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Dyddiad / Date: 9th April 2026

Letter to Dental Contractors

NHS Dentistry: Implantation of the new NHS contract 2026-27

This alert has been cascaded to the following:

- All Wales Dental Practices

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

General Dental Service Contract Holders –
Via NHS Shared Services

09 April 2026

Dear Colleagues,

NHS DENTISTRY: IMPLEMENTATION OF THE NEW NHS CONTRACT 2026-27

As you will be aware, the new dental contract regulations coming into effect at the start of this month represents the most significant change to NHS dentistry in more than twenty years. In recognition of this, and in the spirit of social partnership, we have recently met with your representative body to consider the value of introducing a moratorium on selected elements of the NHS Dental Contract.

These proposed measures are intended to provide additional flexibility and create space for learning throughout the first year of implementation. The attached table outlines the agreed adjustments and concessions and confirms the final arrangements for the 2026–27 financial year.

We hope that these provisions will offer reassurance that performance monitoring will be applied fairly and proportionately. Our aim is to maintain stability across the service while ensuring that high-quality patient care continues to be protected.

Yours sincerely,

Paul Casey Diprwy Cyfarwyddwr o Gofal Sylfaenol ac Iechyd Meddwl Deputy Director of Primary and Community Care	**Craige Wilson** Dirprwy Prif Swyddog Gweithredu /Deputy Chief Operating Officer Grŵp Gwasanaethau Sylfaenol, Gwasanaethau Cymunedol a Therapiau / Group Director, Primary, Community & Therapies Service Group Bwrdd Iechyd Prifysgol Bae Abertawe / Swansea Bay University Health Board On behalf of NHS Wales

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BDA moratorium proposals for FY 2026-27 – Analysis and Final Position

BDA proposal	Analysis	Final position
Absorb 3% contract segment for 18+ month recall patients into the care package segment and remunerate for all check-ups at the recall rate of £50.	• This proposal is at odds with the shift to providing treatment based on the principle of risk and need. • Accepting this proposal will undermine the underpinning shift we are trying to achieve. • Likelihood is that this will just mean more healthy patients getting access and the message about extended recalls will be lost at the first hurdle.	• Recognise that the information practices need to implement this model (who are the 10+ month patients) is more difficult to obtain for some practices depending on their data management systems. • For year one we propose to maintain the expectation that practices recall their patients appropriately but we will instruct **health board not to issue any financial sanctions**. • Instead, the health boards can issue a remedial notice requiring the practice to achieve in year 2. Failure to do so would then give rise to the usual financial or contractual sanctions.
Contractors are permitted to deliver 10% of their overall contract value through the provision of crowns/bridges/onlay/inlay/veneers. Can a +/- 10% tolerance be included on this provision to ensure contractors are not penalised for over provision unknowingly due to any lag in reporting.	• This provision is important to ensure contractors cannot discharge their entire contract by providing complex treatments only. • Doing so would restrict access for basic routine care. • This scenario is unlikely given the low levels of this type of treatment currently being provided. We would need to see a monumental shift in need for this issue to become a reality.	• A small tolerance is already included in the NHSBSA system design to take account for time lag and the fact that 10% will not always equate to an exact number of care packages. • **No claims will be rejected if the 10% threshold is exceeded**. • Contractor will receive a notification that they have exceeded and can then approach the health board for permission should they need to exceed further (prior approval). • These provisions exist within the regulations and system design.

"No Loss" Rule for Lab Fees and Exempt Tariffs	• There is real risk of driving up the price of laboratory items, essentially "writing a blank cheque".	• **Agreed to work with the BDA to review the exempt lab tariff.** • If evidence suggests laboratory items cannot be provided within the limits. • BDA reps agreed to share their current lab tariffs for comparison. • Agreed to review these before finalising the lab tariff for exempt patients. • **Post the review described above the values for certain lab items have been increased.**
The regulations permit the health board to instigate financial recovery if delivery is below 95%. BDA is asking for this to be lowered to 90% and/or for no financial recovery to be permitted in the first year with any under delivery rolled into year two. ±25% tolerance band at segment level, with overall projected floor of 90% of total delivery before any financial action is considered	• Proposal results in no financial loss or loss of activity. • If a practice under delivers by more than 5% the likely reason is workforce shortage. Rolling under delivery into the next year just compounds the problem in this scenario, which is not helpful to the contractor or patients. • Health Boards already have broad discretion on financial recovery and permitting additional delivery over the next financial year. • Formalising this change may encourage under delivery and place practices in financial difficulty.	• **Proposal declined** • Clarification provided to demonstrate that financial recovery is based on overall contract delivery not per segment. See regulation 25 and reference to "sum total" • Review at 6-month point when, if under delivery is widespread and not linked to workforce deficit, Welsh Government will consider giving direction to health boards on managing end of year financial recoveries and increasing carryover of underdelivered activity as we did under variation.
Before a patient receives periodontal treatment they are required to demonstrate oral hygiene engagement (that they are brushing their teeth properly). This is measured via a plaque	• Contrary to extant national guidance issued by the British Society of Periodontology and deemed 'best practice', which highlights personalised care	• **Proposal declined**

score which is measured on a percentage scale with 0% being excellent and 100% being poor. Patients are required to achieve a 30% plaque score to be eligible for periodontal treatment. BDA ask is for this threshold to be relaxed. To allow for professional judgement in specific cases.	• Undermines the prevention message we are trying to embed with this contract • Goes against prudent health care which encourages patients to take responsibility for their health	
Simplify DNA reporting requirements allowing practices to include short notice (<24hrs) cancellations as part of the criteria for de-listing patients.	• DNA policy and guidance have been developed by the profession with the Chief Dental Officer • The position, which is also laid out in regulation, was subject to public consultation.	• The DNA policy developed with the profession allows for a patient to be de-listed for 3 short notice (less than 24 hours) cancellations within a six month period. • **No decision required as the ask is already permitted.**
No enforced reduction of ACV after mid-term review where a contractor has failed to deliver the equivalent of 40% contracted activity. Such a change can only be done by mutual consent	• Mutual consent is the starting point, as laid out in regulation • Health Board must have good reason to enforce a reduction and the regulations provide for the contractor to make an appeal to Welsh Ministers. • Also note that, with the capitated elements of the contract, 40% overall delivery equates to 32%-36% activity depending on how health boards have varied the proportions of mandatory services.	• **Proposal declined**

End of year reporting – sufficient time allowed to submit end of year reconciliation in line with reporting software limitations to enable accurate data submission	• This request is unclear and assumes software systems will not be ready to report in April 2027.	• **Review in year** and take action to extend year end reporting period if necessary.
Period of notice to hand back contract – 3 months throughout the year.	• Regulations permit contract termination by mutual consent. • Health Boards are unlikely to require a contractor to continue operating once they have signalled their intent to terminate their agreement. • In reality a contractor can stop providing services at any time and simply repay any monies due.	• **Proposal declined**
Cluster meetings – supportive not penalising approach – flexibility of dental team representation. Financial penalty for missing one meeting is ¼ annual fee. No breach of contract for non-attendance.	• Practices are paid £1,200 for attendance at 4 professional collaborative meetings in a financial year. • Non-attendance results in the recovery of funds at £300 per meeting missed. • Important to establish the professional collaboratives with attendance from dentists in the first instance. May be appropriate in the future for members of the wider dental team to participate depending on the issues the collaborative decides to work on. • Those attending need to be empowered to evoke change at practice level.	• Opt in or out for the top sliced sum • **BDA content with the pro-rata repayment for non-attendance** • Attendance must be a dentist for the first year. • Financial sanction is sufficient in the first year, so remedial breach notices will not be used until non-attendance continues over consecutive financial years.

Opening hours - Freeze existing hours during the Moratorium Period unless variation mutually agreed.	• This is a health board management issue. • Demand for urgent care is mapped at a local level and the health boards need to commission on that basis. • This might mean that some practices need to be open until 5pm on Fridays.	• **Proposal declined**
Any unilateral contract variation in year requiring 2 weeks' notice be extended to 60 days' notice unless mutually agreed	• Unilateral variations under 2 weeks' notice are only permitted in advance of 1 April 2026 in order to ensure existing contracts are varied to comply with the new regulatory framework or to vary proportions of mandatory service. • Any variations post 1 April are subject to 28 days notice and must be mutually agreed. • BDA appear to have misunderstood the regulatory framework. In year variation has not changed compared to the UDA contract.	• **No decision necessary**