Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar
Health, Social Care and Early Years Group

Llywodraeth Cymru
Welsh Government

North Wales Local Dental Committee

By email via sec.nwldc@gmail.com

30 January 2026

Dear colleagues

North Wales LDC

Thank you for your letter of January 2026 (received 29 January) following our discussion in Bangor on 3 November and your subsequent LDC meeting on 8 December. I appreciate the constructive tone and the commitment to making the new General Dental Services (GDS) contract a success for patients, practices and the wider system.

You ask that Welsh Government establish a two-year transition and implementation period in which financial recovery, clawback and penalty mechanisms would not apply while practices adopt the new remuneration model. This point had been raised and carefully scrutinised during the negotiation process. It was concluded that a blanket suspension of contractual performance and associated financial controls for two years would not be consistent with our duty to ensure accountability for delivery, equity for patients across Wales, or fair stewardship of public funding.

The rationale underpinning this decision is complex, but I will lay out the reasoning in detail for clarification.

1. **The contract was negotiated with - and shaped by - the profession:** Through national engagement and negotiation, professional representatives secured the comprehensive care-package approach precisely to ensure that funding for clinical activity is aligned with the work required to deliver evidence-based care across the pathway. This was a significant gain for the profession and a central design feature of the 2026 contract.
2. **Built-in business stability:** To support business viability through change and to dampen volatility, 15% of the contract value is capitated in year 1 moving to 20% in year 2. Furthermore, the new urgent patient contract segment is paid even when the LHB fails to provide a patient for a scheduled appointment, or the patient fails to attend. This provides a predictable income flow to assist practices manage case mix while the new model beds in and is evaluated.

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3. **The consultation did not identify "underperformance" as a systemic concern.** In both the public and professional consultation phases, respondents raised a range of implementation questions; however, a need to suspend performance management and financial recovery for under-delivery was not identified as a priority risk by the profession. The request now advanced would therefore go beyond the issues surfaced through consultation.
4. **Patient access, quality and equity:** Removing performance controls for two full years risks uneven delivery and variable patient access across Health Boards, with limited recourse to protect patients where contractual obligations are not met. That would be difficult to justify to the public and to colleagues who do meet their commitments.
5. **Consistency and fairness:** Many providers have invested to prepare for the April start and expect the same standards and expectations to apply across Wales. A universal moratorium would create unfairness between practices and Health Boards and could undermine confidence in the reform process.

I recognise the scale of change and your wish to distinguish learning-phase effects from genuine performance failure. To support safe implementation - while maintaining accountability - we have enacted several actions:

- Published clear operational guidance on care-package delivery in the form of Vignettes, which outlines exemplar scenarios linked to national clinical guidance. We have committed to updating this "quick reference" guides for primary care teams as new scenarios emerge.
- Provide national onboarding, with a series of webinars and Q&A updates during late 2025 and continuing in early 2026, ahead of the go-live date. We will commit to maintaining this engagement through the first six months.
- Adopt a proportionate, risk-based assurance approach with NHSBSA in the early part of the 2026/27 contract year. Close monitoring to identify any data/recording errors will be a priority, which will enable Health Boards to provide directed support when under-delivery is identified. Where issues consistently arise, Health Boards will be asked to prioritise remedial action plans and targeted support before considering recovery.
- Enable transparent practice-level reporting and feedback loops, so that providers can track delivery against plan and escalate operational hurdles early.
- Continue joint working with LDCs and the profession, including a structured review at 6 and 12 months to identify any necessary technical refinements. This will form part of the evaluation.

To be clear, this is not a "soft waiver" of contractual obligations. Rather, it is a pragmatic, supportive approach to help practices implement a contract that the profession has helped to shape - one that includes comprehensive time-based care packages, dedicated capitated payments for business stability, and clear expectations on delivery.

I remain grateful for the leadership you show on behalf of colleagues and for the constructive challenge you have provided. Contract delivery and monitoring is the remit of Health Boards, and I would recommend the LDC continues close dialogue with the primary care commissioning team at BCUHB. In the meantime, if there are specific technical areas where additional clarity would be helpful, please share them and we will incorporate them into the national guidance materials.

Yours sincerely,

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