Welsh Government

Regulatory Impact Assessment Document

A Regulatory Impact Assessment on proposals to reform the dental services delivered in primary care in Wales.

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Introduction and Guidance

Regulatory Impact Assessments (RIAs) provide Welsh Ministers, the Accounting Officer, Senedd Cymru and stakeholders with information on the likely impact of proposed legislation and can be regarded as:

- a process to help the Welsh Ministers consider the impact of proposed regulation on the interests of individuals, groups, organisations.
- a tool to enable the Welsh Ministers to weigh the costs and benefits of all options available to them before implementing a policy.
- and a means of presenting for scrutiny the relevant evidence on the positive and negative effects of such interventions.

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 by April 2026, fundamentally changing how dental services are delivered and accessed. This RIA provides an assessment on the likely costs, benefits and risks associated with the proposed legislative changes. Those who may have an interest in this assessment include 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.

This RIA accompanies a twelve-week consultation which sets out the detail of the Welsh Government's proposals to reform the dental services delivered in primary care in Wales.

The Welsh Government has also prepared an *Integrated Impact Assessment (IIA)* alongside the consultation which has considered the main impacts of the policy delivery.

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 is by far 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 of familiarity and minimal disruption 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.

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 the existing allocations, establishing a dedicated new pathway for patients with very high needs (defined as requiring 10 or more interventions, including endodontic treatment) is anticipated to cost around £5 million per annum. This funding will enable a seamless referral process into the CDS or through a separately commissioned arrangement using the existing Personal Dental Services (PDS) regulations, ensuring these patients receive more comprehensive care tailored to their complex clinical requirements. The GDS fee structure would include a stabilisation course of treatment while referrals are processed, reflecting the Welsh Government's commitment to providing equitable access for those with the highest level of need.

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 between 50-60% 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, capped 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 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 50–60% 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. Costs associated with NHSBSA carrying out the collection function will be met by the overall PCR collection.

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 £135 (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.

Furthermore, the collection of PCR will transfer to the NHSBSA, removing the administrative burden and debt recovery obligations from practices. 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 (see Annex B), 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[1]." 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.

- **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."[2] 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

[1] *Taking Oral Health Improvement and Dental Services Forward in Wales - A Framework outlining priorities for dentistry and a future work programme*, March 2017 https://www.gov.wales/sites/default/files/publications/2019-04/taking-oral-health-improvement-and-dental-services-forward-in-wales.pdf

[2] *Health Matters: Health Economics -Making the most of your budget*, July 2018 https://ukhsa.blog.gov.uk/2018/07/27/health-matters-health-economics-making-the-most-of-your-budget/

engaged workforce. In the longer term, improved oral health outcomes can boost social well-being, enhancing quality of life and community resilience.

Conclusion

The Welsh Government is firmly committed to transforming primary care services in Wales, in line with the overarching vision set out in *A Healthier Wales*, to create a 'whole system approach' to health and social care, which is focused on health and well-being, and on preventing illness. The current programme for government reaffirms the Welsh Government's commitment to invest in new ways of delivering primary care services, backed by a workforce which is supported and valued, with a strong emphasis on prevention and early intervention.

By reforming how dental services are commissioned and delivered, this initiative reflects both a drive toward prevention-led oral health and a broader commitment to delivering modern, agile, and patient-focused services across Wales. While the primary care dental contract is a vehicle for change, there will be continuing engagement with the Community and Hospital services to ensure locally delivered specialist services are developed to support the GDS practitioners and their patients.

After careful consideration of the available policy options, the Welsh Government's preferred choice is **Option 2**, which involves revising the current framework within existing powers by updating the secondary legislation. This approach enables the necessary regulatory changes to be implemented efficiently, aligning dental reforms with Wales's overarching goal of improving population health outcomes and prioritises quality, accessibility, and the well-being of every individual in need of dental care.

Competition Assessment

A Competition Assessment has been undertaken to assess the potential impact of making changes to the legislation.
How far will this policy have an effect on industry competition?
Include brief outline considering questions of the competition filter test below.

The results of a filter test (consisting of nine yes/no questions) which support this conclusion are below, followed by evidence to support the answers.

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

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.

Annex A
Current and new fee structure

Summary of Current NHS Dental Charges and Exemptions in Wales
The Welsh Government sets NHS dental charges in Wales under a three-band system, plus an additional urgent band, to reflect the type and complexity of treatment. Certain groups, such as those under 18, pregnant women, and recipients of qualifying benefits, may be exempt from these charges. Additional information and further details on exemptions can be found on the Welsh Government website.

Band	Treatment Coverage	Patient Charge
Band 1	Examination, diagnosis (including X-rays), advice on prevention, and, if required, a scale and polish	£20
Band 2	All Band 1 treatments plus additional procedures such as fillings, root canal treatments, and extractions	£60
Band 3	All Band 1 and Band 2 treatments plus more complex procedures, such as crowns, dentures, and bridges	£260

Exemptions
Individuals who qualify for certain exemptions do not pay NHS dental charges. These include:

- Children under 18 years of age
- 18-year-olds in full-time education
- Pregnant women or those who have given birth in the last 12 months
- Individuals in receipt of qualifying social security benefits or tax credits

Patients who believe they qualify for an exemption should provide evidence of their entitlement to the dental practice. Further details on exemptions and how to claim help with health costs are available on the Welsh Government's official website.

Proposed new structure

Under the proposed reforms, a care package model would replace the longstanding Unit of Dental Activity (UDA) approach. This model sets out specific fees for a range of common dental treatments based on their complexity and the time required, rather than purely on the volume of activity.

Key Features of the New Care Package Model

1. **Adult Fee Scale**
    - A schedule of 14 different care packages covers everything from urgent care (Care Package 1) through to restorative treatments, root canal therapy, and various recall intervals (e.g., 3, 6, 9, or 12-month appointments).
    - **High-Value Treatment Thresholds:** To prevent over-delivery of the costliest treatments (Posterior Root Canal – Package 7, Crown/Bridge – Package 8), there is a maximum threshold of 10% (within the 70% care-package segment of a contract) for these categories unless otherwise agreed by the Health Board.

Care Package	Description	Revised Adult Fee
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

2. **Child Fee Scale**
    - Higher values apply to child assessments (Packages 15–19) to encourage practices to accept and retain younger patients, providing comprehensive preventive support from an early age.
    - If children need more extensive treatment, they will transfer into the corresponding adult care package category.

Care Package	Description	Revised Child Fee
15	Initial Assessment (Under 1 year)	£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

What This Means in Practice for Patients
Under the new care package model, charges for each course of NHS treatment would be set at 60–70% of the total package cost, rather than being divided into the current Band 1–3 system. This equates to a lower contribution than in other areas of the UK—for example, Scottish patients generally pay around 80%. Any extra laboratory work (e.g., crowns, bridges, or dentures) would have a separate but capped fee, ensuring patients are protected from excessive additional costs.

Importantly, these changes shift the focus toward preventing oral health problems before they become serious. Dentists must deliver a broad range of preventive and routine care, rather than investing too heavily in high-cost treatments. For individuals needing those more complex or urgent procedures, a dedicated referral pathway will ensure they receive the necessary level of specialist care in a timely manner. Meanwhile, an online payment system run by the NHSBSA will simplify billing and remove the administrative burden of debt recovery from local practices, ultimately making the patient journey more streamlined and transparent.

Appendix B – Proposed Patient Flow Diagram

The diagram below sets out the patient journey under the proposed structure.