NASDAL highlights the difference a specialist advisor makes

The telltale signs you should be speaking to a specialist

1. When you are having financial problems and your NHS contract isn’t working for you and your non-specialist accountant says: “Why don’t you put your prices up.”
2. When the solicitor you have employed to assist you buy a practice produces a contract of just two pages (the NASDAL standard contract is 80 essential pages).
3. When you are an associate and your accountant advises you to incorporate without warning you of the effect on your NHS pension.
4. When you have claw back to pay but the accountant you are using hasn’t adjusted your taxable profit to reflect the lower earnings – so you have to pay an inflated tax bill as well as the claw back in the same year.
5. When you have just bought an incorporated dental practice and discover that the NHS Contract is in the name of the dentist you bought from and not in the name of the company you had agreed to buy.
6. When you ask your accountant about forming a partnership with your other half and they fail to warn you that to be legal, both partners must be GDC registrants.

Dental contracts and the BDA
Neel Kothari interviews John Milne, Chair of the BDA’s General Dental Practice Committee

I What are we likely to expect from the new dental contract?

At a very basic level, I think we can expect something that is much more focused on prevention and providing care that moves us away from the current system which is based on targets. That would be a significant and very welcome shift.

The detail of what it will look like is still being honed of course, but I think there are some very strong indicators of what can be expected. It’s clear that the new system will be founded on a detailed assessment of patients’ current oral health and risk factors for disease in the future. That assessment is expected to be part of a shift that sees patients better understand how they can maintain their own oral health; more of a partnership between the practitioner and patient.

We can also expect a change in the way the contractual arrangements are underpinned to a system that is capital based. Those two things go hand in hand of course – if dentists are really to improve patients’ oral health in the long term as they wish to then long-term relationships are important. Capitalisation is a system that underpins that kind of approach in a way that episodic care simply does not.

With the move to capitalisation I think we can expect to see a recognition that managing patients’ recall intervals is vital; managing an entire patient base effectively will undeniably mean that seeing people at appropriate and necessary intervals will become crucial. The indications from the pilots thus far seem to indicate that can be made to work.

I think what we can – and indeed should expect – is that new arrangements happen. The Minister, Earl Howe came to BDA Conference in Manchester in April and made a very firm statement that commitment to change remains intact, and he also set out a timetable for moving the process forward from what he described as the piloting of discrete elements of a new system to the testing of prototype whole systems. That was good. I was also pleased that he made the time to attend one of the sessions I led on the pilots – that gave him a chance to hear the comments and questions from the dentists that came along. But promises only mean anything if they are kept, and they must be.

2. How would the BDA judge whether any new NHS system was successful?

I’ve said all along that the new arrangements must work for practitioners, patients and Government alike. They won’t be successful if they don’t.

From the profession’s point of view I think there are several markers that can be used to assess whether a new system is successful. It must be a place in which practices are sustainable and financially viable – if they are not the estate of the pot is not big enough. Constantly squeezing the moment the pot is not big enough.

Looking forward to new arrangements, we also need to think about how the pot is funded. I think there is some challenging thinking to be done. What we are broadly seeing is that younger patients – for the sake of argument let’s say the under 40s – require less treatment than older patients, the cohort often termed ‘the heavy metal generation’, do. And that pattern suggests that patients’ needs will continue to evolve, because those younger patients will grow up to be older patients who require less treatment. That’s a potentially significant shift – both for what’s required of us as practitioners and for the way care is financed – because it could mean less complicated and costly treatment being needed. How significant needs to be mod-

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4. Is the BDA doing enough to protect dentists from the burden of legislation?

There is no doubt at all that legislation and regulation have been placing a heavier and heavier burden on dentistry over the last decade. I don’t think that growing burden is any way a reflection of what is happening in dentistry or that we have been singled out; successive Governments appear to have had an increasingly suspicious and distrustful view of all the professions.

That’s the context against which the BDA is lobbying. So for me, it’s all about the art of the possible. Is the BDA doing all it reasonably can to mitigate the worst excesses of regulation? Yes, it is. In recent years I think we’ve made a good case for the CQC to take account of the realities of dental care – as I said earlier we’re an inherently professional and conscientious profession and that’s very much borne out by the very favourable reviews we have got in successive CQC reports. Other sectors, as we all know, have performed less well. Our message that needs to be taken into account when thinking about the cost basis and requirements of regulation is starting to bear fruit. And I’d also cite the lobbying we did against financial regulation by Monitor as part of the work we did to influence the Health and Social Care Act; we avoided an immediate and potentially-onerous burden there.

The regulation of dentistry – and indeed healthcare generally – is entering a new period of flux now. The publication earlier this year of proposals by the various Law Commissions across the UK has sketched out potential reforms to the way that regulation works – including potentially changed powers for the GDC. Whether those proposals will become legislation is yet to be seen. The BDA will, as ever, be making plain the importance of regulation being effective, proportionate and cost-effective. That’s what it should be.

5. Is dentistry really under attack? And what can the BDA do to help?

It certainly feels like it. As I travel the country meeting practitioners at LDC and BDA events for leading workshops on the pilots I have the opportunity to meet thousands of practitioners and hear their stories.

The experienced dentist who has provided fantastic care for his patients for years but is now so stressed by being unable to meet his UDA target that he is retiring with stress under attack? I think so. Are the dentists who were inappropriately issued with registered manager penalties by CQC being attacked? I think so too. When there appears to be a greater risk of referral to the GDC or litigation by patients are dentists under attack? Again, I think so. Attacks come in different forms of course – when I spent seven hours treating a fifteen-year-old with 21 cavities and got three UDAs for my efforts, the viability of my practice seemed to be under attack.

What the BDA can, and does, do is to lobby to make our lives better on the one hand, while providing the expert advice and support we need to carry on with our working lives and get through the obstacles thrust into our path. That’s what a professional association is for and that’s why I’m involved, and would urge every other dentist to be as well.