groups. This includes clearer pathways for urgent care, ensuring patients receive timely intervention before issues escalate. Improved continuity

of care, supported by shorter end-of-year reconciliation periods and more transparent metrics, can result in earlier treatment, fewer complications, and better overall oral health for patients across Wales. Patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) are being developed to assess the quality of healthcare experiences, which will help healthcare providers, commissioners, and other stakeholders to make informed changes to their services.

Better Resource Allocation

The segmentation of the contract value (e.g., reserving 10% for urgent care and 10% for patient assessments) promotes more efficient use of NHS funding. Practices can direct resources where they are most needed, reducing the likelihood of unnecessary referrals or overly frequent check-ups for low-risk patients. By focusing on genuine clinical need and contract holders being responsible for delivery of level 1 procedures, the new system may also relieve pressures on secondary care services, freeing up capacity for more complex cases. The provision of definitive urgent care where possible has the potential to reduce pressures on urgent dental care access.

Prevention and Well-being

Placing prevention and self-care at the core of the contract is crucial because it addresses the root causes of dental disease before more serious issues arise, leading to better long-term health outcomes and cost savings. By encouraging early intervention strategies, such as fluoride application, tailored recall intervals, and comprehensive oral health education, the new framework significantly lowers the risk of advanced or emergency treatments. Over time, fewer complex procedures will be required, reducing long-term costs for both health boards and social services. Moreover, this emphasis on prevention aligns with wider Welsh Government public health initiatives and helps foster a healthier population overall. This aligns with the priorities and need to “shift resources to address the root causes of oral ill health and reduce the need for interventions that become more costly as disease progresses”[2]. This fundamentally moves care to a population level and away from an individual focus, addressing inequity and inequalities in care.

Workforce resilience

By phasing out the UDA “treadmill”, the new contract framework allows dental professionals to focus on delivering patient-centred care rather than meeting arbitrary activity targets. This shift toward a more transparent, needs-based system not only promotes clinical best practice but also fosters greater job satisfaction and professional autonomy. In turn, it supports a healthier, more stable workforce, reducing burnout and attrition by creating an environment in which positive behaviours are incentivised and valued.

---

[2] https://www.gov.wales/sites/default/files/publications/2019-04/taking-oral-health-improvement-and-dental-services-forward-in-wales.pdf

Economic and Societal Gains

"Preventing ill health doesn't just save lives – it also supports the economy by enabling people to stay in work, contribute to the economy, and reduce healthcare costs for businesses and society"[3]. This in turn will lead to cost savings and heightened productivity across Wales. A system that ensures timely and appropriate care for high-need patients lowers the risk of expensive emergency treatments and helps maintain a healthier, more resilient population. This ultimately reduces long-term costs for the NHS and improves overall wellbeing in the community.

8. Competition Assessment

A Competition Assessment has been undertaken to assess the potential impact of making changes to the legislation.

The results of a filter test (consisting of nine yes/no questions) which support this conclusion are below.

The competition filter test	
Question	**Answer yes or no**
Q1: In the market(s) affected by the new regulation, does any firm have more than 10% market share?	No
Q2: In the market(s) affected by the new regulation, does any firm have more than 20% market share?	No
Q3: In the market(s) affected by the new regulation, do the largest three firms together have at least 50% market share?	No
Q4: Would the costs of the regulation affect some firms substantially more than others?	Yes
Q5: Is the regulation likely to affect the market structure, changing the number or size of firms?	Yes
Q6: Would the regulation lead to higher set-up costs for new or potential suppliers that existing suppliers do not have to meet?	No
Q7: Would the regulation lead to higher ongoing costs for new or potential suppliers that existing suppliers do not have to meet?	No
Q8: Is the sector characterised by rapid technological change?	No
Q9: Would the regulation restrict the ability of suppliers to choose the price, quality, range, or location of their products?	No

[3] https://ukhsa.blog.gov.uk/2018/07/27/health-matters-health-economics-making-the-most-of-your-budget/

9. Post implementation review

Although the largest corporate provider of dental services in Wales (MyDentist) holds approximately 5% of the market share, two elements of the competition filter test do warrant continued monitoring:

• the possibility that those with larger NHS contracts and more private work could benefit from economies of scale; and
• the likelihood that the reforms make the Welsh dental market more attractive to new entrants.

First, larger practices or those with significant private income may be able to spread overheads across a greater treatment volume, resulting in lower unit costs. Post implementation, we will therefore monitor the impact on different contract sizes and private-to-NHS ratios. Should evidence indicate that smaller practices are at a notable disadvantage, we will review the fee scale to assess if any necessary adjustments are required to protect service sustainability and equitable provision.

Second, if reforms encourage more providers to enter the Welsh dental market, there will be a need to ensure sufficient commissioning capacity and potentially allocate additional funds to pay for a growing service. By tracking new contracts and market entrants, we can maintain an appropriate balance of service provision across Wales.

Taken together, these monitoring activities will complement broader evaluations of the reformed GDS contract. We will produce annual interim reports on progress and conduct a formal review five years after the legislation comes into force, assessing the impact on both service delivery and market structure.