

# **DENTISTS**

## **An Industry Accounting and Auditing Guide**

**First edition**

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**CCH**

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## Foreword

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The world of dental general practice finance is in a state of constant change as evolving government policy and tax legislation dictate to dentists how they should run their practices. It is a fascinating, rewarding and worthwhile specialism for accountants and other financial advisers.

This guide provides a comprehensive analysis of dental finance with helpful examples and appendices which include practical specimen documents (partnership agreements, NHS schedules, letter of engagement, taxation documents, etc.) together with checklists and extracts of dental-specific legislation, etc.

The complexities of dental finances led to the formation of the National Association of Specialist Dental Accountants in 1998. The association caters for accountants who specialise in work for dentists and offers information updates, a forum and regular support for firms who are able to fulfil their exacting membership requirements. This guide contains details of their published industry averages. Readers wishing to contact NASDA can do so via their website ([www.nasda.org.uk](http://www.nasda.org.uk)).

Although this guide is aimed primarily at those accountants wishing to acquire a knowledge of the dental profession, it will also be of use to dentists wishing to build a better understanding of their financial world.

(Many thanks to John Dean who allowed me to use relevant extracts from his book *Acting for Doctors* (published in 1993).)

*Paul Kendall 2008*



## **The author**

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## **2.3 The General Dental Service Contract**

Following the introduction of the New NHS General Dental Service Contract on 1 April 2006 the General Statement of Financial Entitlements was published (see **appendix 9**). This introduced a new way of paying dentists for supplying dental services under the NHS contract. Prior to that date, dentists had been paid by a combination of capitation fees and item of service fees, as they currently are in Scotland and Northern Ireland, although in Northern Ireland they will soon be introducing a new system of delivering NHS dentistry, which may be piloted later in 2008. NHS dentistry in Scotland will also be changing as a result of the implementation of the Scottish Executive's Action Plan.

It is interesting to note the emergence of different approaches to NHS dentistry in England, Wales, Northern Ireland and Scotland. Future studies should be able to analyse which is the better system for protecting the nation's teeth!

### **2.3.1 Payment for NHS services**

The new contract in England and Wales is a transitional arrangement that is due to be reviewed in April 2009.

From 1 April 2006 General Dental Services (GDS) dentists have had local contracts with PCOs. PCOs hold budgets for dental services in their areas and they agree contract values with either providers (practices or companies) or performers (individual dentists) for a particular level of service. This is specified in terms of an annual level of units of dental activity (UDAs). The level of service is reported in terms of courses of treatment (CoT), but these are converted into UDAs based on the most complex component of the CoT. The contract service level was based on the level of dental activity during the reference period October 2004–September 2005.

This figure was then reduced by 5 per cent in England and 10 per cent in Wales to establish the contract level of activity. GDS dentists receive payment of their contract values on a monthly basis.

The contract value is paid to the dentists monthly in arrears, after deduction of the 'patient charges' which the dentist has received directly from his non-exempt patients.

The CoT payments work on a three-band system where each band comprises a range of treatments. The higher the band, the higher the charge, but within any one band the charge is uniform although the cost and complexity of the treatment may vary.

The contract is constructed around the contractor (either a practice or an individual dentist) undertaking a course of treatment, with that treatment being given a value/banding and a UDA applied to that banding (see **Tables 2.1** and **2.2**).

**Table 2.1** *Units of dental activity provided under the contract in respect of banded courses of treatment*

<i>Type of course of treatment</i>	<i>Units of dental activity provided</i>
Band 1 course of treatment (excluding urgent treatment)	1.0
Band 1 course of treatment (urgent treatment only)	1.2
Band 2 course of treatment	3.0
Band 3 course of treatment	12.0

**Table 2.2** *Units of dental activity provided under the contract in respect of charge-exempt courses of treatment*

<i>Type of charge-exempt course of treatment</i>	<i>Units of dental activity</i>
Issue a prescription	0.75
Repair a dental appliance (denture)	1.0
Repair a dental appliance (bridge)	1.2
Removal of sutures	1.0
Arrest of bleeding	1.2

Band 1 courses of treatment cover check-ups and simple treatments such as examination, diagnosis (eg, X-rays), advice on preventative measures, and a scale and polish.

Band 2 courses of treatment cover mid-range treatments such as fillings, extractions and root canal work.

Band 3 courses of treatment cover complex treatments such as crowns, dentures and bridges.

Practices which opted to provide GDS services under the new contract were given a target level of units of dental activity to achieve in their first year. A value was applied to each UDA, and that value was calculated to give the practice an income in line with the level of income it had previously earned from supplying NHS services under the old contract (less the deduction of either 5 per cent or 10 per cent, as mentioned above).

The practice annual contract income, as calculated above, is paid over in 12 equal monthly payments in arrears. However, the monthly payment is reduced by the amount of ‘patient charges’ that the practice should have received in respect of the work undertaken. Patient charges are the amounts that the non-exempt patients (ie, those patients not eligible for a reduction in their dental costs) pay as a contribution to their dental work. These charges used to be set as a percentage of the cost of the treatment but have now been simplified to agree to the banding system and from 1 April 2007 they have been:

- Band 1: £15.90;
- Band 2: £43.60, and
- Band 3: £194.00.

This figure increases each year in line with agreed NHS increases. Further details regarding patient charges can be found in **appendix 10**.

As mentioned above, the practice has its monthly NHS income reduced by the amount that it should have collected from its patients under the scheme and not by the actual amount of patient charges that the practice receives. The difference between what the practice should have received and the actual amount collected can be due to a number of factors, such as the inability of the practice to obtain the money from patients as they leave the practice or errors in form filling by the dentist.

In order for the PCT to obtain details of the number and type of units of dental activity that a practice has performed, and how much the practice should have collected from patients, a form is completed after each task performed by the dentist. This form is called the FP17 form (see **appendix 11**) and it has to include the:

- details of the patient (name and address, etc.);
- details of the dentist performing the work;
- details of what charge band the treatment falls into and any other services provided;
- whether the patient is exempt from paying the patient charges, and
- the signature of both the patient and the dentist.

Upon receipt of the form FP17 the PCT is able to monitor the practice’s progress in achieving its UDA target and also calculate the amount to deduct from the practice payment for the patient charges. The PCT then sends a schedule to the practice detailing the following:

1. Annual contract value for the practice.
2. Contract value for the month analysed into performers’ shares.
3. The amount of patient charges deducted from each performer’s share.
4. The amount of seniority receivable (if applicable) (see **2.4.3**).

5. The deduction for the superannuation contributions for each of the performers.
6. Notification of how much the PCT has contributed to the performer's superannuation.
7. Details of the total annual activity (UDA) for the contract.
8. Details of UDAs achieved per performer.
9. Details of how many courses of treatment have been processed in the period.
10. Details of Vocational Dental Practitioner (VDP) salary reimbursement and National Insurance costs, if appropriate.
11. Total Local Dental Committee (LDC) levy (statutory or voluntary) collected against the contract. (The levy is an amount collected from dentists to fund the Local Dental Committee.)

More detail regarding this schedule can be found in **appendix 12**.

In order to ease workload, the processing of the monthly FP17 forms has been staggered so that some practices receive their pay based on a date early in the month whilst the monthly cut-off dates of others may be towards the end of the month. In order to facilitate this, practices are given group and schedule numbers that correspond to certain dates within the month. Details of the group numbers and payment dates can be found in **appendix 13**.

The values of the UDA activity are uplifted by the Doctors and Dentist Pay Review Board each year.

NASDA has recently revealed that the average UDA value under the new contract in 2007 was £22.76, with the highest rate being £34.97 and the lowest being £13.62.

Superannuation is deducted from the payments received by contractors and allocated to the performer's pension records. Further details of the superannuation scheme can be found in **chapter 9**.

### **2.3.2 Supply of NHS services**

The General Dental Services Contract states that the contractor must provide to its patients, during the period of normal surgery hours, all proper and necessary dental care and treatment which includes the following.

1. The care which a dental practitioner usually undertakes for a patient and which the patient is willing to undergo.
2. Treatment, including urgent treatment.
3. Where appropriate, the referral of the patient for advanced mandatory services, domiciliary services, sedation services or other relevant services.

The contractor must provide urgent treatment and:

- examination;
- diagnosis;
- advice and planning of treatment;
- preventative care and treatment;
- periodontal treatment;
- conservative treatment;
- surgical treatment;
- supply and repair of dental appliances;
- the taking of radiographs;
- the supply of listed drugs and listed appliances, and
- the issue of prescriptions.

It was hoped that the new contract would improve NHS services in England and Wales and make those services available to more patients. This does not appear to have happened.

‘In the twenty-four months leading up to 30 September 2007 a total of 27.6 million patients were seen by an NHS dentist in England, which is equivalent to 54.4% of the total population. This is a fall of 0.5 million compared with the twenty-four months leading up to the end of the old contract on 31 March 2006, where 28.1 million patients were seen by an NHS dentist, equivalent to 55.8% of the population at that time.

19.9 million adults aged 18 and over were seen by an NHS dentist, equivalent to 50.0 per cent of the adults in England. However, the percentage of all adults seen varies amongst Strategic Health Authority (SHA) areas, with figures ranging from 39.6 per cent in South Central SHA to 59 per cent in North East SHA.

7.7 million children under the age of 18 were seen by an NHS dentist, equivalent to 70.3 per cent of all children in England. As with adults, the percentage of all children seen varies amongst SHA areas, with figures ranging from 65.3 per cent in London SHA to 73.7 per cent in North East SHA.’

The above information was released by the NHS Information Centre in February 2008.

One of the reasons for the reduction in the number of patients seeing an NHS dentist is that a lot of practices took the opportunity to go private upon the introduction of the new contract as many objected to the reduction of 5 to 10 per cent of their income and their perceptions of the conditions being imposed on them. This had the effect of reducing the number of dentists providing an NHS service.

Amongst those dentists that took up the new contract there are many who are less than happy with the results.

For example, in 2007 a British Dental Association (BDA) sample survey of Local Dental Committees and PCTs suggested that around a third of all dentists were being penalised for either overshooting or not reaching their target. In addition, the BDA passed on evidence to the Doctors and Dentist Review Body from the NHS obtained through a Freedom of Information request showing that, from information on 8,507 contracts, 47 per cent had not achieved the minimum target of 96 per cent of contracted UDAs. The Dental Practitioners Association (DPA) evidence in 2007 included the results of a survey of 194 dentists (representing 650 providers). This revealed that 49.5 per cent of those surveyed were angry, and a further 37.6 per cent disappointed, with the present NHS GDS terms and conditions. This same survey also showed that 61.8 per cent described their practice UDA target as difficult or impossible.

As a result of the above, the BDA is calling for the UDA system of payment to be scrapped. It is also calling for the following.

1. The whole of a PCT's dental commissioning budget to be paid directly to the PCT. (The BDA states that currently around 25 per cent of a PCT's budget has to be collected through the patient charge revenue, but lack of predictability over receipts understandably leads them to be nervous about fully commissioning all of the services that their budgets could potentially support.)
2. The restoration of the link between the NHS patient charge revenue and the overall spend on dentistry to be re-established in order to maintain a safeguard on the total expenditure available to commission NHS dentistry.

The BDA suggests that the UDA system should be replaced by a range of qualitative and quantitative performance indicators which will allow dental practitioners to provide a more satisfactory service.

In March 2008 Susie Sanderson, Chair of the Executive Board of the British Dental Association, issued a statement to mark the second anniversary of the new NHS dental contract, introduced in England and Wales on 1 April 2006.

She stated:

‘This is a bleak second birthday for the new dental contract with criticism from the profession and patients continuing to gain momentum. The level of concern is starkly revealed in the evidence given to the Health Select Committee, currently investigating the impact of the Government's troubled and controversial reforms of NHS dentistry.

In the course of this second year, we have seen:

- statistics released that revealed 47% of dentists failed to meet their first year UDA targets;
- figures that show access to NHS dentistry has still not been improved by the reforms;
- a Patients Association survey of MPs that found dentistry was the health issue that caused most concern to their constituents;
- the decision by the House of Commons' Health Select Committee to undertake an inquiry into the dental reforms.

The BDA will continue to call for action to tackle the flaws in this target-driven system and is also working proactively at a local level to encourage the commissioning of dentistry which genuinely meets local people's needs.'

It is interesting to note, following the comments above, the movements in the number of dentists that were offering NHS dentistry in 2005 and 2006 (unfortunately there are no up-to-date figures for 2007 and 2008). The following figures have been extracted from the Doctors and Dentists Review Body 2008 Report (Table 2.3).

**Table 2.3** *Number of dentists offering NHS dentistry, 2005 and 2006*

<i>England – full-time equivalent dentists</i>	<i>2005</i>	<i>2006</i>	<i>%</i>
General dental practitioners	19,800	21,110	+6.6
GDS only	15,210	13,590	-10.7
PDS only	3,670	6,220	+69.7
GDS and PDS	920	1,310	+41.5
<i>Wales – full-time equivalent dentists</i>			
General dental practitioners	1,020	1,070	+4.5
General dental practitioner	930	970	+4.3
Vocational dental practitioner	50	60	+3.8
Assistant dental practitioner	40	50	+9.1
<i>Scotland – full-time equivalent dentists</i>			
General dental practitioners	2,280	2,440	+7.1
General dental practitioner	2,100	2,260	+7.5
Vocational dental practitioner	140	150	+8.1
Assistant dental practitioner	50	40	-13.0
<i>Northern Ireland – full-time equivalent dentists</i>			
General dental practitioners	760	780	2.9



## **2.4 Dentists' pay and the Review Body**

NHS dentists, whilst not salaried, are nevertheless not entirely in control of their own income levels. In an almost unique situation their income is determined by the Doctors and Dentists Review Body, which normally reports in January or February each year, making recommendations as to the level of dentists' pay increases for the ensuing year.

Usually the Review Body pay awards are granted in line with the fiscal policy of the government of the day.

The Review Body was formed in 1960 following the recommendations of a Royal Commission that was charged with suggesting the level of remuneration for doctors and dentists working within the NHS. Their work extends not only to general dental and medical practitioners but also to doctors and dentists who are employed in the National Health Service. The Royal Commission recommended the establishment of an independent review body and laid down rules by which it should operate. The Review Body receives evidence from all interested parties, but in practice it concentrates upon that received from a number of established sources, as can be seen below.

### **2.4.1 Principal sources of evidence provided to the Review Body**

These include the following.

1. Written evidence from the profession, prepared by a committee of the BDA.
2. Written evidence from health departments.
3. Joint written evidence from the profession and the health departments, usually dealing with matters which have been agreed in negotiations.
4. Jointly agreed statistical information, for example evidence of dentists' earnings and expenses.
5. Independent evidence prepared by the Review Body's Secretariat.

When its enquiries are complete, the Review Body reports to the Prime Minister, after which the report is published and a decision is announced.

It is fair to say that the degree of independence of the Review Body is not so absolute as might at first appear, as there have been several occasions when their recommendations have been moderated so as to accord with the policies of the government of the day.

The Review Body Report for 2008 was published on 27 February 2008 and recommended that the contract value for providers of NHS dental services in

England and Wales should be increased by 3.4 per cent from 1 April 2008. An uplift of 3.4 per cent also applies to gross fees from 1 April 2008 in Scotland and Northern Ireland.

The report also recommended the following in respect of dentists providing sessional cover to the National Health Service.

1. The sessional fee for practitioners working a three-hour session under Emergency Dental Service schemes should be increased from £115.37 to £119.30.
2. The sessional fee for part-time salaried dentists working six three-hour sessions a week or less in a health centre should be increased from £81.67 to £84.45.
3. The hourly rate payable in relation to the continuing professional development allowance and for clinical audit/peer review should be increased from £62.93 to £65.07.

## **2.4.2 Commitment payments**

Dentists in Scotland and Northern Ireland receive commitment payments as a reward for their commitment to providing NHS services. Dentists in England and Wales no longer receive these payments as they are deemed to be included in the UDA calculations.

Commitment payments are an allowance paid to a dentist based on the number of years served in general dental service subject to certain criteria.

The commitment payments scheme includes all dentists with at least five years' service in the general dental service as a principal (or one year as a trainee plus four years as a principal). In those five years they must have earned at least qualifying gross earnings in five separate years (so these need not be continuous, they may have been working in GDS dentistry for longer). They must also have had gross earnings of £25,000 in the year ending with the first day of the applicable quarter (this figure is uprated each year when the fees rise).

Gross income can include the following:

- gross fees;
- training grants;
- maternity payments, and
- postgraduate education allowances.

Earnings from any trainees or other assistants cannot be used to calculate gross earnings, but earnings from deputies can. Seniority pay does not count towards these earnings.

Those dentists not reaching the minimum gross earnings threshold may still apply using a form from the PCT if at least 90 per cent of their earnings from dentistry are from the GDS.

If a dentist undertakes non-clinical GDS-related activities for at least half a day a week for a quarter, they will be entitled to a payment at a higher level (up to four bands higher, to a maximum of Level 10).

The current list of non-clinical GDS-related activities that can be included for the calculation of gross income is as follows.

1. Advising HAs/ PCTs.
2. Undertaking practice inspections for a PCT.
3. Filling part-time Clinical Assistant posts in hospitals.
4. Work associated with, participation in, management and organisation of the mandatory Vocational Training scheme (excluding trainers and trainees).
5. Service on the Committee on Vocational Training (and equivalents).
6. Service on the Dental Vocational Training Authority (and equivalents).
7. Postgraduate/clinical tutors.
8. Audit and peer review facilitators.
9. Those serving on postgraduate/audit/peer review committees.
10. Membership of and/or involvement in Dental Discipline Committees and all related work for complaints, conciliation, etc. (but not representational activities).

If a dentist considers he has undertaken non-clinical GDS-related activities which are not on this list, he may apply to the PCT to have the activities considered as qualifiers.

Payments are made quarterly in arrears (in April, July, October and January). The Dental Practice Board (DPB) will make the payments automatically.

For the higher payments in the top three bands there is an additional 'qualifier', which is the number of patients the dentist has registered. However, there are a number of substitution measures which the DPB will count towards this number.

1. For every occasional examination claim submitted to the DPB, the dentist's registration level will be increased by two patients.
2. If the dentist is a specialist who sees patients on referral, he can submit a form acquired during the relevant earning period containing details of treatment on referrals and fees will be deemed to be the equivalent of one registered patient.
3. The method of calculation of registration levels is the average over the three months preceding the last month of the applicable quarter. An

example would be that the registration figures at the end of March, April and May would be used to determine the registration levels for the quarter ending June.

All payments are pensionable, subject to the maximum allowable remuneration limit. None of the payments will count towards calculating the dentist's gross fees for other allowances, except the business rates reimbursement.

The Review Body recommended for 2008 that the quarterly payments under the commitment payments scheme should be increased as follows:

- Level 1 payment from £44 to £46 a quarter;
- Level 2 payment from £358 to £371 a quarter;
- Level 3 payment from £462 to £478 a quarter;
- Level 4 payment from £554 to £573 a quarter;
- Level 5 payment from £645 to £667 a quarter;
- Level 6 payment from £735 to £760 a quarter;
- Level 7 payment from £829 to £858 a quarter;
- Level 8 payment from £921 to £953 a quarter;
- Level 9 payment from £1,012 to £1,047 a quarter, and
- Level 10 payment from £1,104 to £1,142 a quarter.

An extract of the Doctors and Dentists Review Body Report for 2008, in respect of their recommendations for dentists' remuneration for the year from 1 April 2008, can be found in **appendix 6**.

### **2.4.3 Seniority payments**

Seniority payments are additional monies that are paid to GDS practitioners who have reached the age of 55. They are designed primarily to reward practitioners for staying within the NHS and to compensate them for the perceived reduction in their ability to perform their role in the GDS at the same pace as younger colleagues. The seniority payments scheme is self-funded by the profession in that all fees and allowances have been reduced by a very small percentage to pay for the scheme.

Seniority payments are paid every quarter in arrears, and the qualifying criteria are judged on a quarterly basis.

The quarterly dates for each year are 30 June, 30 September, 31 December and 31 March.

Seniority payments cannot be backdated, so if a dentist forgets to claim until he is 56 or older he will lose payments for earlier years. Dentists are no longer eligible to claim seniority payments once they start receiving superannuation benefits, ie their NHS pension.

In addition to being over the age of 55 the dentist must have practised in the GDS for not less than 10 years in total since July 1948. Additionally, they must have practised for at least five years within the last 10 years preceding their application, though neither of the time periods need be continuous.

Also, within the last 10 years the dentist must have had pensionable earnings of not less than £207,000. To assess this they must add up all of their gross earnings during that period, then multiply these by 43.9 per cent. The reason for this is that a notional 56.1 per cent is deducted from dentists' earnings in order to calculate how much of that amount is superannuable (this issue is explained in more detail in **chapter 9**).

In addition the dentist needs to have undertaken at least two approved post-graduate sessions in the five quarters before the first day of the quarter for which he is applying.

The system of payment used is rather complex and is based on the accumulated earnings at the end of each quarter. The DPB will pay the dentist 10 per cent of his fees earned, added as a supplement, in his normal schedule at the beginning of the next quarter, but subject to minimum and maximum fees. For 2005/06 these were as shown in Table 2.4.

**Table 2.4** *Minimum and maximum fees, 2005/06*

30 June 2005	£6,250 to £18,750
30 September 2005	£12,500 to £37,500
31 December 2005	£18,750 to £56,250
31 March 2006	£25,000 to £75,000

So for 2005/06, £7,500 is the maximum payment that it is possible to receive.

These payments are pensionable at the normal rate, subject to the maximum allowable remuneration limit.

For the accountant drawing up accounts for his client practice, it is important to ensure that the accounts show clearly the partners' intention as to the allocation of these seniority payments. In many cases these are retained by the partners in whose names they are paid. In such cases the seniority payments should be allocated as prior shares of profit.

It is planned that seniority will be phased out in England and Wales in 2008.

#### **2.4.4 Continuing professional development allowances**

The payment of travel and subsistence for dentists undertaking verifiable continuing professional development (CPD) is delegated to PCTs along with the

delegation of the commissioning of primary care dental services. Funds from the DoH are allocated for the postgraduate training of dentists under Section 63 of the Public Health Act 1968, and these are delegated to PCTs to make the payments.

Dentists need to send a form to their PCTs if they are claiming travel and subsistence expenditure, and it is important for them to keep a copy of the form for their records as it acts as a certificate of attendance which may be required in relation to seniority payments or as evidence of their completion of their compulsory CPD requirement.

The form required is a FP84–0306 (see **appendix 7**) and it shows the rates at which expenses are reimbursed. Dentists are permitted to claim their expenses as there is a general understanding that as much as possible of the Section 63 funding should be used to support the delivery of training without burdening dentists who work long distances from dental education centres with unreasonable travel costs.

The current rates are as follows.

1. Mileage: using their own vehicle, taking the shortest practical route between either practice or home and place to be visited, £0.23 per mile; dentists carrying one or more named eligible dentists to the same course can claim an extra £0.02 per mile.
2. Overnight stays: actual receipted cost of bed and breakfast up to a maximum of £55 per night; non-commercial accommodation (ie friends or relatives), £25 per night.
4. Meals: lunch (applicable when more than five hours away from the practice), £5; evening meal (applicable when away from the practice for more than 10 hours) £15.

#### **2.4.5 Reimbursement of non-domestic rates**

A dentist undertaking a GDS contract who pays the business rates is entitled to claim reimbursement of the rates payable in any financial year for any building where general dental services are provided. However, the amount payable may be ‘abated’ according to the proportion of private work carried out as a proportion of the total gross income of the practice.

The dentist making the claim must be shown as a principal on the dental list of the PCT.

The reimbursement will not be received if the gross GDS earnings of all the dentists practising in the premises for the financial year before application for reimbursement are below a minimum threshold. The thresholds for earlier years have been:

- for 2003/04: £23,497;
- for 2004/05: £24,178, and
- for 2005/06 to date: £25,000.

The PCT has the discretionary power to waive this criterion when it considers it reasonable to do so, for example for a new practice.

The amount reimbursed is the whole of the rates bill if the practice's total income is 90 per cent derived from the GDS. Otherwise, the amount is abated according to the level of GDS income as a proportion of total income; if the GDS proportion is less than 10 per cent then the reimbursement is abated by 90 per cent.

The amount payable will be paid on the principal's normal schedule by the DPB. As this is a reimbursement of expenses, the rates reimbursement is not pensionable and is not counted towards gross income for the purposes of the other allowances such as seniority and commitment payments.

The backdating of payments by PCTs is not permitted after six months. This rule is absolute and PCTs are unlikely to waive it.

## **2.4.6 Vocational training allowances**

Historically, upon finishing Dental College dentists went straight into self-employment as associates in practice. Many found the transition between study and self-employment difficult.

As a result the Vocational Dental Practitioner (VDP) system was introduced whereby the trainee takes up employment at a registered practice for a period of 12 months. In return the practice receives reimbursement of the trainee's salary plus a training grant.

For the practice to receive the reimbursement the following qualifying criteria must be present.

1. The trainer's name must be included in the dental list of his PCT.
2. The dentist must have been approved to act as a trainer in a vocational training scheme for general dental practice by the local postgraduate dental dean or director, acting on the advice of a trainer selection committee established by the Local Postgraduate Dental Education Committee.
3. The trainer must have entered into a contract of employment with the VDP as an assistant for a period of one year's full-time employment (or the part-time equivalent).
4. The trainee must have a basic dental qualification that may be registered by the General Dental Council and he must be a UK or EEA national.

The allowances are payable by the Dental Practice Board each month on the trainer's schedule, during the existence of the employment contract with the trainer.

The training grant to a trainer for a full-time trainee is currently paid at a rate of £719 a month (£8,628 annually).

The salary reimbursement for a full-time trainee is currently paid at a rate of £2,396 a month (£28,752 annually).

The trainer can claim 100 per cent of the National Insurance contributions for the VDP.

The practice is given an additional amount of UDAs in order that it can provide the additional work for the VDP to do. The contract value varies in different PCT areas according to available funding.

### **2.4.7 Long-term sickness payments**

Most private insurance schemes cover up to 75 per cent of lost earnings, so the NHS covers the remaining 25 per cent, thus giving a dentist with private cover up to 100 per cent of their normal earnings when they are ill for a long period. The purpose of the GDS long-term sickness payments is not to provide a substitute for private health insurance, but to act as a complement.

A dentist may claim the allowances when he has been ill for at least four weeks. He can get the allowance for a maximum of the 22 following weeks. But in order to qualify, the dentist must have been on a dental list for at least two years.

In addition the dentist must *either* have had the following minimum gross NHS earnings in the previous and current financial years:

- for 2003/04: £23,497;
- for 2004/05: £24,178, and
- for 2005/06: £25,000

*or*, if at least 90 per cent of his earnings were part of NHS gross, during the test period.

A dentist cannot receive these payments if she is in receipt of maternity payments, has been suspended or is an assistant.

During the period of sickness superannuation is not deducted, but a notional credit is given for the amount the dentist should have paid, together with the 'employer's' contribution (that is paid into the superannuation fund as if the dentist had been earning normally).



A maximum of £314 a week can be claimed.

## **2.4.8 Maternity, paternity and adoption leave payments**

These are allowances paid to principal and associate dentists when they or, in the case of paternity leave, their partner either gives birth to a child or adopts a child.

The process for applying for maternity and paternity leave payments works slightly differently, so they are summarised here separately. The process is similar for parents adopting; however, this is noted at the end of the section.

### **2.4.8.1 Maternity leave payments**

The dentist must have been included on a dental list for two years. However, they should have been on a dental list continuously for the six months immediately preceding 15 weeks before the expected date of birth of the baby – it is vital that a break is not taken during that period.

They need to *either* have had minimum gross NHS earnings in the year before the date of conception as follows:

- for 2003/04: £23,497;
- for 2004/05: £24,178, and
- for 2005/06: £25,000

*or*, during this same period, at least 90 per cent of their dental earnings must have been from the NHS.

They will be paid their net earnings for up to 26 weeks, subject to a maximum payment.

Net earnings are calculated as 43.9 per cent of their gross earnings over the period mentioned above. This is subject to a maximum payment of £1,256 per week and can be claimed for a maximum of 26 weeks.

If the dentist does not return to work within a year of the birth they may be asked to repay their maternity payments.

### **2.4.8.2 Paternity leave payments**

The dentist must have been included on a dental list for two years. However, they should have been on a dental list continuously for the six months immediately preceding the baby's birth – it is vital that a break is not taken during that period.

They also need to *either* have had minimum gross earnings in the year before the baby's birth as follows:

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- for 2003/04: £23,497;
- for 2004/05: £24,178, and
- for 2005/06: £25,000

or, during this same period, at least 90 per cent of their dental earnings must have been from the NHS.

Net earnings are calculated as 42.6 per cent of their gross earnings over the period mentioned above. This is subject to a maximum payment of £1,256 per week.

Paternity payments may be claimed for up to two weeks. The claim must relate to complete weeks during which the dentist remains on a NHS list but no general dental services are provided. The dentist may choose when to take these two weeks of leave at any time within 26 weeks of the birth.

If the dentist does not return to work within a year of the birth the recipient of the paternity benefit may be asked to repay the monies.

***2.4.8.3 Adoption leave***

The process is similar for a parent who is adopting. The main care provider – not necessarily the female parent – is entitled to payments equivalent to the above maternity leave payments. The other parent is entitled to payments equivalent to paternity leave.

The leave may only be taken immediately following the date of adoption.