Who is in control of your future profits?

asks Seema Sharma

It looks like £60-£80 billion of NHS funds may be handed to general practitioners by the new government, making them responsible for their own budgets and cutting out layers and layers of middle management.

Responsibility will be handed to GPs working in local groups, who will commission services or provide them by working in rotas with each other. The health secretary Mr Lansley believes that if GPs are responsible for their own budgets and have to commission out-of-hours care, most will decide to go back to offering weekend and evening cover themselves or in local groups.

At present, funds are given by the Government to PCTs, which pay for patients from their area to be treated in hospital. Under new plans, GPs – who are currently not responsible for paying for hospital bills – will become responsible for the money instead and pay the hospitals directly for each patient they refer!

As dentists, we have spent the last three years bemoaning the UDA system and the general lack of understanding of what it costs to run a successful dental practice. What would happen if we were given the same opportunity as GPs? Is there a glimmer of hope that we might hold our own funding too in the future, and if so would we have the confidence that the hands in the hands of clinicians, dentistry would make the headlines for the right reasons instead of the wrong reasons?

Last year, my PCT Tower Hamlets set up the first dental practice-based commissioning group in the country, of which I am co-chair. It has been a journey of revelation for my colleagues and I, and we have realised the opportunities are enormous, as are the responsibilities. If dentists were entrusted as clinical commissioners, and we came to realise that huge chunks of our budgets were being gobbled up by specialist opinions for patients with their own expectations and moral and periodontal opinions for patients with localised gingivitis, might we be tempted to explore ideas to keep more patients, and spend less of that funding in our practices?

Perhaps we could develop a GDP model for in-house X-ray screening and upskilling ourselves. Perhaps we would allocate funds for DCPs to work on the NHS in general practice, freeing the dentist up to concentrate on more technical work and reserving expert hospital care for those with more severe periodontal disease. Alternatively, we might prefer to concentrate on funding innovative children centred schemes and establish joint initiatives with midwives, health workers, schools and children's centres, to get to the heart of dental prevention from a young age. Perhaps we would buy in fluoride toothpaste for dentists to give away, knowing it was the most effective antidote to caries.

For some time we would still have to concentrate on the ravages of damage that already exist in our ageing population and incite the use of dentists with special interests and specialists in primary care. This would bring higher skills and funds into practices, and provide patients with a better choice of services under one roof. Perhaps we would fulfil the access dilemma by taking turns with colleagues to provide evening and weekend care, instead of offering to keep nurses at work, away from their children until 9pm every night, in our desperate bid to win NHS tenders. Would we spend huge amounts on performance management or would we move from a stick based to a carrot based approach?

In fact any and all of these are possible – we could do things differently, we could do different things and we could do things for different people – and all of them could work if they were correctly funded.

The reality in any dental practice is that if we get practice revenue numbers right, cutting salaries and personnel costs and causing disenchantment throughout the practice would not be necessary. Practices have base costs which are impossible to circumvent – the fixed costs of equipment and premises, and those of compliance and a core complement of staff.

The financial profile of a dental practice is not rocket science. Sadly, when figures of 25-40 per cent profit are reported, and dentists are considered greedy, a litany on the part of the assessors to interpret practice figures – a job that accountants and practice valuers could probably do on the back of an envelope.

Many dentists own the premises they work in – if they rented their premises to another dentist to run the practice, as landlord they would receive rental income from their investment in property, and the tenant would show a lower practice profit. However because practice owners do not charge themselves rent, they mistakenly count the “rent savings” as “dental practice profit”, when it is actually direct return on investment in property and nothing to do with the practice per se.

The other source of extra perceived “profit” is a direct result of practice owners providing a significant chunk of clinical services themselves. When the practice owner working in the business as a clinician throws his own blood, sweat and tears into the profit area, too, dentists are horrified to learn that if they paid themselves the same rate they paid their associates, the profit figures for the practice would look unsustainably. This dependence on the owner of the practice has resulted in smaller practices being particularly hard hit recently. Along with the economic crisis, the reality of reallocating work to DCPs, reallocating clinical time to unfunded administration, or engaging more experienced managers is an impact on the bottom line.

Would you like to increase your revenue streams, prepare for a new way of working under the new government, meet the regulations of Care Quality Commission and be in control of your own profits? Email the author at seema.sharma@dentabyte.co.uk or log onto www. dentabyte.co.uk to find out more about our PEP conference on 1st October 2010, when Seema, Andy Action of Frank Taylor Associates and Kevin Lewis of Dental Protection will take you through the secrets of succeeding in the changing clinical and commercial environment by “pepping up your practice”.

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About the author

Seema Sharma qualified as a dentist but gave up clinical work after 10 years in practice to go into full time practice management. Today she runs three practices, including one which is a multi-disciplinary specialist centre. Seema established Dentabyte Ltd to provide affordable “real-world” practice management programmes to help practice managers and practice owners keep pace with the changing clinical and commercial environment facing them today. Visit www.dentabyte.co.uk to register for updates on practice management or email Seema at seema.sharma@dentabyte.co.uk to find out more.

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