Advice sheet

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The essential nature of associateships - a property licence

Working as an associate is the most common way for dentists to work in general dental practice (unless, of course, they are the practice owner). However, associateships are a unique arrangement, not seen outside the dental profession.

In an associateship: the practice owner provides the surgery to the associate; the associate pays the practice owner for the use of the facilities. It is a business relationship between two dentists – the associate being self-employed, not the employee of the practice owner. However, although it involves the associate hiring the surgery, the associate is a lodger, not a tenant. The legal definition of this type of arrangement is that the associate has the practice owner’s licence (permission) to use the facilities.

The practice owner also provides the associate with patients, equipment, materials and staff assistance. The associate normally pays for the use of the facilities monthly, the amount generally based on a proportion of fees earned.

Whilst associateships may be popular across the profession with both practice owners and associates, the nature of the arrangement has some basic pitfalls. It is important that dentists do all they can to minimise the effects of these by having a written contract which is as sound as possible. Associates in particular are advised to be very wary of any agreements which are not based on the BDA’s model and to check that those which appear at first sight to be based on our model do not lack vital safeguards.

The practice owner, by selling a licence rather than a lease, avoids giving the associate any rights in land law to exclusive possession of the surgery or security of tenure.

Associates working under the NHS in England and Wales are defined as dental performers under the General Dental Services (GDS) or the Personal Dental Services (PDS) regulations. The GDS and PDS do not distinguish between practice owners and associates (or employed dentists or locums). The GDS and PDS distinguish between NHS contract holders (who are called providers in the GDS and PDS regulations) and performers.

Performers are the dentist actually treating the patients under the NHS. In many practices the NHS contract holder (the provider) will be the practice owner. Though in some situations associates may hold their own NHS contract or bid for an NHS contract.

Self-employed status

A major feature of being an associate is being self-employed. The associate makes independent professional judgements and takes full clinical responsibility for their work. The practice owner may control the facilities offered but should not control the associate’s day to day work.

Self-employed status cannot be taken for granted. To an outside observer, perhaps a tax inspector, the arrangement may look like that of employer and employee. Therefore it is vital to have a written agreement defining the self-employed nature of the associateship so that it cannot be mistaken for a contract of employment.

The contract should state that the associate is self-employed and that the associate is paying the practice owner for the use of the facilities. However, it is not enough for an agreement simply to declare that the associate is not an employee. In the event of a legal dispute a court or employment tribunal would decide whether or not the associate was an employee by looking at the extent to which the practice owner exercised control over the associate’s work or working practices. Both parties need to be stringent in observing the day to day aspects of self-employed status. Just because the taxman accepts it for income tax purposes, does not rule out the possibility that an employment tribunal may find that someone is an employee for employment law purposes, or vice versa.

The contract needs to provide clinical freedom for the associate. The associate should also be able to offer private care and chose their which laboratory to use. However, they would be obliged to make full use of the facilities, including sending in a locum if they are ill. Also they could be bound asked to promote the interests of the practice – which could mean complying with the practice’s NHS contract or private fee scale.
Implications of self-employed status

Self-employed status could be compromised if the contract or actually daily working practices are too prescriptive. Associates should not be told which treatments to provide, which materials to use or which laboratory to use.

For an associate, the main advantage of being self-employed is that Income Tax is paid differently. It is not deducted at source but is paid later under Income Tax ‘Schedule D’ and it is possible to claim tax allowances for certain legitimate expenses. New associates must remember to save up for their tax liabilities and to complete their tax return accurately. Even with the relatively simple tax affairs of an associate, it is advisable to employ an accountant to ensure that they are in order. (Incidentally, some tax inspectors increasingly question self-employed status, especially if an associate remains in the practice where he or she was a vocational dental practitioner).

There is also a tax saving for the practice owner as they will not be liable for employer’s National Insurance contributions.

In employment law, the practice owner avoids most employer responsibilities, though the associate is equally denied statutory employee protections. Rules on protection from unfair dismissal, which provide job security to employees, do not apply to associates. A practice can decide at any time to dispense with an associate, whether or not a replacement is found, and the only obligation it has is to follow the agreed notice period. If there is no contract, it can be very difficult to enforce any notice period at all and associates can find themselves suddenly out of a job.

Nor is there any right to Statutory Sick Pay. Associates should take out appropriate sickness and accident insurance to cover themselves if they are unable to work.

Equalities and discrimination legislation

Discrimination laws, however, do apply to associates as these cover all workers. Therefore a practice owner must not treat an associate less favourably on grounds of gender, marital status, sexuality, race, nationality, religion, or age. Therefore, whilst associates do not have security of tenure under employment law, they do have protection under the Equalities Act 2010.

One practical effect of this is that associates are entitled to maternity, paternity or adoption leave. If a practice owner terminates a contract for a reason connected with pregnancy, for example, the associate will be able to go to an employment tribunal for compensation or reinstatement. Women are also able to seek to return to work under different hours than before their maternity leave - working fewer hours, for example - provided that the adjustments the practice has to make to accommodate this are not unreasonable. Practice owners and associates encountering these circumstances can obtain individual advice from the Practice Support team at the BDA, see Further Information or BDA Advice Sheet A14 Dentists Parental Leave and Pay.

Assigning associateships

Associateships are personal to the parties to the agreement and cannot be assigned. So if a practice is sold the agreement would normally come to an end. A new owner would have to enter into a new contract with existing associates if they want the associates to continue. This contrasts with the situation of employees, whose contracts automatically transfer to a new owner when a business is sold.

Clinical freedom and responsibility

A key aspect of self-employed status is the associate’s clinical freedom in treating patients. Subject to the normal rules of ethical practice, associates should be free to decide upon the treatment they offer to patients. Nevertheless, the practice owner may exert a strong influence on the way dental care is provided at the practice, the associate may well be limited by practice standards and policies relating to equipment, materials, use of laboratories, collection of fees, and staffing. So it is important for an associate, before taking a job, to look very carefully at the practice and talk in detail to the owner so that a full picture of the job can be gained and to be sure that the practice will provide the facilities and framework for the quality of dentistry to which they aspire.

On the other hand, associates are directly responsible for the clinical work that they provide. There can also be problems for practice owners where the associate’s clinical standards cause concern for the goodwill of the practice. It is not an easy situation to resolve and may
ultimately end in the termination of the associateship. Where patients complain, the associate should comply with the practice’s complaints procedure, see Failed treatment, below. In other instances practice owners should initially raise concerns through practice procedures, such as the practice’s underperformance policy. Associates should be open to accept constructive comments about their performance as it is in everybody’s interest to solve any problems at the earliest possibility. Further information is available in the BDA Advice Sheets B1 Ethics in dentistry and B12 Performance concerns.

Furthering the interests of the practice
Associateships are about working co-operatively. The associate is being provided with the facilities and patients. The practice owner will want the associate to make a positive contribution to their practice. The associate also has an interest in ensuring a steady flow of patients. Associate contracts often contain a general clause on promoting the interests of the practice.

The associate should promote the interests of the practice, dealing with patients professionally and politely complying with the practice owner’s business plan. The associate should not harm the practice’s business. The associate should not criticise the practice or care provided in the practice (genuine concerns about a colleague’s performance should be brought up through the proper procedures). Generally, unless there is a clinical need, the patient should not refer patients outside the practice or promote products or payment schemes not approved by the practice owner.

Ownership of goodwill
Goodwill is the reputation of a business and the tendency of its customers to use it again and recommend it. Goodwill represents the potential of a business. So although not tangible, in general dental practice goodwill is an important asset of the practice owner. A practitioner can own and sell on to a new owner the goodwill relating to a group of patients. Therefore associate contracts generally have clauses to protect the practice owner’s goodwill. Many customers will be patients of the associate but the contract often states that all goodwill belongs to the practice owner. A clause protecting a practice owner’s goodwill would cover:

- A statement that the practice owner owns the goodwill of the practice.
- Conditions on what an outgoing associate can tell patients about their new practice, limiting the extent to which an associate gives patients information about a new practice location, while taking care not to mislead patients
- A requirement that an outgoing associate agree the arrangements for completion of treatment on departure with the practice owner.
- A restriction on where the associate can work once they leave. These binding-out clauses must be reasonable – they must be limited to a defined area (usually a given radius from the practice) and limited to a defined period of time (usually no more than a few years). Practice owners may find that unreasonable or excessive restrictions are not legally binding upon former associates. Guidance on reasonable restriction is difficult to provide as it depends on the particular practice, its location and patient base.

However, if there is no specific agreement about goodwill, then the associate may be able to vie for patients of their former practice after the termination of an associateship. However, this can still be fraught; the associate would in effect be starting to openly compete against the practice owner. Patient records should not be misused to solicit patients. It is likely that personal details such as addresses would be covered by the Data Protection Act.

Practicalities of associateships

Facilities

Equipment
When entering into an associate agreement, the associate should be provided with a full inventory of the equipment and facilities that they are entitled to use during their associateship. The associate should double check the inventory and the current condition of each piece of equipment.
The standard of an Associate’s surgery, quality of support from dental care professionals and the general clinical environment may be reflected in the financial arrangements. A practice owner providing excellent facilities could charge a higher percentage of gross fees.

**Responsibility for servicing and repairs**

Associates pay to use the facilities at the Practice so they can expect them to be in reasonable working order. Where appropriate, equipment should be regularly serviced. If any equipment breaks down or requires repair, the practice should attend to it. The BDA model contract obliges the practice owner to arrange for repairs promptly. It gives some leeway for the time to arrange for an engineer to visit or obtain spares. But the practice owner should indemnify the associate if a repair or replacement is not arranged within a reasonable time.

Conversely the associate should use the equipment properly. They should follow manufacturer’s instructions. Any damage caused by the associate’s negligence or neglect would be their responsibility.

Issues relating to the nature of the associate’s relationship with practice staff are generally twofold. First, what staff should a practice owner provide for an associate? The other issue can appear because the Associate is clearly not the employer of these members of staff, but is often involved in day to day supervision of staff. This prompts the question of what role an Associate should adopt in relation to practice staff.

**The dental team**

Who does an associate need to work with, in the practice? This issue should be relatively straightforward. Though, for clarity, practice staff should be covered by the associate agreement. Essentially, associates should expect a practice owner to supply enough staff support to enable them to work effectively – as a minimum you may expect a dental nurse to support them in surgery and a receptionist to help with appointments and administrative work.

Chairside assistance from a dental nurse employed by the practice is almost universal (the BDA has come across a handful of cases where specialist peripatetic associates directly employ their own specialist dental nurse). Dental nurses should either be registered with the General Dental Council (GDC) or enrolled in training. Will the associate be working with a trainee? Will this require additional supervision by the associate? If the associate considers that working with a trainee nurse may be a problem, this should be discussed with the practice owner prior to commencing work. It is possible for the associate agreement to specify that the associate will be provided with a qualified dental nurse.

General dental practice throws up a lot of administrative work. Someone needs to deal with the associates appointments, greeting patients and collecting payments. The same person may deal with these tasks for all dentists within a practice but the individual associate needs to know who is responsible for these tasks.

The associate may also be able to utilise the services of other staff, perhaps a dental hygienist or a practice manager. If so these, also, should be listed in the associate agreement.

**Supervising practice staff**

The associate is not the employer of staff members, yet heads up a team and is frequently responsible for the day-to-day supervision and allocation of work, particularly in the case of the dental nurse. This can be a complex relationship.

The associate needs to treat team members fairly and equally. Respect and courtesy should be shown to all employees regardless of experience or background. The Associate should provide guidance and support to employees and be ready to answer any queries that may arise. In return the associate is entitled to expect dedicated service from their colleagues. Also the associate is paying the practice owner for the service of practice staff (part of the fee apportionment each month covers staff costs); consequently the practice owner has a contractual obligation to ensure as well as they can that staff do their job properly.
So what happens if the Associate has a problem with an employee? If the associate tries to improve the employee’s performance without the support of the employer, the employee could have perceived this as unimportant, unjustified or even a form of bullying and harassment. The employee could well have brought a grievance against the associate. If an associate’s actions are bullying the practice owner has an obligation to resolve their employee’s grievance. The associate may even find themselves in breach of the associate contract, jeopardising not only their working relationship with the dental nurse, but also their position at the surgery.

Where concerns cannot be resolved easily the associate should approach the practice owner with details of the issues. As the employer, the practice owner is the correct person to put in place a strategy designed to help the dental nurse improve. The Associate is not the employer and therefore is not in a position to hold formal appraisals or indeed take any disciplinary action in relation to employees. Moreover the practice owner should have a contractual obligation to deal with staff where the associate has genuine concerns.

Nevertheless, as a leading member of the team, the associate must keep a sense of perspective. Many issues can and should be resolved directly between the associate and employee. However, both parties need to be confident that the practice owner will handle legitimate concerns about the other appropriately and promptly.

Both parties need to know when the associate will be working. By hiring a surgery to an associate a practice owner gets the services an extra dentist - making full use of surgery facilities and enabling the practice to see a wider patient base. Although the associate will be a self employed dentist working in business on their own account they are, however, not purely their own boss. If the associate takes time off there are repercussions for the practice owner. Payments to the practice owner are often based on patients seen and fees earned by the associate. The practice will be employing a dental nurse to work with the associate and booking in patient appointments. The contract should normally define which sessions the associate will work on each day of the week.

Flexible working
Flexible part-time working - where sessions may vary from week to week - is a valuable option for general dental practices. However, where an associate is working flexibly this needs to be adequately covered in the written agreement. This cannot, of course, stipulate the actual sessions that will be worked from week to week because this would defeat the point of flexible working. But the contract can give the parameters within which the associate will work.

Clauses can be written to give a wide degree of flexibility. It may be that the practice can offer a surgery to an associate for, say, 21 hours a week but the actual days to be worked may vary from week to week. Nevertheless, both the practice and associate should be clear about when and how the days to be worked will be agreed: a month in advance, for example. Also, it should be clear who in the practice has the authority to agree the sessions with the associate. Perhaps the practice manager and associate could meet on the first working day of each month to agree the times for the month ahead. If so, this should all be written in the contract.

The number of weekly hours may vary from week to week. The contract could say that the associate should use the surgery for a minimum of 21 hours a week. The contract can also give a maximum because the associate may have other commitments or the practice may have another use for the surgery on other days. Associate contracts, therefore, do not have to bind both parties in rigidly. There is room for flexibility.

Holidays and time off
 Associates need clear arrangement for taking leave. This should be written into a contract. The maximum amount of leave an associate can take each year must also be stated in the contract. Working time rules for staff allow for 5.6 working weeks leave a year, which works out as 28 days a year, including bank holidays for someone working a full five day week. However, this is only the legal minimum. Additionally for associates, what about time off for study leave to fulfil continuing professional development (CPD) requirements?
Associates should give adequate notice of taking leave. Patients may be booked in for some weeks ahead. In small businesses it may also be necessary to co-ordinate leave. Associate contracts should have holiday notification requirements. Holiday notification requirements can vary from a few days to several weeks. The contract may allow more leeway for taking off a single day at the last minute but for a long summer vacation notice should be given to the practice well in advance.

Similarly, it is usual to ask that the practice owner to notify the associate of their holiday and staff holiday. If the practice owner is away this can affect day to day issues, such as ordering supplies or dealing with staff problems, so the associate should be given reasonable notice. If the associate’s dental nurse is going to be away then the associate should be provided with a substitute. Again they should be given notice of this in advance. And the substitute should have equivalent skills and experience. In many instances practices may wish an associate and their dental nurse to take leave at the same time. This resolves the practical issue of having one away and the other not being able to work effectively as a result. However, how should the dates be agreed with practice owner, associate and dental nurse? The contract should set a framework and all involved should be aware of the expectation to co-ordinate holidays beforehand.

**Associates and sickness absence**

Any absence caused by sickness or injury creates problems for the business, however, sickness or injury absence is unforeseeable. Therefore it is vital that the associate agreement has clear arrangements about the associates’ responsibilities where the associate has to take time off work due to sickness or injury. The associate and the practice owner have to consider how to deal with notifying the practice about absence and dealing with the associate’s workload.

When notifying the practice about illness or injury absence initial contact by telephone is vital. The associate should speak directly to the practice owner rather than leaving a message with the receptionist so that you can make an assessment on the telephone in order to decide how to ensure minimum disruption to the practice and most importantly to the patients. It may be practical for the associate to have the practice owner’s mobile telephone number so that this can be done. The associate should understand that they need to call as early as possible allowing the practice to cancel the first patient.

Keep the communications open. The associate may not know how long they are going to be absent or may not recover as soon as they would have hoped. They must contact the practice on a regular basis, initially probably daily, unless it is certain that they will be absent for a prolonged period. Even then the associate must keep the practice owner up to date – estimate when it is likely the associate will be able to return to work, tell the practice owner about progress, medical advice received and if the expected date of return to work changes.

For short term absences (an absence of, say, up to two weeks) the associate’s workload can probably be absorbed by the practice. The practice owner or other associates can see urgent cases, whilst the associate can make up cancelled appointments on their return to work. In any case the rigmarole of finding and appointing a locum for such a short period may not be appropriate. Generally, written agreements should say that there is no obligation to employ a locum unless the associate’s absence is likely to be away for more than a fortnight.

To provide cover for long term absences it is likely that the self employed associate will have to engage a locum. For more details see the section on Locums, below.

**Locums**

Being self-employed, associates are ultimately responsible for arranging cover if they are absent from the practice. (Most dentists refer to such cover as a locum but this is no longer a recognised term under NHS regulations and so is often not understood by primary care organisations). One of the elements of self-employed status is the responsibility to find your own cover when absent. Whilst employees undertake to provide their services personally and their employer is responsible for arranging cover in their absence, independent contractors agree to get the job done, whether personally or through an agent.
Associate contracts, usually include a term that the associate is required to appoint a temporary performer if they are absent from the practice for more than a specified period. As a general guideline, the BDA advises that a period of seven to ten working days is reasonable, after which the associate is required to appoint a temporary performer. The obligation to do so applies to any absence, including holiday, sickness or maternity or paternity leave.

In practice, however, the owner commonly arranges cover. Both practice owner and associate are commonly happy for the former to assume responsibility for cover arrangements. It is in the practice owner’s interest to ensure that the locum is acceptable and to maintain control over the terms on which they do so, whilst the associate is saved the job of finding and managing the locum. Indeed, if the associate is ill they not able to take a lead in co-ordinating all the arrangements.

The choice of who assumes responsibility has ramifications for payments and the liability if something goes wrong. For instance, where the associate does so, the temporary performer is the agent of the associate. The associate remains liable to the practice owner for any breach of contractual duties. There is a contractual chain as the practice owner has recourse against the associate; and, in turn, the associate has recourse against the temporary performer.

The associate needs to agree a written contract with the temporary performer, setting out their obligations which should mirror those of the associate under their contract with the owner. The owner continues to pay fees to the associate as normal, which the associate uses to pay the locum.

Where the practice owner takes responsibility for arranging cover, the associate will not be liable in the event of any breach of their contractual duties. If the owner appoints a locum they pay them directly out of the fees that they would otherwise have paid to the associate. The practice owner agrees a written contract with the temporary performer and so has recourse against them directly if they underperform or otherwise fail to carry out their duties.

In either case ensure that the locum has a written agreement. In affect they are either an employee or associate engaged on the short term basis. For more advice on appointing a locum see BDA Advice Sheet A13 Locumships in general dental practice.

**Failed treatment**

During the course of the associateship the associate should comply with the practice procedures, including the patient complaints policy, when handling any replacement work. Generally, the associate is responsible for the care and treatment provided and so should bear the full cost of any necessary repairs or replacements.

Certain NHS treatment must be replaced free-of-charge to the patient and the repair and replacement qualify for UDA credit. If relevant NHS treatment fails, it should be replaced by the associate personally, unless the patient does not agree. If the patient wishes another dentist at the practice to undertake the work, the dentist providing the treatment would have those UDAs credited to their target and the patient charge element should be paid to the practice owner by the associate.

For the situation after leaving the practice see the section on Handling failed treatment after leaving the practice.

**Leaving a practice**

**Notice periods**

Associate agreements should have a reasonable period of notice to the practice for terminating the contract. Both the practice owner and the associate should have to give notice if they want to end the associateship. The length of notice is a matter for decision by both parties, though the common period of notice both for professional nature of the contract and for completing patient treatments is around three months’ notice. The notice period must be defined in the contract and notice should be in writing.

In situations where no notice period has been specified the courts have implied a reasonable notice period. Therefore, written notice should be given even in these circumstances.
Occasionally the working relationship between the parties has broken down to such a degree that one wishes to end the agreement immediately. This can be done if it can be shown that the other party has committed a serious breach of contract. Even then they should be given the opportunity to rectify the matter and independent advice should be sought before the contract is ended. The contract can also make provision for the agreement to end immediately in certain circumstances, such as one party being suspended from the GDC Dentists Register or being declared bankrupt.

An associate working under a practice owner’s GDS or PDS contract will not be required to give notice to the NHS if they wish to leave. NHS patients will not need to be notified or transferred from the associate’s list, but the practice owner will need to notify the PCO that the associate has left and will probably be asked how the UDA target will continue to be met. Of course practice owners should nevertheless notify patients of practice changes, to maintain goodwill.

An associate holding their own GDS contract must give three months’ notice of termination to the PCO as well as notice to the practice owner. When the associate leave their contract value is likely to return to the PCO for tendering. However, the practice owner could seek to add the associate’s contract value to the practice contract value or the associate could seek to take the contract to their new practice; though the PCO would not be obliged to agree in either case.

**Minimum duration contracts - binding out**
Beware of contracts which state that they will run for a minimum period. Practice owners may be concerned about a high turnover of associates, which can cause patient care to suffer. However, it is not reasonable to force associate to remain at a practice for a fixed period, such as one or two years. If the parties sign up to a clause of this type it will be binding and compensation is payable if one party terminates it before the term expires. Nevertheless, it is not possible to know whether the arrangement will work out for both parties, either in business or personal terms. Associates should not be expected to commit themselves to a fixed term, especially if they find that the practice is unsuitable for any reason.

**Restriction clauses**
Restrictive covenants or binding-out clauses restrict the associate agrees, on leaving the practice, from working within a given area for a given period of time or from treating patients of the former practice. These restrictions protect the goodwill of the practice by stopping the associate from leaving and setting up in direct competition. However, restrictive covenants are only legally-binding on associate if the practice owner can prove that they are reasonable and proportionate.

In order to be reasonable and proportionate the restriction must be limited. It should only apply within a defined radius or a particular geographical area. And it should only apply for a limited amount of time. It is very difficult to advise on what time and distance terms would be considered reasonable and local legal advice should be taken on individual circumstances. In general terms, it is unlikely that more than a few miles and few years would be upheld by the courts. In urban areas a shorter distance is appropriate. Beware, if the courts do not uphold the clause, they will simply determine that it is unreasonable - they will not substitute acceptable terms. Also restrictions cannot be imposed where there is no written clause in the contract.

**Handling failed treatment after leaving the practice**
After the associapeship has ended some former patients of the associate will return to the practice needing replacement work. The associate remains liable for treatment provided and any reasonable repair or replacement costs. It is suggested that the parties agree a reasonable sum for the practice owner to retain to cover the costs of this work. This figure should be based on the actual value of replacement work carried out in the previous year. The practice owner should provide the former associate with details of all replacement work carried out and repay any surplus at the end of an agreed period, say six or twelve months.
Financial arrangements

Fee collection

In most practices all patient revenue, whether from patient payments, the NHS or private capitation schemes will be collected by the practice. Indeed, this is part of the reception and administrative services that the practice owner provides for the associate. An everyday example of this are the fees collected directly from the patient over the counter at the reception.

Fee assignments

For NHS or private capitation payments in most practices the associate formally assigns them to the practice owner. Any fees then due for the associate are paid to the practice owner. Fee assignments need formal documentation which associates would be required to sign. Often if there is a disagreement and the associate wishes to cancel the assignment the NHS or private insurance company will freeze the payments. They will be paid neither to practice owner nor associate until they have been informed by both parties that the dispute has been resolved.

In the GDS and PDS in England and Wales where the contract is practice-based NHS payments will in any case be paid directly to the practice owner as the contract holder. There is no need for a fee assignment. However, where associates hold the GDS or PDS contract personally they are likely to be required by the practice owner to assign the fees to the practice.

Bad debts

Clear agreement is needed on the treatment of bad debts. The cost of bad debts are frequently shared between associates and practice owners are both parties have some responsibility – the associate treats the patients and explains the fee to the patient, the practice collects the payment and should monitor and chase late payments.

Bad debts will automatically be carried over if the practice bases its monthly accounts on fees actually collected. Therefore in terms of monthly income bad debts are dealt with immediately but will be added back into patient revenue if they are collected in a subsequent month.

Laboratory bills

Where fees are collected by the practice owner then the practice owner should settle the associate’s laboratory bills when they are due. As a self-employed dentist the bills should be addressed to the associate but it will be the practice owner who has the cash-flow to pay the bills on the associate’s behalf. Associates should check that their laboratory bills are being paid on a regular basis as they may find themselves liable for unpaid bills.

In accounting for laboratory bills it is recommended that, since they are a personal cost incurred by the associate in the course of treating their patients, they should be met in full by the associate, with the practice owner being reimbursed from the fees collected. This should be done before any subsequent fee apportionment (see Fee apportionments, below). This is the most appropriate way of dealing with laboratory charges as it effectively means that the costs of bills are shared. Mathematically (though crucially not legally) the laboratory bill is paid from the associate’s gross earnings thereby reducing the total sum that is subsequently apportioned between the associate and practice owner. To see how this works in practice please see the Model statement for associate’s monthly accounts, below.

Hygienist payments

Where patients of an associate are treated by a practice hygienist the fee should ideally be apportioned between the associate and hygienist or practice. The associate has a reasonable claim on part of the fee for work carried out for their patients by the hygienist since they have examined the patient and prescribed the hygienist’s treatment. The practice owner and associate should devise a mutually agreeable formula for dealing with these payments.
Some practices deal with associate fees in a similar way to laboratory bills (see Laboratory bills, above). The fee for hygienist treatment would count as part of the associate’s gross earnings but the associate would then be billed for the hygienist’s costs (including wages and materials). In this method the associate makes a specific contribution to the payment of the hygienist.

For simplicity, other some practices pay a basic referral fee to the associate for each patient referred for hygienist treatment. In this case the practice would not credit the patient fee to the associate’s earnings. Whatever the arrangement, it is essential to have a clear agreement from the start.

Associates generally pay practice owners for the license through an apportionment of their fees. Where for practical purposes NHS and private payments are made to the practice, the practice owner deducts expenses such as laboratory charges and splits the income in the agreed manner. The practice owner will pay the associate the amount due to them (less any personal expenses such as superannuation) retaining the payment due to the practice for the license. This can appear as if the practice owner is paying the associate rather than remitting to the associate the money that the practice has collected on the associate’s behalf. Therefore, both parties must check that the arrangements for this are clear.

Fee apportionments
The associate’s earnings may be apportioned with the practice owner by either:
- Splitting the gross earnings according to an agreed percentage. There is no set percentage rate for apportioning an associate’s earnings as this is a business decision for both parties to consider. You should have regard to the patient base, practice costs and the local market conditions in deciding this figure. Or
- A fixed monthly sum being retained by the practice owner. This enables the practice owner to receive a flat rate that should take account of practice costs, desired profit margins and the associate’s ability to meet, and indeed exceed, this figure from the practice’s patient base.

Fee apportionments are generally based on final schedules and monthly receipts. When a new associate joins a practice it may be helpful for a new associate to agree some interim day book arrangements with the practice owner to tide him or her over until there is a proper flow of completed treatment on schedules. But there should be a change-over to payment on schedules at the earliest opportunity, with adjustment to take account of any interim payments made.

Date of payment and monthly statement
The associate agreement should provide for a payment date on an agreed day per month. This is the day on which the practice owner should give the associate all fees collected on the associate’s behalf less all deductions (including the licence fee and laboratory bills). Late payment can be a problem, so it is vital that a set date is given in the contract, such as the fifth of each month, five working days after the receipt of NHS schedules or the first Friday of each month.

The practice owner should also provide the associate with a written statement detailing all fees collected, all deductions and their calculations. A model statement appears in Model statement for associate’s monthly accounts.

NHS superannuation contributions should be calculated from based on figures provided to the PCO by the contractor. At the start of each contract year estimated pensionable earnings must be provided for each performer. After the end of the contract year (or mid-way through if a performer leaves) the contractor should confirm the actual pensionable earnings for each performer. Since these figures affect pension entitlements, and the level of NHS Sickness, maternity, paternity or adoption leave payments associates must ensure that their practice owner is both supplying these figures and doing so accurately. Both parties should note that the agreed gross UDA value in the associate contract affects the calculation of net pensionable earnings. See also UDA values and NHS Sickness, maternity, paternity or adoption leave payments. For further details on the NHS pension scheme please see BDA Advice Sheet C7 Superannuation in the GDS.
NHS superannuation contributions are deducted from NHS gross earnings at source but are a personal payment by the associate for their pension fund. Practice owners should include the superannuation contribution within the associate’s gross earnings but should then deduct the contribution from the associate’s net NHS earnings.

Associates’ private pension arrangements will be directly paid by them and will not be of concern to the practice.

A statement may summarise a practitioner’s monthly payments as follows:

<table>
<thead>
<tr>
<th>Payments</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate’s monthly NHS Performer Fee (at £25 per UDA for 160 UDAs)</td>
<td>4,000</td>
</tr>
<tr>
<td>Less NHS laboratory costs</td>
<td>800</td>
</tr>
<tr>
<td>Less bad debts for uncollected NHS patient fees</td>
<td>400</td>
</tr>
<tr>
<td>Plus previous NHS bad debts that have since been collected</td>
<td>200</td>
</tr>
<tr>
<td>Sub-total for NHS work</td>
<td>3,000</td>
</tr>
<tr>
<td>Less Licence Fee payable to Practice Owner at rate of 50 per cent of the Sub-total</td>
<td>1,500</td>
</tr>
<tr>
<td>Less Associate’s NHS superannuation contributions</td>
<td>100</td>
</tr>
<tr>
<td>Total amount payable to Associate in respect of NHS work</td>
<td>1,400</td>
</tr>
<tr>
<td>Private Payments</td>
<td>6,000</td>
</tr>
<tr>
<td>Associate’s Private Fees</td>
<td>2,100</td>
</tr>
<tr>
<td>Less private laboratory costs</td>
<td>200</td>
</tr>
<tr>
<td>Less bad debts for uncollected private fees</td>
<td>300</td>
</tr>
<tr>
<td>Plus previous private bad debts that have since been collected</td>
<td>4,000</td>
</tr>
<tr>
<td>Sub-total for private work</td>
<td></td>
</tr>
<tr>
<td>Less Licence Fee payable to Practice Owner at rate of 55 per cent (45:55 split)</td>
<td>2,200</td>
</tr>
<tr>
<td>Total amount payable to Associate in respect of private work</td>
<td>1,800</td>
</tr>
<tr>
<td><strong>OVERALL TOTAL PAYABLE TO ASSOCIATE FOR NHS AND PRIVATE WORK</strong></td>
<td><strong>3,200</strong></td>
</tr>
</tbody>
</table>

Associates and NHS general dental practice in England and Wales

Under the General Dental Services (GDS) and Personal Dental Services (PDS) regulations Primary Care Organisations (PCOs; that is Primary Care Trusts in England, Local Health Boards in Wales) contract with dentists and dental practices. PCOs commission a fixed annual amount of dentistry, measured in Units of Dental Activity (UDAs), in return for a fixed annual amount of money. Full details are included in the BDA Advice Sheet E11 Guide to General Dental Services and Personal Dental Services in England and Wales. (Please note the government proposals in the White Paper, Equity and excellence: Liberating the NHS, July 2010, sets out the vision for the future management of the NHS in England and how contracting and commissioning arrangements will work - it is envisaged that changes will be implemented from 2013 or 2014).

NHS earnings are fixed and, as practice owners need to meet UDA commitments, they have to set performance targets for associates, who will also be required to comply with the terms of the GDS contract or PDS agreement under which they are working.

Some associates may hold their own GDS contract or PDS agreement. Generally, however, PCOs prefer to contract with a practice as a whole and so where individual associates hold a personal contract this will largely be for reasons connected to the change-over to current system in April 2006.
Associates with a personal contract will have to pay the practice a share of the monthly contract amount for the use of practice facilities, see Financial arrangements, above. This should be paid promptly to the practice, say within five working days of the associate being paid. However, in many practices the associate will probably be asked to assign their contract payments to the practice owner, see Fee assignments, above. This is not essential. It defeats the benefits of the associate having their own contract from a self-employed point of view, since it is the associate's contract, and they are responsible for the completion of targets.

With practice-based contracts the practice owner subcontracts the performance, or part of the performance, of their UDA target to the associate (as noted above under the GDS and PDS regulations associates are known as performers). There are alternative ways that self-employed associates can be paid in an NHS practice:

- Payment per UDA
- A fixed performer fee with a UDA target and withholdings for incomplete performance.

Whichever method is used it is essential that practices and associates make arrangements to monitor each performer’s UDAs closely. Associates should be given the information they need to assess their own performance.

**Payment per UDA**

A system based on a fixed payment per UDA means that the associate is paid for work done and provides an incentive for the associate to fulfil the required numbers. The associate could receive an agreed payment per UDA provided in the previous month, up to a monthly maximum. The monthly maximum helps ensure that the associate does not exceed the UDA target. There must be a maximum annual number of UDAs payable per performer which reflects the practice’s UDA total. This ensures that the practice stays within its NHS budget and UDA target. If the associate performs more UDAs than the maximum, the excess could be carried forward against future shortfalls.

As self-employed performers the associates should be paid a gross amount per UDA and pay an agreed proportion back to the practice for the use of the facilities, see Fee apportionments, above. The associate and contractor negotiate a mutually acceptable UDA rate, though it is suggested that unless there is a good business reason otherwise this should reflect the practice’s average gross UDA value.

**Performer fee with UDA target and withholdings for non-performance**

The method of a flat fee with a fixed UDA target and withholdings for non-performance reflects the practice owner’s agreement with the PCO. The practice must work within a fixed target and the PCO’s expect that the UDAs are spread across the course of full year. However, there needs to be some flexibility in the number of UDAs the associate performs each month because of the varying length of months, holidays, bank holidays and weekends. Calculate a daily target. Each associate’s monthly UDA target should be based on their annual target divided by their number of working days per year and the number of working days in a particular month. A daily target automatically takes into account and does not penalise the associate for perceived shortfalls when, for example, they take their annual holiday.

The associate receives a fixed gross performer fee each month. This is based on one twelfth of their annual UDA target. The associate then pays the practice a licence fee for the use of the facilities, see Fee apportionments. However, failure to meet the UDA target (taking holidays into account) would result in a proportional withholding of part of the performer fee. Though, once the associate has made up any shortfall, the withholding must be repaid. The practice owner and associate must monitor UDA performance on at least a weekly basis and reconcile their records of UDAs completed at least monthly. Where targets are not being achieved, both parties need to understand the reasons why. Targets should be reviewed at the end of every quarter.

If an associate leave part way through the contract year the associate’s final payment should take account of their pro-rata UDA target for the year-to-date. Any shortfall should be
deducted from their final pay. If they have not achieved the pro-rata required number of UDAs, another dentist will have to undertake them and will expect payment.

**UDA values**
Many practice owners do not pass on the full UDA value and percentage uplifts to associates. Practice owners and associates are, of course, free to negotiate a UDA rate for the work done by the associate and there is no rule that says that practice owners must pass the full UDA rate to associates. It is a question of market forces, of supply and demand. The more good people applying for an associateship, the less a practice owner might offer and vice versa.

NHS benefits are calculated based on gross earnings and so the amount of gross payments an associate receives can have a significant effect on benefits such as superannuation, sickness and maternity pay. Because of the effect on benefits, the BDA recommends that practice owners give the full UDA rate to associates, but if necessary pay a smaller percentage. For example: a practice owner may receive £22.22 per UDA and gives only £20 gross to an associate with a 50% licence fee (resulting in net £10 per UDA for the associate); alternatively the practice owner could pay the associate £22.22 gross per UDA with a 55:45 per cent split (also resulting in net £10 per UDA). With the higher gross income, the associate will benefit from higher pension provisions and greater long-term sickness, maternity and paternity pay. The extra money an associate could get from these changes could be considerable, especially for the associate's eventual pension. Passing on the full UDA value may also help demonstrate the associate's self-employed status.

**Passing on DDRB uplifts**
Each year, the Doctors and Dentists' Review Body (DDRB) recommends and increase in contract values, which the Department of Health may or may not accept; or accept in part. The recommendation can be earmarked to cover increased practice costs, as a specific boost to dentists' earnings or a mixture of both.

The BDA believes that, if the Department of Health does increase the contract value as a result of a DDRB recommendation or otherwise, practice owners and associates should review their agreed UDA value and percentage split. If the DDRB recommendation is based partly on providing dentists with an increase in income, it would make sense to pass that increase onto associates. However, both parties must consider practice costs and the effect of the associate's performance on the finances of the practice.

**Failure to meet UDA targets**
Prevention is much better than the cure. Practice owners should carefully monitor the number of UDAs being performed by associates. If an associate is underperforming, the issue should be discussed as soon as possible and remedial action put in place.

In any event, it is essential that expectations are properly set in a written contract. Failure of a practice to meet its UDA target is likely to result in clawback by the PCO. If that failure is as a result of an associate, the practice owner will want to claw that money back from the associate.

The question of how much of that claw back should be paid by the associate and how much by the practice owner is a commercial matter for the parties. There are two schools of thought:

a) Under the pre-2006 GDS system, the practice owner would receive half of the amount of money an associate brought in. If an associate brought in less money, the practice owner would receive less money from the associate’s work. Why should it be different now? Surely the claw back should be split between the parties as it would have been under the old system?

b) Why should the practice owner suffer if the associate does not work as hard as they agreed to work? The practice owner still has the same costs regardless of how many UDAs an associate performs. Surely the associate should bear the full cost of their failure to perform their allotted UDAs?
The BDA suggests that, to a large extent, the associate should bear the cost of clawback for non-completed UDAs. But that position is conditional. The principle, we believe, is that risk should follow control. If the associate controls how many UDAs they do, they should take the full financial risk. But if the practice owner has some control over how many UDAs the associates can do, then the practice owner should also take some of the financial risk by sharing the cost of any clawback.

For example, if the practice owner does nothing to introduce sufficient patients, if the equipment keeps breaking down, if the practice never calls patients the day before to remind them of appointments, or if the associate’s nurse is not properly managed and takes a lot of time off, then there is an argument that the practice owner should share the costs of clawback.

If either practice owner or associate can see that the associate is not going to reach their target, they should discuss the issue as soon as possible with the other party with a view to reaching agreement on whether some UDAs can be passed to another dentist in the practice and whether the associate’s target can therefore be reduced.

Some practice owners may give associates unrealistically high UDA targets. If they do, and if the associates are responsible for all the clawback, the associate is at a substantial disadvantage and the practice owner can be confident of receiving their percentage of the contract value at the expense of the associate. However, if the PCT takes action against the practice for breach of contract, the practice owner will suffer.

An associate with a personal GDS/PDS contract should be compensated financially if they are going to lose out through the failure of the practice owner to provide adequate facilities, or, with agreement, the practice owner should cooperate to give the associate the opportunity to make up the UDAs.

These are all matters that need careful consideration at the start of an associateship to avoid a difficult dispute in difficult times. The objective is to ensure that targets are achievable and there is consistent provision of support services to enable the associate to reach the target.

The GDS and PDS regulations require the practice owner (in a practice-based contract) to make reasonable arrangements for CPD for performers. Normally this is in the form of a certain number of days’ leave for CPD.

NHS Sickness, maternity, paternity or adoption leave payments

NHS Sickness, maternity, paternity or adoption leave payments are payable by PCOs to GDS/PDS dentist performers who meet the qualifying conditions. However, payments are made directly to the contractor and should be passed on to the dentist concerned. Indeed, the contractor is required to pay the performer in full.

The contractor’s contractual sum will continue to be paid provided the UDAs are met. As discussed in the section on Locums, above, the self-employed associate is responsible for engaging a locum or another performer at the practice to undertake their UDAs while on leave; though the practice owner may decide to deal with these arrangements directly. If it is not possible to obtain locum cover, the absent associate should either complete the UDA shortfall or compensate the practice owner for the non-performance of the contract. However, care must be taken is asking associates (especially those on maternity leave) for a contribution as this could be discriminatory. It is suggested that if there is no locum the practice owner and associate could agree to a percentage split of the NHS Sickness, maternity, paternity or adoption leave payment. Practice owners should also discuss this as soon as possible with the PCO. It may be possible for the practice owner to obtain a temporary reduction in the contract value and UDA target amount from the PCO, but the associate would still have to compensate the contractor for the loss.

In any event, associates are strongly advised to discuss any absence with the practice owner as soon as possible to ensure that there is early agreement on the best way to manage the absence and UDA target.
Further advice is available in the BDA Advice Sheet A14 Dentists’ parental arrangements and pay. For the way in which entitlements to NHS Sickness, maternity, paternity or adoption leave payments are calculated see Pensions and superannuation contributions, above.

An associate providing orthodontic care on the NHS should be given an agreement that is slightly modified to take account of the way NHS orthodontic agreements are monitored. Orthodontic contract payments are based on a specified workload. This is measured by Units of Orthodontic Activity (UOAs), which generally record case starts and do not take account of incomplete courses of treatment or courses of treatment completed by another performer. For associates thought must be given to whether payment will be made according to a fixed target or for each case started or completed.

### Choosing carefully

The best way to avoid potential future problems is of course to choose your practice owner or associate very carefully. The following checklists of questions for practice owners and associates to ask and points to look for could provide a basis for the interview. At interview each is assessing the other, prospective associates, in particular, should spend time in the practice - a full working day if possible - in order to evaluate the practice.

#### Recruiting an associate

**Questions for practice owners to ask**

Practice owners generally like associates who:
- Work hard
- Have good clinical standards
- Are reliable
- Are able to work in a team
- Are interested in the practice and its future
- Would like to stay
- To whom they can relate

The following questions are suggested for interview:
- Where did you qualify?
- Summarise your career to date
- What are your long-term career plans?
- How many postgraduate sessions did you do last year?
- What are your continuing education interests and why?
- How much did you gross in your previous practice?
- What was your patient base like?
- What sort of patients do you enjoy treating, and why?
- Are you involved in any local dental groups?
- Do you want to run your own practice?
- What are your earnings expectations?
- What do you think are the three most important qualities in a dentist?
- What do you think are the three most important qualities in a dental nurse?
- What sort of mix of patients would you like?
- Are you prepared to sign a contract?

**Questions for associates to ask**

- Why did the previous associate leave or is it a new vacancy?
- How many staff are employed in the practice?
- Will I have a dedicated dental nurse and will my dental nurse be qualified or a trainee?
- Is there a dental hygienist?
- What are the practice opening hours?
- Would I be taking over a full list of patients? Or am I expected to build up a book?
- How many new patients does the practice attract each month? How many patients attend regularly?
- What mix of patients will I be seeing?
- What is the practice policy regarding acceptance of NHS patients?
● Does the practice see private patients?
● Does the practice use a private dental plan scheme? If so what are the arrangements?
● What is the infection control routine?
● What are the emergency arrangements?
● Do the nurses or the dentists usually take radiographs?
● What are the materials ordering policies?
● Is a local laboratory used? Do I have a choice of laboratory?
● Would we have a written agreement and if so please can I see a draft?
● What are the financial arrangements?
● How are bad debts handled?
● Is the practice owner a member of a professional organisation such as the BDA?
● Is the practice computerised?

And ask to see

● The associate’s surgery and equipment
● Appointment books
● Record cards
● Materials and store cupboards
● Oxygen equipment and emergency drugs kit
● Autoclaves
● Radiographic machine and developer
● The practice computer system

Ask to meet

● Reception staff
● Nursing staff
● Hygienists
● Other dentists

Check the proposed contract

● Understand it, seek independent advice if necessary
● Query the terms of the contract
● Negotiate

Amazingly, around a third of associates do not have a written contract (BDA Business Trends Survey 2010 showed that: 63.5% of associates had a written contract; 34.0% did not have a written contract; and 2.5% did not say). The BDA Practice Support team report that those without written contracts experience severe problems if the arrangement breaks down, since there is no clarity about each party’s rights and obligations in respect of each other. Also the lack of a written contract does not mean that either party is free of legal obligations, the courts would merely imply a verbal contract. In fact it is likely that in this way those without a written contract are encumbered by more difficult legal obligations than those who have signed a written contract.

Whilst written contracts must contain legal jargon in order to be precise the BDA has simplified this by producing a model contract. It is designed to be straightforward and to balance the interests of practice owners and associates. You must make every effort to understand your contract. A little work at the beginning will pay dividends in the longer term. Individual legal advice is also essential. The BDA Practice Support team are happy to comment on the content of individual contracts.

Nevertheless even a written contract depends upon trust and cannot guarantee complete success if one party is determined to act unreasonably, but at least it can provide a legal framework if you need to challenge actions or make a claim.
Associateship contracts - essential elements

- Names and addresses of parties
- Date of commencement
- Address of the practice
- Facilities and equipment to be provided, including terms for breakdowns
- Hours, holidays, emergency cover
- Patients
- Record keeping
- Collection of fees
- Payment methods, including regular payment date
- Maternity, paternity and adoption arrangements
- Absences and locum cover
- Termination, including notice period and restriction clauses
- Dispute resolution procedures such as independent arbitration and mediation
- Regular review of terms
- Signature of the parties

The BDA produces a model contract, which accompanies this advice sheet A17A Model associate-performer agreement (England & Wales).

Further information

The BDA Practice Support team advises members on associate issues and can conciliate or mediate disputes between practice owners and associates. Please contact BDA Practice Support on PracticeSupport@bda.org or telephone 020 7563 4574.

The full range of BDA advice sheets can be accessed on-line at www.bda.org/advicesheets.

BDA code of practice for associates and practice owners

The BDA recommends that both practice owners and associates adhere to this code of practice. Keeping to the code will help maintain a good working relationship and avoid disputes.

The job market for associates is changing. Competition for associateship positions is increasing in many areas and disputes are becoming more serious. These reflect the complex new contractual relationships in NHS practice in England and Wales, working to UDA targets, the limits on practice expansion and the influence of practice owners on associates’ pay.

Fair treatment for associates is becoming more important to young dentists and practice owners with NHS contracts also need to be able to recruit and retain good and reliable associates. Working to a code of practice where both sides understand what is expected of them will help to reduce the disputes that arise all too frequently.

PRACTICE OWNER/ASSOCIATE CODE OF PRACTICE

Associates seek to contract with a practice/company that can give them the opportunity to provide quality dentistry for a reasonable reward. Practice owners seek to contract with associates who provide quality dentistry and customer care and who meet their targets. The BDA’s Code of Practice sets out the reasonable expectations of practice owners, associates and patients, which we believe form the basis for productive and successful business relationship between dentists.

Associates and practice owners will

- Deal openly and honestly with each other
- Provide each other with clear and transparent information
- Deal promptly and openly with problems and disagreements that arise
- Seek the help of the BDA in resolving disputes
An associate expects their practice owner to

- Provide a reasonable and fair written agreement with time to consider the terms before signing
- Provide a copy of the signed, written agreement
- Provide a copy of their monthly NHS Schedule/Performer Statement and a monthly summary of private patient fees earned
- Provide sufficient patients to obtain their expected level of earnings and performance targets
- Agree with the associate reasonable appointment times
- Agree performance targets that are reasonable and achievable in the circumstances of the practice
- Not to penalise the associate financially if targets cannot be met for reasons that are the responsibility of the practice owner
- Provide opportunities to increase their professional experience and clinical skills if they wish
- Provide the services of a suitably experienced and trained dental nurse
- Provide a reasonable period of maternity/paternity/adoption leave
- Pay the full amount of any NHS maternity, sickness, paternity, adoption and commitment payments to which they are entitled
- Keep the associate informed of practice changes, particularly if the practice is to be sold
- Ensure that the associate’s NHS claims are completed accurately and submitted promptly
- Enable the associate to use the services of a dental laboratory of their choice
- Agree with the associate the dental materials to be used
- Provide a surgery that is fit for purpose and any breakdowns rectified quickly
- Provide protected time to ensure that their knowledge and skills are up to date
- Give a reasonable period of notice of termination of their contract and enable reasonable arrangements to be made for their departure from the practice, including the information that is to be given to the patient
- Enable the associate to be an integral part of the practice team
- Provide a copy of any NHS contract to which the practice is party.

The Practice Owner expects that their associates will

- Provide a high standard of clinical care to their patients
- Comply with reasonable practice rules and procedures
- Work as part of the practice team and treat members of the practice team with courtesy and respect
- Use the surgery time that is made available to them for the treatment of practice patients
- Make every effort to meet agreed performance targets
- Pay a reasonable amount for their licence to practise at the practice
- Comply with any contract that the practice has with the NHS
- When leaving the practice, complete treatment commenced
- Take responsibility for work that needs to be replaced or repaired
- Keep full and accurate records of clinical work
- Maintain high professional standards
- Adopt high standards of customer service
- Give reasonable notice of their intention to take holidays or study leave.

Patients expect

- Practice owners and associates to work together as part of the practice team
- Practice owners to ensure that they work with associates who provide a good standard of clinical care
- Associates and practice owners to cover for each other in the case of illness or holidays
- Associates and practice owners to share information where this is in the best interests of patients
- Not to be involved in disputes between associates and practice owners
- To be advised when an associate is leaving the practice and to be told, if they ask, where the associate is now practising.