IDH Finance plc

Annual report for Bondholders

Year ended 31 March 2020

Contents

Presentation of financial data

This report summarises consolidated financial and operating data derived from the audited consolidated financial statements of Turnstone Midco 2 Limited, the parent company of IDH Finance plc. The financial information provided has been derived from our records for the years ended 31 March 2020 and 31 March 2019.

The financial information in this report has been prepared in accordance with International Financial Reporting Standards as adopted by the European Union ("IFRS").

Non-IFRS financial measures

We have presented certain non-IFRS information in the Annual report. This information includes metrics derived from "EBITDA", including EBITDA before non-underlying items, which represents earnings before interest, tax, depreciation, amortisation, impairment and one-off, exceptional, or strategic items (referred to as 'non-underlying' items), and estimated pro forma adjusted EBITDA, which represents EBITDA before non-underlying items and an add back to EBITDA for losses from practice closures. We also present certain items derived from EBITDA-related metrics, including EBITDA margin and cash conversion. For the definitions and reconciliations of such terms to other financial metrics, see "Management's discussion and analysis of financial condition and results of operations—Results of operations for the years ended 31 March 2020 and 31 March 2019—Other financial data". Our management believes metrics derived from EBITDA are meaningful for investors because they provide an analysis of our operating results, profitability and ability to service debt. Metrics derived from EBITDA are also used by management to track our business development, establish operational and strategic targets and make important business decisions. EBITDA is the measure commonly used by investors and other interested parties in our industry, although our presentation of such metrics may not be comparable with that of other similar metrics presented by other companies.

We have also included other measures in this Annual report, some of which we refer to as "key performance indicators" ("KPIs"), including EBITDA margin, gross profit margin, NHS dentistry services revenue as a percentage of total revenue, total annual UDA delivery percentage, UDA contract uplift (as defined herein), private dentistry services revenue as a percentage of total revenue, like-for-like private revenue growth, like-for-like private revenue growth per working day, non-dental practice revenue as a percentage of total revenue, overheads as a percentage of revenue and total number of dental practices. We believe that it is useful to include these non-IFRS measures as they are used by us for internal performance analysis. These other non-IFRS measures should not be considered in isolation or construed as a substitute for IFRS measures. For a description of certain of our KPIs, see "Management's discussion and analysis of financial condition and results of operations—Description of key line items—Other financial information (non-IFRS)".

Comparative information has been provided for both the year ended 31 March 2019 and the quarter ended 31 March 2019. IFRS 16 "Leases" has been adopted with effect from 1 April 2019 using the modified retrospective method of adoption. Consequently, the comparative information has not been restated. The impact of adoption can be seen on page 89. "Adjusted EBITDA", which represents EBITDA before non-underlying items adjusted to include rental and other lease charges, has been presented to provide comparable information to the prior period.

Information presented in this report and described as like-for-like excludes any practices or other operating units trading in the group in the current financial year or the year ended 31 March 2019 but not in both.

References to "Integrated Dental Holdings", "IDH" and "the group" refer to Turnstone Midco 2 Limited and all of its subsidiaries.

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Forward-Looking Statements

This Annual report includes statements that are forward-looking in nature. Forward-looking statements involve known and unknown risks, uncertainties and other factors which may cause the actual results, performance or achievements of the company to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements.

Summary

Integrated Dental Holdings ("IDH") is Europe's largest vertically-integrated dental business and the United Kingdom's number one dental practice chain, with a focus on delivering the best possible patient care, the highest clinical standards and a comprehensive choice of treatments through our UK dental practice network. The group operates through two divisions: {my}dentist and DD (formerly Dental Directory).

{my}dentist is the leading provider of dental services in the United Kingdom, with 548 NHS dentistry contracts across our network of 597 dental practices throughout England, Scotland, Wales and Northern Ireland. Our dental practices, operating mainly under the "{my}dentist" brand, offer a broad range of primary care dental services in our dental practices, including dental examinations, fillings and extractions, as well as more specialised dental services such as cosmetic dentistry and orthodontics.

DD is a leading supplier of dental and other medical consumables, materials and services (including the installation and servicing of specialised dental equipment), selling dental supplies and services to at least 8,000 dental practices, including {my}dentist dental practices. DD has an estimated market share of 25% in the United Kingdom, by revenue. The principal trading entities of DD are DD Products and Services Ltd (formerly Billericay Dental Supply Co. Limited) trading as DD, along with a number of smaller businesses including Dolby Medical Limited, Med-FX Ltd and BF Mulholland Limited.

The results for the year demonstrate that the group's strategy is starting to improve underlying operational financial results. We have continued the growth in financial performance seen in the year-ended 31 March 2019 in the {my}dentist business and following the appointment last year of a new management team, the DD business has seen a significant improvement. Our results in the {my}dentist network have benefitted from higher like-for-like growth in private revenue with a successful roll-out of {my}options affordable private treatments, continued controls in dentist fees and the disposal of loss making practices in the prior year, however they have been adversely affected by a lower level of UDA delivery. DD has made significant improvements in its customer service and stock management and has also been able to develop new business lines in aesthetic products.

The improvement in performance was delivered mainly through to the end of February 2020 with the last two weeks of March 2020 subject to lockdown measures across the United Kingdom implemented to slow the spread of the Covid-19 outbreak. During March 2020, the dental industry received regular updates from the Chief Dental Officers ("CDOs") for England, Scotland, Wales and Northern Ireland. From 20 March, this included recommendations to avoid, as far as possible, treating vulnerable patients and performing aerosol generating procedures ("AGP"). On 23 March, {my}dentist took the decision, for the safety of patients and staff, to stop all non-emergency treatments across all practices in the group. On 24 March, the CDO for England followed the action of the other CDOs and recommended that all non-urgent dental care be stopped. Routine dental treatment was allowed to restart, with modifications in operating procedures, from 8 June 2020.

The group continues to focus on three key priorities

- Putting our patients first through maintaining high clinical standards
- Improving our clinician and nurse resourcing and retention
- Continuing to grow and develop choice for patients through improvements in private dentistry

{my}dentist understands that while dentists still appreciate the opportunities provided by NHS dentistry, as they progress in their career they generally wish to develop their skills by providing a wider range of treatments, some of which are not available on the NHS. In historically concentrating on NHS services, {my}dentist has not provided the opportunities for experienced dentists to develop their practice through offering additional private sessions and this has led to a decrease in the number of hours the group can make available to patients. The clear feedback from dentists led to the piloting during Q4 of FY2019 of a new affordable private treatment choice for patients, branded as "{my}options". Due to the success of the pilot, {my}options was rolled out quickly to over 400 practices during the first half of this financial year. As at the end of February 2020 (pre-Covid-19 crisis), like-for-like practice private revenue growth per working day was up more than 19% year-on-year, driven by the roll out of {my}options. Over 60% of patients treated under {my}options were also new to {my}dentist.

{my}dentist has continued to recruit more dentists in order to increase the hours available to patients. During the year ended 31 March 2020, the business continued to develop new recruitment channels in order to accelerate dentist recruitment from both UK and overseas channels. The total number of dentists engaged by the group increased by 163 over the year, including over 100 newly-qualified dentists and added 3,900 weekly hours of clinical time. The business also successfully completed 4 internal training programmes to assist dentists from European dental schools to transition to the UK. Once the training is complete, the dentists provide private treatments in practice to build up the experience required to apply for an NHS performer number. The group continues to monitor the progress of changes to UK immigration law and the potential new recruitment routes that could open up.

During this year a small number of practices were identified as no longer viable due to structural issues such as, for example, very low UDA contract values, the loss of orthodontic contracts or where geographical isolation had made it difficult to recruit dentists. The group has continued to review on a practice by practice basis the portfolio of NHS contracts held by practices and the services available to be provided in the practice. This resulted in the decision to close a further 4 dental practices during the year. A pilot programme has also been implemented during the year to move smaller 1-2 chair practices into larger premises in higher footfall, "High Street" locations. Overall during the year-ended 31 March 2020, 1 greenfield site was opened, 1 practice merged into another existing practice and 3 existing practices merged into one new practice.

In October 2019, Nilesh Pandya was appointed Chief Financial Officer of the group and started formally in role from 1 January 2020.

IFRS 16 'Leases' has been adopted by the group from 1 April 2019 using the modified retrospective method of adoption. Under this method, the standard is applied retrospectively with the cumulative effect of initially applying the standard recognised at the date of initial application. Consequently, the comparative information for the year ended 31 March 2019 has not been restated. Upon transition, the group recognised a right of use lease asset of £96.4 million (after a £4.4 million deduction relating to the release of property related provisions and £0.5 million increase following adjustments for prepaid and accrued property expenses) and a lease liability of £100.3 million. The adoption of IFRS 16 has resulted in a £14.1 million increase in underlying EBITDA and a £2.5 million increase in operating profit following the replacement of the operating lease costs that were previously expensed, with a depreciation charge on the leased assets. Finance costs have also increased by £4.4 million owing to the unwinding of the discount on the lease liability. See the impact of adoption of IFRS 16 on page 89 for more information.

Financial highlights

- EBITDA before non-underlying items for the year ended 31 March 2020 increased by 31.2% to £76.2 million.
- Following the adoption of IFRS 16, EBITDA has increased by £14.1 million as rent and other lease costs are no longer recognised in overheads, instead they reduce the lease liability on the balance sheet.
- EBITDA before non-underlying items for the year ended 31 March 2020 less charges for rental and other previously categorised operating leases ("Adjusted EBITDA") increased by 6.9% to £62.1 million.
- Revenue was £600.5 million, which was 5.0% higher than the year ended 31 March 2019, predominantly due to growth in both DD revenues and private dentistry as well as the NHS contract uplift offset by decreases due to lower UDA delivery in {my}dentist and practice disposals.
- Like-for-like private revenue growth was 16.0% (2019: 6.5%). Like-for-like private revenue growth per working day for the full year was 15.6% (2019: 5.7%).
- UDA delivery percentage of 81.5%, after temporary and permanent NHS contract handbacks, for the year ended 31 March 2020 compared with 85.7% for the year ended 31 March 2019. Delivery in the current year includes 326,000 UDAs to bring March 2020 in line with performance in March 2019 under the NHS policy for contract management during the pandemic.
- Overheads, excluding depreciation, the amortisation and impairment of intangible assets, and other non-underlying items, as a percentage of revenue was 30.5% (2019: 34.6%). Adjusted overheads (overheads including rent and other lease costs), excluding depreciation, the amortisation and impairment of intangible assets, and other non-underlying items, as a percentage of revenue was 32.8%.
- Estimated pro forma EBITDA at 31 March 2020 of £75.4 million and estimated pro forma adjusted EBITDA of £61.3 million.
- Like-for-like UDA delivery per working day was down 5.3% year-on-year.
- Cash generated from operations for the year ended 31 March 2020 was £78.3 million compared to £37.6 million for the year ended 31 March 2019 (restated). The underlying strong cash generation properties of the group's business units has been boosted by a change in classification of cash flows due to the adoption of IFRS 16.
- Capital expenditure for the year ended 31 March 2020 was £27.3 million, of which £25.8 million relates to {my}dentist, representing 5.5% of {my}dentist revenues.
- Cash and cash equivalents at 31 March 2020 of £76.1 million and net debt was £569.9 million.
- Gearing levels are 9.17 times LTM adjusted EBITDA and 9.30 times estimated pro forma LTM adjusted EBITDA.

Q4 FY2020 Financial Highlights

- EBITDA before non-underlying items of £22.4 million for the three months ended 31 March 2020 ('Q4 FY2020'), up £5.5 million or 32.4% from the three months ended 31 March 2019 ('Q4 FY 2019').
- EBITDA before non-underlying items for the three months ended 31 March 2020 ('Q4 FY2020') less charges for rental and other previously categorised operating leases ("Adjusted EBITDA"), up £2.0 million or 11.8% to £18.9 million from the three months ended 31 March 2019 ('Q4 FY2019').
- Revenue for Q4 FY2020 of £154.2 million, 6.6% higher than Q4 FY2019.
- Q4 FY2020 like-for-like private revenue growth of 8.8% within {my}dentist. Like-for-like private revenue growth per working day was 7.1%.
- Overheads, excluding depreciation, the amortisation and impairment of intangible assets, and other non-underlying items, as a percentage of revenue was 29.0% (Q4 FY2019: 33.6%). Adjusted overheads (overheads including rent and other lease costs), excluding depreciation, the amortisation and impairment of intangible assets, and other non-underlying items, as a percentage of revenue was 31.2%.
- Cash generated from operations of £16.5 million in the three months to 31 March 2020 (Q4 FY2019: £14.0 million).
- Capital expenditure for the quarter ended 31 March 2020 was £5.1 million (Q4 FY2019: £7.0 million).
- Like-for-like UDA delivery per working day was down 4.6% for Q4 FY2020. This includes the 326,000 UDAs recognised in March 2020 based on March 2019 delivery under the NHS contract management process during the Covid-19 pandemic.

Management's discussion and analysis of financial condition and results of operations

The following discussion and analysis of IDH's financial condition and results of operations should be read in conjunction with the audited consolidated financial statements and the related notes thereto contained in this Annual report.

Certain information in the discussion and analysis set out below includes forward-looking statements that involve risks and uncertainties. See "Forward-looking statements" and "Risk factors" for a discussion of important factors that could cause actual results to differ materially from the results described in the forward-looking statements contained in this Annual report.

Overview

We are Europe's largest vertically-integrated dental business and the United Kingdom's number one dental practice chain, with a focus on delivering the best possible patient care, highest clinical standards and a comprehensive choice of treatments through our growing UK dental practice network. We operate our business through two divisions: {my}dentist and DD. We are the leading provider of dental services in the United Kingdom through {my}dentist, with 548 NHS dentistry contracts across our network of 597 dental practices throughout England, Scotland, Wales and Northern Ireland. As at 31 March 2020, {my}dentist had a market share of approximately 6% in terms of revenue and a market share of approximately 5% in terms of number of practices and held contracts for approximately 14% of all units of dental activity ("UDAs") commissioned by the NHS in England and Wales. Our dental practices, operating under the "{my}dentist" brand, offer a broad range of primary care dental services, including dental examinations, fillings and extractions, as well as more specialised dental services such as cosmetic dentistry and orthodontics. We are also a leading provider of private dentistry services in the United Kingdom, and in particular we offer an affordable private treatment option as "{my}options". We operate in the UK dental market, which has historically benefitted from stability in terms of volume and pricing and from systemic trends, including continued government focus on improving access to dental services, favourable demographic trends and an increasing overall spend on dentistry. Through DD, we are a leading supplier of dental and other medical consumables, materials and services (including installation and servicing of specialised dental equipment), selling dental supplies and services to at least 8,000 dental practices, including {my}dentist's dental practices, with an estimated market share of 25% in the United Kingdom, by revenue. In the twelve months ended 31 March 2020, the group recorded revenue of £600.5 million and generated EBITDA before non-underlying items of £76.2 million. Adjusted EBITDA before non-underlying items was £62.1 million.

Significant factors affecting results of operations

{my}dentist

Availability of dentists and other dental professionals

Without dentists, our dental practices cannot provide dental services or generate revenue from either NHS dentistry services or private dentistry services. It has historically proven difficult to attract dentists to work in certain regions of the United Kingdom, such as coastal and certain rural areas. This can impact our results in that we may not be able to deliver contracted UDAs in respect of NHS dentistry services in localities where we have NHS dentistry contracts if we are unable to source dentists in or to such localities.

In recent years, we have seen a decline in our UDA delivery rates. This decline has been due to a combination of factors, including:

i. disposal of loss-making practices due to recruitment challenges or low UDA rates;
ii. a reduction in the number of hours dentists make available for NHS work;
iii. a reduction in the volume of contracted UDA's held by individual dentists;
iv. a reduction in the number of eligible exempt patients resulting in changes in the UDA band mix; and
v. the impact of the strategy to grow private revenues.

We understand that while dentists still appreciate the opportunities provided by NHS dentistry, as they progress in their career they generally wish to develop their skills by providing a wider range of treatments, some of which are not available on the NHS. In historically concentrating on NHS services, {my}dentist has not provided the opportunities for experienced dentists to develop their practice through offering additional private sessions. This has led to a decrease in the number of hours the group can make available to patients as experienced dentists have added sessions in other practices. The clear feedback from dentists led to the piloting during Q4 of FY2019 of a new affordable private treatment choice for patients, branded as "{my}options". Due to the success of the pilot, {my}options was rolled out quickly to over 400 practices during the first half of this financial year. As at the end of

February 2020 (pre-Covid-19 crisis), like-for-like practice private revenue growth per working day was up more than 19% year-on-year, driven by the roll out of {my}options. Over 60% of patients treated under {my}options were also new to {my}dentist.

{my}dentist has continued to recruit more dentists in order to increase the hours available to patients. During the year ended 31 March 2020, the business continued to develop new recruitment channels in order to accelerate dentist recruitment from both UK and overseas channels. The total number of dentists engaged by the group increased by 163 over the year, including over 100 newly-qualified dentists and added 3,900 weekly hours of clinical time. The business also successfully completed 4 internal training programmes to assist dentists from European dental schools to transition to the UK. Once the training is complete, the dentists provide private treatments in practice to build up the experience required to apply for an NHS performer number. The group continues to monitor the progress of changes to UK immigration law and the potential new recruitment routes that could open up.

As we have outlined previously, with regulatory and registration requirements it can take between six to nine months for a NHS clinician position to be filled. Furthermore, clinicians new to the country can be subject to some regulatory restrictions on the amount of UDAs they can perform in their first year, including the requirement to have a named mentor.

As of 31 March 2020, approximately half of our dentists qualified in British dental schools.

Sourcing and retention of hygienists and nurses also affect our results. Hygienists operate in conjunction with dentists, but no longer necessarily require a referral from a dentist to provide a limited number of services and so are, to a certain extent, a source of revenue generation complementary to our dentists. Dentists are prohibited from providing dental services to patients without a nurse present, so the recruitment and retention of nurses also drive our results and operational efficiency. We constantly review our salary and training packages for nurses in order to improve sourcing and retention, including identifying career progression opportunities and achieving the most appropriate staff to dentist ratio for our practices.

Industry-wide factors affecting UDA delivery rates

{my}dentist provides NHS dentistry services to patients under various types of framework NHS dentistry contracts. Under the current system, the value of these contracts is primarily based on volume, specifically UDAs.

We are paid the annual contract value for our NHS dentistry services in twelve equal monthly instalments. This results in a well-matched cash flow and cost profile, as we typically receive payments on our NHS dentistry contracts prior to paying related costs. Any underperformance in terms of UDA delivery must be repaid, where requested, to the NHS after the contract year end, or repaid over subsequent contract years. In certain instances, the underperformance can be repaid during the contract year (which we refer to as a "handback"). We have never had to make a repayment of more than £2 million to the NHS in respect of any of our contracts. However, during the year ended 31 March 2020, a number of small permanent contract handbacks have been agreed with the NHS Regions, principally in areas where there has persistently been either insufficient patient demand for NHS dentistry, or it has proved difficult to recruit sufficient clinicians, in order to deliver the number of contracted UDAs. These permanent contract handbacks equate to approximately 0.6% of the total number of UDA's contracted by {my}dentist as at 31 March 2020, and have resulted in a write down of £1.4 million being recorded in the income statement for the year ended 31 March 2020.

In general, UDA values differ across the United Kingdom and amongst our dental practices. The average value of a UDA in England is currently approximately £28. The number of UDAs awarded for a particular treatment depends on the type of treatment provided. Dental treatments are split into four bands based on the type of treatment, the number of UDAs applicable to such treatment and the patient contribution in respect of such treatment.

We recognise revenue based on the number of UDAs that our dental practices complete in a contract year. Revenue generated by {my}dentist is therefore affected by our UDA delivery rates. These rates are impacted by various factors, which have been outlined above, including factors which affect the industry as a whole. For the five contract years ended 31 March 2015, our UDA delivery rates averaged 96.8%. Our UDA delivery rates, after temporary and permanent handbacks, for the contract years ended 31 March 2016, 31 March 2017, 31 March 2018, 31 March 2019 and 31 March 2020 decreased to 92.4%, 90.4%, 86.1%, 85.7% and 81.4% respectively. Delivery in the current year includes includes 326,000 UDAs to bring March 2020 in line with performance in March 2019 under the NHS policy for contract management during the pandemic.

Over the past three years, we have also experienced a decrease in the number of exempt patients, who are not required to contribute to the cost of the NHS dentistry services they receive. This has resulted in a change to the mix of UDA bands delivered, since exempt patients tend to receive services requiring a higher number of UDAs compared to patients who are required to contribute to the cost of NHS dentistry services provided. Over the past five years, this change in UDA band mix has reduced the number of band 3 treatments (for which a higher number

of UDAs are awarded) we have completed from 30.4% of all UDAs in the year ended 31 March 2015 to 27.0% in the year ended 31 March 2020, thereby reducing the total number of UDAs that we have delivered by approximately 330,000 (excluding the March 2020 Covid-19 adjustment).

Some of this decrease in productivity under NHS dentistry contracts has been offset by growth in the provision of private dentistry services and in the NHS dentistry contract price uplifts.

In addition, we continue to implement a number of other measures, including actively providing training to dentists to improve UDA productivity, improving diary and claims management and working with dentists to increase their working hours. Over the course of the year ended 31 March 2020, permanent contract handbacks and completed practice closures reduced our contracted UDA's by approximately 2.4%. Of this, approximately 0.6% of the reduction was attributable to permanent contract handbacks and approximately 1.8% was attributable to practice closures that completed before 31 March 2020. Because unclaimed UDAs result in foregone revenue in a period, but not necessarily a loss of potential revenue for future periods, we expect any future improvement in UDA delivery to result in a corresponding increase in EBITDA before non-underlying items.

Dental chair efficiency and utilisation

We refer to our ability to utilise our dentists' time and drive efficiency in terms of revenue generation as "time in the dental chair," or "the time a dentist spends with patients." The drivers for maximising time in the dental chair consist of maximising opening hours and patient numbers and minimising downtime for maintenance and non-dentistry burdens, such as recording practice notes or responding to NHS enquiries.

We have scope to increase time in the dental chair by extending our opening hours, as most of our practices do not currently offer weekend or evening services. Because our dentists' hours and workload in practice tend to be fixed to weekday trading days and normal trading hours, our results of operations are affected by the number of trading days in a year and by other factors that result in closure or fewer or more trading days. We also leverage our central support function to drive patient numbers, and to that end we have implemented a variety of targeted marketing efforts that are aimed at attracting new patients and increasing visit frequency from existing patients.

We regularly invest in capital expenditures to provide new chairs and other equipment, and to make our suite of chairs and equipment uniform across our estate, which we believe will reduce money and time spent on maintenance. By removing the administrative, compliance and regulatory burdens of dentists, we believe that we provide dentists with a platform for maximising the time they spend with patients, and thereby increasing UDAs delivered, private dentistry services revenue generated, and overall quality of care and patient satisfaction.

Private revenue

For the twelve months ended 31 March 2020, we generated £119.3 million in revenue, or 19.9% of our total revenue through the provision of private dentistry services. Private revenue growth in like-for-like practices during the year-ended 31 March 2020 was 16.0%, however this was reduced by the impact of Covid-19 and the restrictions placed on practices during March 2020. At the February 2020, like-for-like private revenue was up more than 19%.

Private dentistry services, including general dentistry, hygienist and cosmetic services, are provided by most of our dental practices, along with such practices' NHS dentistry services offering. Private dentistry services are one of the key drivers of our organic growth, and our expansive offering of private dentistry services provides us with opportunities to complement revenues we generate under our NHS dentistry contracts. Private dentistry services are provided solely at the election of the patient who funds the work (whether out-of-pocket or through insurance or payment plans), and on average the cost of private dentistry services is higher than the cost of comparable NHS dentistry services. The result is that revenues generated from traditional private dentistry services tend to be significantly more sensitive to general macroeconomic conditions and the level of disposable income available to our patients than revenues generated from NHS dentistry services. Prices for private dentistry services are set by the individual dentist working within guidelines determined by us. We generally compensate dentists for the provision of private dentistry services on a fixed percentage of fees paid for private dentistry services provided.

The clear feedback from dentists that they would like opportunities to deliver more private treatment led to the piloting during Q4 of FY2019 of a new affordable private treatment choice for patients, branded as "{my}options". {my}options was rolled out to over 400 practices during the first half of this financial year and was the main driver of the significant like-for-like improvements in private revenue. Over 60% of patients treated under {my}options were also new to {my}dentist.

Dentist fees, costs of materials and costs of laboratory work

Cost of sales in {my}dentist, which was £242.8 million for the twelve months ended 31 March 2020, was primarily comprised of dentist and hygienist compensation, the cost of materials and laboratory work performed and the cost of consumables, materials and equipment supplied by DD. Dentists working in our practices are self-employed, independent contractors who pay us a notional license fee and receive a fixed rate per UDA delivered (in the case of

the majority of NHS dentistry services) and a percentage of fees paid for private dentistry services. We negotiate dentist contracts on an individual basis, depending in part on demand for dentists and UDA prices prevalent in the locality in which the relevant dentist operates, and such fees are agreed in our associate contracts with our dentists. We also use floating dentists (locums), who generally receive higher fees per UDA than dentists operating out of one dental practice.

Our second most significant variable cost is the cost of materials. The cost of materials we procure for our dental practices are subject to general inflationary pressures in line with the macroeconomy. We have been able to drive efficiencies and achieve economies of scale in the procurement of materials by selecting the range of materials used by our practices and purchasing such materials with the benefit of volume discounts. In addition, through the development of DD, we have in-sourced the supply of the majority of dental materials, equipment and equipment maintenance to our dental practices, which has resulted in a number of cost savings for our dental practices. Our third most significant variable cost is the net costs of laboratory work performed, which we generally split evenly with dentists. Both the costs of materials and the net costs (after dentist contribution) of laboratory work performed are directly tied to our sales volumes and activity.

Practice overhead and support centre costs

Practice overhead and support centre costs constitute the primary components of our overheads, which were £151.2 million in {my}dentist, or 32.6% of our divisional revenue (after excluding depreciation, amortisation and impairment of intangible assets, amortisation of grant income and non-underlying items), for the twelve months ended 31 March 2020. Practice overhead and support centre costs adjusted to add back rental and other lease costs as reported in the previous year were £165.0 million or 35.4% of our divisional revenue. We benefit from low property costs for our dental practices, with rent costs constituting around 3% of {my}dentist revenues for the twelve months ended 31 March 2020.

Practice overheads include the salaries of support staff, which consist of nurses and administrative support at the dental practice, the provision of equipment and estate management.

Support centre costs include the salaries of management and central support function employees providing IT, compliance, regulatory support, property and equipment maintenance, legal, finance, human resources, marketing, health and safety, risk management, recruitment, training, insurance and logistics services to our dental practices and our central support systems.

Regulatory environment

Our results of operations are also affected from time to time by changes to the regulatory environment in relation to healthcare generally, and dentistry specifically, in the United Kingdom. As 57.8% of our group revenue in the year ended 31 March 2020 was generated through the provision of NHS dentistry services, we are particularly affected by UK Government policy in relation to contracts and funding for the provision of dental services. This includes the framework of contracts for the provision to provide dentistry, the determination of UDA volumes for a particular locality and the determination of indices governing UDA prices and contract uplifts. Under the current contract framework, which was introduced in 2006, the value of NHS dentistry contracts is primarily based on the volume of UDAs delivered. Each UDA delivered under an NHS dentistry contract is assigned a fixed UDA rate, which varies by contract year-to-year, with the number of UDAs per treatment varying based on the actual treatment provided.

Local contracting

Our results are also affected by the determination of the number of UDAs required for a particular locality. NHS Regions on behalf of the NHS determine the number of UDAs required for a locality, and then solicit tenders for contracts to provide such UDAs. The NHS Regions take into account demand for dental services, population, demographics, socioeconomic factors and the penetration of dentistry access in an area when determining the number of UDAs for such locality. Increased demand for NHS dentistry and numbers of UDAs in a particular locality will result in new contracts for the provision of NHS dentistry services, for which we may tender. If UDAs allocated to a particular locality do not meet the contracted targets, the number of contracted UDAs may be reduced through cuts to contracts where there is cumulative UDA underperformance of more than 4% (or 5% in Wales). We have never lost a contract due to significant underperformance, however during the year ended 31 March 2020, a number of small permanent contract handbacks have been agreed with the NHS Regions.

NHS budget

Whilst funding for certain other UK healthcare sectors has been subject to funding freezes or cuts due to government austerity measures, historically UDA prices have been subject to annual contract uplift, with increases of 0.5%, 1.5%, 1.6%, 1.34%, 0.7%, 1.14% and 1.67% for the contract years ended 31 March 2013, 2014, 2015, 2016, 2017, 2018 and 2019 respectively, and a total increase of 2.42% for the contract year ending 31 March 2020 (with an uplift of 2.50% in Wales and Scotland). The uplift for the contract year ending 31 March 2021 has not yet been announced, however in the last 15 years, NHS England has never reduced prices. Under the current system, UDA

rates vary significantly depending on the locality in which the dental services related to such UDAs were provided. During April and May 2020 and the Covid-19 pandemic lockdown period in the UK, the NHS continued to make monthly contractual payments to dental practices while activity was limited to triage activities only.

General regulatory requirements

Our costs of operations are also impacted by regulation more generally as it relates to health and safety, quality of care, the handling and storage of controlled drugs and medicines and other regulatory requirements with which we are required to comply in providing dentistry services and in purchasing and distributing dental consumables, materials and equipment. As the leading provider of dental services in the United Kingdom, we believe we are well placed to respond to and comply with regulatory changes in terms of having both dedicated regulatory and compliance teams to minimise such costs, and a sizeable revenue base and infrastructure to absorb increased costs.

Proposed NHS dentistry contract changes

A prototype trial process commenced in April 2016 as the next stage in the proposed reform of the NHS dentistry contract. Under the proposed changes to the current contract frameworks, NHS dentistry contracts could combine aspects of the existing UDA-based system with fixed payments for the number of patients treated. The prototypes also involve active performance management by NHS England, which includes monitoring of operational key performance indicators, such as clinical effectiveness, best practice, patient experience, safety and data quality. We believe that these changes, if they occur, will generally prove revenue neutral, and that we will be able to leverage our scale to derive a competitive advantage in terms of patient recruitment and delivery of quality care under any new NHS dentistry contractual framework. The timing of the implementation of any change, if any, is uncertain.

The NHS Regions have also over the last two years run a competitive re-tendering process for the majority of its PDS contracts to deliver orthodontic dentistry services across England. The early tender results in the South of England identified a clear trend in terms of reductions in rate for orthodontic services and a smaller overall contract size as the NHS looks to increase the number of treatment locations. With the trend for smaller contracts, it is likely that the overall size of our orthodontic practice NHS contracts will reduce in size. In mitigation, the group is exploring options to provide more private orthodontics including using products such as clear aligners for the treatment of adults. However, the contract process is "paused" at present in certain regions due to a number of legal challenges to the bid process.

Clinicians and other qualified staff

The group requires skilled clinicians, hygienists and nurses in order to care for its patient base. The expansion of the European Union ('EU') over recent years and, until recently, the increased capacity of UK dental schools have increased the supply of clinicians available to the group. The group has also significantly invested in increasing the recruitment capabilities of the group in order to attract new and retain existing clinicians. We recognise the importance of quality clinicians and their self-employed status for ensuring the continued success of the group. The group manages the risk associated with the supply of clinicians through offering access and subscription to training and development programmes to enhance retention. Due to factors which have resulted in a decrease in UDA delivery rates over recent years, the group continues to work to recruit additional clinicians in order to deliver its NHS contracts and to develop the provision of private dentistry including {my}options. In addition, the UK's withdrawal from membership of the EU may impact the supply of clinicians in future but could also open up alternative recruitment options through changes in immigration regulations. The group continues to monitor developments.

The most common method for a practice owner of engaging with clinicians in the dental industry is for the clinician to operate as a self-employed associate dentist. This enables dentists to retain their clinical freedom over the appropriate course of treatment for patients, to develop their interests in specific specialities by having the flexibility to work across different practices and to have control of the amount they can earn through the hours they make available for appointments. In return, they contribute to the running costs of the practice and are responsible for a share of the laboratory costs relating to their treatment plans. This method of engagement has been recognised historically as the normal approach for the industry through the use of a model contract developed by the BDA. HMRC have published guidance that confirms if an associate is engaged on the terms of the model contract and the terms are followed, then the associate can consider themselves to be self-employed.

In common with many industries where self-employed individuals are utilised widely, HMRC have undertaken an industry review of the engagement terms used and the way these terms are applied in practice. The group utilises the model contract developed by the BDA as its basis of engagement with dentists and has clear policies and procedures about how associates work with employed practice teams. The group, supported by external advisors, has engaged with HMRC in this review, including through discussions with senior operational management and practice teams. The group is aware that HMRC have approached a number of clinicians engaged by the group in order to discuss their self-employed status.

As of the date of this report, HMRC's review is still in progress. HMRC had previously notified the group that they were considering withdrawing or amending the guidance relating to the model contract with effect from 5 April 2020. This action has subsequently been paused. HMRC have stated previously that their view is that they should not now be providing guidance on individual industry-specific contracts. Given the existence of the current guidance, the group considers that any changes will relate to prospective rather than retrospective engagements and that status will need to be considered against HMRC's general guidance for self-employment in the future. Any change this has on the nature of engagement with clinicians is also likely to affect the entire industry.

The group continues to invest in improving pay structures and incentivisation for nurses and other clinical staff and continues to monitor the impact of future increases to the National Living Wage and other potential regulatory future changes upon its staffing structures. During the prior year, the group introduced a defined career path for training nurses in order to improve retention of highly skilled nursing staff.

The group has also continued to invest in its own training resource, the {my}dentist Academy, along with an accompanying online training system.

Sourcing and acquisition of dental practices

Acquisitions of dental practices have historically been the core driver of our growth. A limited number of new NHS dentistry contracts become available each year, so the primary method for growing our revenues has been through acquiring dental practices holding existing NHS dentistry contracts. Since 11 May 2011, we have acquired 237 dental practices and we have employed a disciplined strategy centred on the acquisition of practices with NHS dentistry contracts with three or more chairs.

With 11,725 high street dental practices (according to the 2019 LaingBuisson report on Dentistry), the large majority of which are independent, the UK dental market remains highly fragmented, and we believe there is scope for additional consolidation as dentists retire or sell their dental practices to become independent contractors, whether due to the administrative, regulatory and compliance burden of owning their own dental practice or otherwise.

In recent times, valuations being attributed to dental practices by prospective vendors have increased substantially and, together with our high levels of gearing, have led us to pause our dental practice acquisition programme.

In the previous financial year we concluded our portfolio review where we identied dental practices which were no longer viable due to structural issues such as very low UDA rates or difficutly to recruit dentists due to geographical location. This review resulted in the closure of 40 dental practices and sale of 31 dental practices over the previous three financial years.

The group has continued to review on a practice by practice basis the portfolio of NHS contracts held by practices and the services available to be provided in the practice. This resulted in the decision to close a further 4 dental practices during the current year. A pilot programme has also been implemented during the year to move smaller 1-2 chair practices into larger premises in higher footfall, "High Street" locations. Overall during the year-ended 31 March 2020, 1 greenfield site was opened, 1 practice merged into another existing practice and 3 existing practices merged into one new practice.

DD

DD revenues

Revenues generated within DD, before intragroup trading eliminations, have increased from £135.4 million for the twelve months ended 31 March 2019 to £160.8 million for the twelve months ended 31 March 2020, driven primarily by increases in medical aesthetics from an exclusive UK distributor arrangement with Galderma. Wholesale, equipment and engineering revenues have also grown but this has been partially offset by sales to high street independent dental practices due to the increasing consolidation in the sector.

DD provides support to {my}dentist's dental practices as well as providing a range of products and services to the wider UK dental and healthcare sectors, including at least 8,000 dental practices in the United Kingdom. The integration of {my}dentist's dental practices with its supply chain and service providers in the DD division has resulted in significant cost savings and synergies, as we capture margin that would otherwise be paid to third-party providers and benefit from certain VAT exemptions.

The majority of DD's revenues result from the sale of dental materials and consumables to dental practices across the United Kingdom, however the division also supplies dental equipment, engineering, dental laboratory, calibration and training services to dental practices.

Demand for the products and services offered by DD is principally dependent upon the demand for dentistry services by the end customer. However, fluctuations in demand for NHS or private dentistry services within the

market as a whole may impact the demand for dental materials since the cost of materials and consumables used to deliver private dentistry treatments will often be higher than for similar NHS treatments.

Cost of goods sold

The cost of goods sold by DD principally comprises the wholesale cost of purchasing dental materials, equipment and consumables. Materials, consumables and equipment are sourced from a wide range of suppliers, many of whom are located overseas. Approximately 40% of the cost of goods sold by DD are denominated in currencies other than pounds sterling, predominantly Euros or US dollars, and are therefore subject to foreign exchange risk. Since we do not generate any significant revenues in currencies other than pounds sterling, our policy is to hedge the pound sterling equivalent costs of a proportion of our foreign currency purchases using ordinary course foreign exchange derivative contracts, in order to reduce uncertainty over future cash flows. In addition to fluctuations resulting from movements in foreign exchange rates, cost of goods sold also fluctuate due to changes in supply and demand in the market and changes in the cost of associated raw materials. DD manages the impact of these fluctuations through competitive tendering of significant supply contracts and through volume purchasing to take advantage of supplier discount arrangements or rebate mechanisms.

While gross profit is up, gross margins have declined in DD due to the increase in lower margin aesthetic toxin sales. The new management team introduced during FY2019 have radically overhauled customer service to improve the order process and customer experience. Significant improvements have also been made in back office processes to support the development of higher margin activities such as equipment installation and repairs and maintenance. As part of this process the business was relaunched as “DD” to reflect its move in to other sectors whilst also retaining specialist dental knowledge.

Distribution and sales overheads

Distribution and sales overheads include the freight and carriage costs associated with distributing products to our customers and the salary and associated costs of our sales teams. Over the past three years, we have invested significantly into these sales teams, including the implementation of new CRM software and improvements to the functionality of the website and we expect to continue investing in these areas in the future. For engineering and other similar services, overheads also include the cost of direct labour associated with delivering the service.

Subsequent events - Impact of the coronavirus pandemic

The Covid-19 coronavirus outbreak has had a significant impact on the group post year-end.

During March, {my}dentist practices moved quickly from normal operations to following restrictions where only emergency procedures with no aerosol generating procedures (“AGP”) could be provided to patients. During the nationwide lockdown period, dental practices were still staffed, with most practices operating a telephone only triage system and emergency cases referred into the network of NHS Urgent Dental Care Centres (UDC’s). {my}dentist operated over 70 UDCs from its practices. No private dentistry was carried out during this period and therefore private revenues came to a halt. NHS England confirmed that mixed NHS and private practices could claim for furloughed workers in proportion to the private income of the practice and {my}dentist placed just under 25% of practice staff on furlough and claimed under the Coronavirus Job Retention Scheme.

The NHS have stated that FY2020 UDA delivery would be measured with any shortfall in March delivery due to Covid-19 related practice closures to be replaced by March 2019 performance.

As the lockdown conditions eased, the CDO in England announced on 28 May 2020 that dental practices in England could restart face-to face care with effect from 8 June 2020. {my}dentist delayed restarting activity until 15 June 2020 to enable practices to fully train staff on new Standard Operating Procedures (“SOPs”) including staggered appointment times, social distancing and personal protective equipment. Protective screens, hand sanitiser stations and social distancing vinyls were installed in practices and surgeries were reviewed for air flow and suction capacity. From 1 July 2020 all treatment options including AGPs are being performed in practice subject to Personal Protective Equipment (“PPE”), however a downtime fallow period is required in surgery after a treatment involving AGP.

A key focus of the business during the pandemic was to maintain communication with all stakeholders – patients, self-employed clinicians, practice and Support Centre staff, the NHS and industry bodies. Regular email and video communications have been made available to keep groups updated with information relevant to their situation such as pay, infection control procedures and PPE for clinicians and oral health advice for patients. Management have also been in close contact with the NHS across the regions, the Association of Dental Groups (“ADG”) and the British Dental Association (“BDA”) on the approach of dentistry to the lockdown and then on restart procedures.

Post year-end, NHS contractual payments have continued to be made each month to dental practices at 1/12th of the annual contract value on condition that practices were operational and self-employed clinicians and staff contined to be paid in line with contract. An abatement to the UDA contract will be made for variable costs, such as laboratories

and materials, that will not be incurred while practices were running as triage facilities and therefore at lower activity levels. The level of abatement in England has been set at 16.75% from 1 April 2020 to 7 June 2020 and at 0% from 8 June 2020 provided that 20% of usual patient activity is completed. NHS Wales have confirmed that the abatement will be 20% in Q1 FY2021 reducing to 10% in Q2 and that UDA completion will not be monitored for Q1. Payments in Scotland and Northern Ireland have continued at 80% of normal levels.

The significant reduction in dental activity across the United Kingdom resulted in the main sales channels in DD such as High Street consumables, engineering and aesthetics being heavily impacted. However, the increase in the demand for PPE across many private and public sector organisations led the business to expand and diversify both the supply chain and customer bases.

In order to maximise group liquidity the £100 million Super Senior Revolving Credit Facility ("SSRCF") was drawn down in full during March 2020, meaning that the group entered FY21 with £68 million more cash on hand than under normal circumstances. Management have carried out detailed scenario planning based on the NHS contractual position at varying levels of abatement and a range of activity levels for the post-lockdown part of the year and into FY2022. Activity levels have been considered for NHS and private revenue recognition and for DD activity including continuing private revenue growth and maintaining the current NHS/private balance. The group's 548 NHS UDA contracts in England and Wales provide a significant source of certainty and cash flow resilience. The scenarios demonstrate sufficient liquidity and that all funding covenants can be met, even under a 'severe but plausible' downside scenario.

Description of key line items

Income statement

Set out below is a brief description of the composition of the key line items of our income statement under IFRS.

Revenue

Revenue represents the income received in the ordinary course of business for dentistry or other goods or services provided to the extent that the group has completed the specific performance obligations and has therefore obtained the right to consideration. Amounts are stated net of discounts, returns and value added taxes. Revenue derived from NHS contracts in England and Wales is recognised based upon the volume of dental activity delivered in the financial year. Amounts received from the NHS in advance of dental activity delivered are held on the balance sheet within accruals. Revenue from all private dental work and NHS patients in Scotland is recognised based upon the completion of each piece of treatment carried out, with the exception of orthodontic treatment, which is recognised based upon the stage of completion reached during the course of treatment. Revenue generated from the sale of goods by DD is recognised upon despatch and revenue generated from the installation or repair of equipment, or from other services, is recognised upon completion of the service.

From early March 2020, due to the coronavirus outbreak NHS dental practices were restricted to emergency procedures only. The NHS confirmed that for the contract year-ended 31 March 2020, any shortfall in March 2020 activity performance due to the restrictions placed on practices could be mitigated by substituting the number of March 2019 claims for March 2020 performance. This resulted in the recognition of revenue from an additional 326,000 UDAs in March 2020.

Cost of sales

Cost of sales represents the operating expenses incurred in delivering our dental goods and services, including the cost of goods sold, dentist compensation and the cost of laboratory work, dental materials and prostheses.

Distribution costs

Distribution costs include expenses that are directly attributable to the distribution of goods sold by DD and principally comprise sales and distribution staff salaries and transportation costs.

Administrative expenses

Administrative expenses represent all other operating expenses that are not directly attributable to the actual provision of our dentistry services, including dental practice staff costs, property services and facilities management costs and other variable dental-related expenses. Administrative expenses also include support centre costs, including central staff and employee support costs, communications and systems costs, legal and professional fees, and marketing and development costs. In addition, administrative expenses includes amortisation and impairment charges in respect of goodwill and other intangible assets and the depreciation of owned tangible assets as well as depreciation on right of use lease assets following the introduction of IFRS 16 on 1 April 2019.

Other income

Other income primarily represents additional income to assist in the upkeep of premises received from Scottish health boards and is based on the proportion of NHS treatment carried out by a dental practice in Scotland. Other income also includes income received from property rentals.

Other gains/(losses)

Other gains/(losses) comprise realised and unrealised gains or losses arising from foreign exchange forward contracts entered into by DD to mitigate the impact of fluctuations in foreign exchange rates and to provide reasonable certainty over cash flows.

Operating profit

Operating profit represents the sum of (i) gross profit, (ii) distribution expenses, (iii) administrative expenses, (iv) other income and (v) other gains/(losses).

Finance income

Finance income comprises interest income and gains on interest rate hedging instruments which are recognised as they arise.

Finance costs

Finance costs comprise the interest paid by us on our bond and bank debt including the amortisation of financing costs in respect of bank facilities together with losses on interest rate hedging instruments, which are recognised as they arise. In addition, finance costs also include interest in respect of lease liabilities and the unwinding of discounts on provisions.

Income tax

Income tax represents the corporation tax charge or credit on our profit or loss for the year and includes both current and deferred income tax. Income tax is recognised in the income statement unless it relates to items recognised directly in equity, when it is recognised through the statement of comprehensive income.

Current income tax is the expected tax payable on the taxable income for the year, using rates enacted or substantively enacted at the end of the reporting period, and any adjustments in respect of previous periods.

Deferred income tax is provided on certain temporary differences between the carrying amount of the assets and liabilities for financial reporting purposes and taxation purposes at the end of each reporting period. The amount of deferred income tax provided is based on the expected manner of realisation or settlement of the carrying amount of assets and liabilities, using the tax rates enacted in each jurisdiction at the end of the reporting period.

Other financial information

Set out below is a brief description of other non-IFRS financial information.

Gross profit margin

Gross profit margin represents gross profit divided by revenue.

EBITDA margin

EBITDA margin represents EBITDA before non-underlying items divided by revenue.

Adjusted EBITDA margin

Adjusted EBITDA margin represents adjusted EBITDA before non-underlying items divided by revenue. Adjusted EBITDA represents EBITDA before non-underlying items plus rental and other lease charges. This is comparable to EBITDA in previous years before the introduction of IFRS 16.

NHS dentistry services revenue as a percentage of total revenue

NHS dentistry services revenue as a percentage of total group revenue represents revenue generated through the provision of NHS dentistry services under NHS dentistry contracts divided by group revenue.

Total annual UDA delivery percentage

Total annual UDA delivery percentage represents the total number of UDAs we deliver in a given year divided by our total number of contracted UDAs in place at the end of a given year (after any temporary or permanent handbacks).

UDA contract uplift

UDA contract uplift represents the percentage increase of UDA prices under each NHS dentistry contract over the prior year's prices in each respective NHS dentistry contract.

Private dentistry services revenue as a percentage of total revenue

Private dentistry services revenue as a percentage of total group revenue represents revenue generated through the provision of private dentistry services divided by revenue.

Like-for-like private revenue growth

Like-for-like private revenue growth represents the total private revenue generated by all the practices owned for the whole of a financial year divided by the private revenue generated by the same practices in the preceding financial year.

Like-for-like private revenue growth per working day

Like-for-like private revenue growth per working day represents the average private revenue per working day generated by all the practices owned for the whole of a financial year, divided by the average private revenue per working day generated by the same practices in the preceding financial year.

Overheads as a percentage of total revenue

Overheads expenditure as a percentage of total revenue represents administrative expenses, plus distribution costs less depreciation, amortisation and impairment of intangible assets and amortisation of grant income and other non-underlying items, divided by revenue.

Total number of dental practices

Total number of dental practices represents the total number of dental practices we own as at a specified date.

Results of operations for the years ended 31 March 2020 and 31 March 2019

The following tables set out the key line items from the consolidated income statement and the consolidated cash flow statement for the years ended 31 March 2020 and 31 March 2019 and from the consolidated balance sheet at 31 March 2020 and 31 March 2019.

Consolidated income statement

(£ in millions)	For the year ended 31 March 2020	For the year ended 31 March 2019
Revenue	**600.5**	**571.9**
Cost of sales	(342.9)	(317.7)
Gross profit	**257.6**	**254.2**
Distribution costs	(19.8)	(17.3)
Administrative expenses	(322.6)	(278.5)
Other operating income	1.5	2.0
Other losses	(0.1)	(0.4)
Operating loss	**(83.4)**	**(40.0)**
Finance costs	(48.5)	(43.3)
Finance income	0.1	-
Loss before income tax	**(131.8)**	**(83.3)**
Income tax (charge)/credit	(8.7)	9.8
Loss for the year	**(140.5)**	**(73.5)**
Attributable to:		
Owners of the parent	(140.5)	(73.5)
Non-controlling interests	-	-
	(140.5)	**(73.5)**

Consolidated balance sheet

(£ in millions)	As at 31 March 2020	As at 31 March 2019 Restated
Non-current assets		
Goodwill	142.1	224.3
Other intangible assets	295.6	331.0
Property, plant and equipment	99.8	95.1
Right of use assets	88.0	–
	625.5	**650.4**
Current assets		
Inventories	25.1	28.4
Trade and other receivables	51.1	39.7
Corporation tax	–	0.1
Derivative financial instruments	0.3	–
Cash and cash equivalents	76.1	8.9
	152.6	**77.1**
Assets classified as held for sale	–	–
Total assets	**778.1**	**727.5**
Equity attributable to the owners of the parent		
Share capital	411.0	411.0
Accumulated losses	(545.0)	(405.6)
	(134.0)	**5.4**
Non-controlling interest	–	–
Total equity	**(134.0)**	**5.4**
Non-current liabilities		
Borrowings	646.0	570.2
Other payables	0.2	0.2
Deferred income tax liabilities	19.5	10.7
Defined benefit pension obligation	0.4	0.6
Provisions	4.2	7.8
Other liabilities - leases	79.4	–
	749.7	**589.5**
Current liabilities		
Trade and other payables	147.5	130.4
Corporation tax	–	–
Provisions	0.6	1.8
Other liabilities - leases	14.3	–
Derivative financial instruments	–	0.4
	162.4	**132.6**
Total liabilities	**912.1**	**722.1**
Total equity and liabilities	**778.1**	**727.5**

Consolidated cash flow statement

(£ in millions)	For the year ended 31 March 2020	For the year ended 31 March 2019 Restated
Cash flows from operating activities		
Cash generated from operations	78.3	37.6
Tax received	–	–
Net cash inflow from operating activities	**78.3**	**37.6**
Investing activities		
Acquisitions (net of cash acquired)	–	(0.2)
Contingent consideration paid	(0.5)	(0.3)
Purchase of property, plant and equipment	(27.4)	(24.2)
(Costs of)/proceeds from business and asset disposals	(0.1)	0.4
Interest received	0.1	–
Net cash outflow from investing activities	**(27.9)**	**(24.3)**
Financing activities		
Drawdown of bank loans	78.2	20.0
Repayment of bank loans	(5.0)	–
Bank and bond interest paid	(41.4)	(40.6)
Lease cash payments	(15.0)	–
Net cash inflow/(outflow) from financing activities	**16.8**	**(20.6)**
Net increase/(decrease) in cash and cash equivalents	**67.2**	**(7.3)**
Cash and cash equivalents at the start of the year	8.9	16.2
Cash and cash equivalents at the end of the year	**76.1**	**8.9**

The prior year comparatives have been restated to correct the misclassification of an element of contingent consideration paid which should have been reported as an operating cash flow rather than a financing cash flow.

Other financial data

(£ in millions, except as specified)	For the year ended 31 March 2020	For the year ended 31 March 2019
Other profit and cash flow data		
EBITDA before non-underlying items[1]	76.2	58.1
Adjusted EBITDA before non-underlying items[1]	62.1	58.1
Estimated pro forma LTM EBITDA[2]	75.4	59.4
Estimated pro forma LTM adjusted EBITDA[2]	61.3	59.4
EBITDA margin[3]	12.7%	10.2%
Adjusted EBITDA margin[3]	10.3%	10.2%
Gross profit margin[4]	42.9%	44.4%
Capital expenditure[5]	27.3	24.3
Cash conversion[6]	73.2%	34.9%
Adjusted cash conversion[6]	89.8%	34.9%
Other debt and credit data		
Net senior secured debt[7]	442.1	434.1
Net total debt[8]	569.9	561.3
Ratio of net senior secured debt to estimated pro forma LTM EBITDA	5.86	7.30
Ratio of net senior secured debt to estimated pro forma LTM adjusted EBITDA	7.21	7.30
Ratio of net total debt to estimated pro forma LTM EBITDA	7.56	9.44
Ratio of net total debt to estimated pro forma LTM adjusted EBITDA	9.30	9.44

Key performance indicators

	For the year ended 31 March 2020	For the year ended 31 March 2019
NHS dentistry services revenue as a percentage of total revenue	57.8%	62.7%
Private dentistry services revenue as a percentage of total revenue	19.9%	18.1%
Non-dental practice revenue as a percentage of total revenue.	22.3%	19.2%
Total annual UDA delivery percentage[9]	81.4%	85.7%
Like-for-like private revenue growth[10]	16.0%	6.5%
Like-for-like private revenue growth per working day[11]	15.6%	5.7%
Overheads as a percentage of revenue[12]	30.5%	34.6%
Adjusted overheads as a percentage of revenue[12]	32.8%	34.6%
Total number of dental practices[13]	597	603

	For the year ended 31 March 2017	For the year ended 31 March 2018	For the year ended 31 March 2019	For the year ended 31 March 2020
£ per UDA contract uplift[14]	0.70%	1.14%	1.67%	2.42%

The following table reconciles EBITDA before non-underlying items to operating profit:

	For the year ended 31 March 2020	For the year ended 31 March 2019
Operating loss	(83.4)	(40.0)
Amortisation of intangible assets	30.5	30.9
Depreciation	33.6	21.1
Amortisation of government grant income	(0.1)	(0.1)
Impairment of intangible assets	79.1	16.3
Impairment of right of use assets	0.5	-
Impairment of non-current assets reclassified as held for sale and loss on closure or disposal of dental practices	10.0	24.2
Differences between contingent consideration paid and estimates initially recognised	(0.1)	(0.4)
Value of employee services arising from shares granted	1.1	1.1
Other non-underlying items*	4.9	4.6
Foreign exchange gains	0.1	0.4
EBITDA before non-underlying items	**76.2**	**58.1**
Less rental and other lease charges	(14.1)	-
Adjusted EBITDA before non-underlying items	**62.1**	**58.1**

* Non-underlying items in respect of the year ended 31 March 2020 include £1.9 million relating to senior management and other staff and business restructuring, including associated professional fees, £1.6m legal and professional fees, £1.1m of business development costs, £0.3 million dilapidation costs and £0.2 million of other non-underlying expenditure.

We are not presenting EBITDA/adjusted EBITDA before non-underlying items and other EBITDA-based measures as measures of our results of operations. EBITDA/adjusted EBITDA before non-underlying items and other EBITDA-based measures have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results of operations. EBITDA/adjusted EBITDA before non-underlying items, estimated pro forma LTM/LTM adjusted EBITDA and related leverage and coverage ratios are not measurements of financial performance under IFRS and should not be considered as alternatives to other indicators of our operating performance, cash flows or any other measure of performance derived in accordance with IFRS. Our management believes that the presentation of EBITDA/adjusted EBITDA before non-underlying items and EBITDA-based measures is helpful to investors as measures of our operating performance and ability to service our debt. Our EBITDA/adjusted EBITDA before non-underlying items and our other EBITDA-based measures may not be comparable to similarly titled measures used by other companies.

(1) EBITDA before non-underlying items represents operating profit before the amortisation and impairment of intangible assets, depreciation, amortisation of grant income, foreign exchange gains or losses and other non-underlying items. Accordingly, EBITDA before non-underlying items can be extracted from our consolidated financial statements by taking operating profit and adding back amortisation and impairment of intangible assets, depreciation, amortisation of grant income, foreign exchange gains or losses and other non-underlying items. In order to provide comparability with the previous year, adjusted EBITDA has also been quoted within this report and represents EBITDA before non-underlying items adjusted to include rental and other lease charges.

(2) Estimated pro forma LTM adjusted EBITDA for the year ended 31 March 2020 has been calculated following the methodology set out in the IDH Finance Plc Offering Memorandum dated 22 July 2016.

In arriving at estimated pro forma adjusted EBITDA, management have also added back the EBITDA profits/losses generated by the 4 dental practices that were closed during the year ended 31 March 2020.

The following table reconciles estimated pro forma LTM adjusted EBITDA to adjusted EBITDA before non-underlying items:

(£ in millions)	**Year ended 31 March 2020**
EBITDA before non-underlying items	62.1
Subtract EBITDA profits from practice disposals	(0.8)
Estimated pro forma LTM adjusted EBITDA	61.3

(3) Represents EBITDA/adjusted EBITDA before non-underlying items divided by revenue.

(4) Represents gross profit divided by revenue.

(5) Represents capital expenditures excluding acquisitions refurbishments. Capital expenditures include capital expenditures required for routine maintenance, equipment replacement, additional equipment purchases, building refurbishment not in connection with an acquisition and capital expenditures associated with growth projects such as practice relocations, but exclude capital expenditures made in connection with acquisitions.

(6) Represents cash generated from operations before non-underlying items, less capital expenditures, divided by EBITDA/adjusted EBITDA before non-underlying items.

(7) Represents total senior secured borrowings less available cash at bank and in hand and unamortised arrangement fees.

(8) Represents total borrowings less available cash at bank and in hand and unamortised arrangement fees.

(9) Represents the total number of UDAs per dental practices owned at the beginning of a given contract year delivered in such year, divided by the total number of contracted UDAs in place in respect of such dental practices at the end of that contract year (after any temporary or permanent handbacks). This percentage is calculated based on the agreed total number of UDAs at 31 March of the applicable year and, in respect of the percentage calculated on the agreed total number of UDAs at 31 March 2020, immaterial changes to this percentage may occur pending final agreement with NHS Regions regarding over performance paid or carried over to the next contract year. Because UDAs are delivered under full year contracts, interim UDA delivery is not useful in an analysis of annual UDA delivery percentage. FY2020 figures includes 326,000 UDA's to supplement delivery for March 2020 during the Covid-19 crisis under the NHS contract management arrangements.

(10) Represents total private revenues generated by all the practices owned for the whole of the financial year ended 31 March 2020 divided by the private revenue generated by the same practices in the corresponding periods of the preceding financial year.

(11) Represents the average private revenue per working day generated by all the practices owned for the whole of a financial year, divided by the average private revenue per working day generated by the same practices in corresponding periods of the preceding financial year.

(12) Represents administrative expenses, plus distribution costs, less amortisation and impairment of intangible assets, depreciation, amortisation of grant income and other non-underlying items, divided by revenue. Adjusted overheads represents administrative expenses plus rental and other lease charges.

(13) Represents the total number of dental practices we own as at a specified date.

(14) Represents the nationwide price per UDA per year contract uplift in England promulgated by the UK Government in a given year.

Year ended 31 March 2020 compared to the year ended 31 March 2019

In the year ended 31 March 2020, we closed four practices, opened one new greenfield practice, merged one practice into an exitsting practice and merged three existing practices into one new practice for a total of 597 dental practices in our estate as at 31 March 2020.

Revenue

Revenue for the year ended 31 March 2020 has increased by £28.6 million, or 5.0%, from £571.9 million for the year ended 31 March 2019 to £600.5 million. This was predominantly due to the growth in private dentistry, NHS contract uplift and DD revenue growth partially offset by lower UDA delivery, practice disposals and a fall in orthodontic revenues in {my}dentist.

The table below analyses the movement in our revenues between the year ended 31 March 2019 and the year ended 31 March 2020:

Revenue (£ in millions)	For the year ended 31 March 2020	For the year ended 31 March 2019	Movement
NHS revenue	315.6	322.1	(6.5)
Private revenue	110.4	93.3	17.1
Dental practices	**426.0**	**415.4**	**10.6**
Orthodontics	40.4	41.2	(0.8)
Practice disposals	-	6.7	(6.7)
Non-dental practice revenue	0.3	0.1	0.2
Total {my}dentist revenue	**466.7**	**463.4**	**3.3**
DD revenue	160.8	135.4	25.4
Eliminations	(27.0)	(26.9)	(0.1)
Group revenue	**600.5**	**571.9**	**28.6**

Revenue generated from base dental practices excluding disposals and orthodontic revenue, increased by £10.6 million, or 2.6%, from £415.4 million for the year ended 31 March 2019 to £426.0 million for the year ended 31 March 2020. The increase principally reflects an increase in private revenues of £17.1 million. Growth in private revenue accelerated during the year with like-for-like revenue up 16.0% (15.6% when adjusted for the number of working days). This growth was driven by the roll-out of the new {my}options affordable private dentistry proposition and also includes strong revenue growth in our 14 Advanced Oral Health Centres which provide implants and more complex treatment plans on referral from other group practices.

The growth in private revenues has been partially offset by a decrease in NHS revenue of £6.5 million. The decrease in NHS revenue has arisen from a lower UDA delivery percentage of 81.4%, after handbacks, compared with 85.7% for the year ended 31 March 2019. Delivery in the current year includes 326,000 UDAs recognised in March 2020 to align performance with March 2019 under the NHS policy for contract management during the pandemic. NHS revenue also includes the annual contract uplift of 2.42% in England (2.5% in Scotland and Wales).

The decline in the number of UDAs delivered is due to disposals of loss making sites, a reduction in the number of hours dentists provide for NHS work, a reduction in the volume of contracted UDAs held by dentists, and the impact of growth in private revenues. In addition, continued changes in the UK economy have reduced the number of exempt patients being seen by {my}dentist, which has resulted in a change in UDA band mix away from higher value band 2 (3 UDAs) and 3 (12 UDAs) treatments. Band 2 treatments, which include fillings, root canal work and the removal of teeth, require a patient contribution of £62.10, whilst band 3 treatments, which include crowns, dentures, bridges and other laboratory work, require a patient contribution of £269.30.

In response to these factors, we continue to recruit more dentists in order to fulfil our NHS contracts. During the year ended 31 March 2020, the business continued to utilise different recruitment channels including both UK and overseas routes. The total number of dentists engaged by the group increased by 163 over the year, including over 100 newly-qualified dentists and this added 3,900 weekly hours of clinical time. The business also successfully completed 4 internal training programmes to assist dentists from European dental schools to transition to the UK. Once the training is complete, the dentists provide private treatments in practice to build up the experience required to apply for an NHS performer number. The group continues to monitor the progress of changes to UK immigration law and the potential new recruitment routes that could open up.

As we have outlined previously, with regulatory and registration requirements it can take between six to nine months for a NHS clinician position to be filled. Furthermore, clinicians new to the country can be subject to some regulatory restrictions on the amount of UDA's they can perform in their first year. As these new clinicians settle in and their productivity starts to increase, we expect to see an increase in the volume of hours year-on-year during the second half of the next financial year.

Orthodontic revenues have been separated out from the base dental practice revenues as a standalone division: {my}orthodontist. Orthodontic revenue decreased by £0.8m from £41.2m for the year ended 31 March 2019 to £40.4m for the year ended 31 March 2020 due to NHS contract changes. The orthodontic contract tender process has seen new contracts awarded to practices at lower rates and for lower volumes of UOAs.

DD revenue increased by £25.4 million, or 18.7%, from £135.4 million for the year ended 31 March 2019 to £160.8 million for the year ended 31 March 2020. Growth is due to increases in medical aesthetics particularly products supplied under an exclusive arrangement for the UK by Galderma, wholesale, equipment and engineering revenues but this has been partially offset by a slowdown in high street independent dental practice sales, including when practices are acquired by a corporate body.

Cost of sales

Cost of sales increased by £25.2 million, or 7.9%, from £317.7 million for the year ended 31 March 2019, to £342.8 million for the year ended 31 March 2020. Gross profit margin decreased by 1.5 percentage points, from 44.4% for the year ended 31 March 2019 to 42.9% for the year ended 31 March 2020.

{my}dentist gross margin for the year ended 31 March 2020 was 48.0%, compared to 48.4% for the year ended 31 March 2019 principally due to changes in sales mix relating to increasing private revenues and reductions in orthodontic contracts rates per UOA. The increase in private revenue reduces gross margin due to the higher dentist fees, laboratory and material costs associated with private treatment, however due to the higher revenue possible per hour, gross profit will increase with changes in the mix.

The gross margin in DD was 24.3%, a decrease of 2.1 percentage points from 26.4% for the year ended 31 March 2020 due to the lower margins associated with aesthetic toxin sales, but gross profit is up overall due to the higher volume of sales.

Other operating income

Other operating income decreased by £0.4 million, or 22.3%, from £2.0 million for the year ended 31 March 2019 to £1.5 million for the year ended 31 March 2020. We generate other operating income primarily from Scottish Health Boards to assist in the upkeep of our dental practices, based on the proportion of NHS treatment carried out by each dental practice, and through property rental income.

Distribution costs

Distribution costs increased by £2.6 million, or 14.9%, from £17.3 million for the year ended 31 March 2019 to £19.9 million for the year ended 31 March 2020. This increase is due to higher carriage costs for the higher volume of transactions recorded by DD.

Administrative expenses

Administrative expenses increased by £44.1 million, or 15.8%, from £278.5 million for the year ended 31 March 2019, to £322.6 million for the year ended 31 March 2020. This increase is due to the recognition of impairment charges on the carrying value of goodwill and other assets but is offset by the change in treatment of rental costs.

The change in the treatment of rental and other lease charges under IFRS 16 reduces administrative expenses but is partially offset by an increase in related depreciation. In the year ended 31 March 2019, administrative expenses included rent charges of £14.7 million. Following the adoption of IFRS 16 on 1 April 2019, rental and other lease charges of £14.1 million are not included in administrative expenses, however depreciation (relating to the right of use lease asset) has increased by £11.9 million.

In the year ended 31 March 2020, £79.5 million of impairment charges were recorded in the income statement including £77.6 million recorded against the carrying value of goodwill within {my}dentist to reduce the book value to the total fair value. The reduction in the fair value calculations is due to an increase in uncertainty arising from the Covid-19 pandemic which required more pessimistic assumptions to be used for impairment modelling. A £1.4 million impairment was also identified against the carrying value of goodwill in {my}dentist resulting from permanent contract handbacks and a £0.5 million impairment was recorded against the right of use lease assets in relation to the release of property provisions. In the year ended 31 March 2019, £3.0 million impairment was identified against the carrying value of goodwill in {my}dentist resulting from permanent contract handbacks. An

impairment was also recorded against the carrying value of goodwill in DD totaling £13.3 million as a result of the decline in performance experienced in the previous year, the timing of the expected recovery of the business and the impact this has on estimated discounted future cash flows.

A charge of £10.0 million has been recorded against the carrying value of assets related to practices which have been identified for closure (year ended 31 March 2019: £24.2 million). The assets have been written down to their estimated recoverable amounts.

Staff costs are flat year on year however this includes an increase in practice staff costs during the first half of the financial year offset by savings from practice disposals and lower Support centre staff costs.

Finance costs

Finance costs increased by £5.2 million from £43.3 million for the year ended 31 March 2019, to £48.5 million for the year ended 31 March 2020, mainly due to the recognition of interest on the lease liability following the introduction of IFRS 16.

Finance income

Finance income for the year ended 31 March 2020 is in line with the previous year and comprises interest receivable on cash and cash equivalents.

Income tax credit

The income tax charge increased by £18.4 million, from a £9.7 million credit for the year ended 31 March 2019, to a £8.7 million charge for the year ended 31 March 2020. The deferred tax liability arising from the net book value of intangible assets compared to the tax value has increased due to writing down the value of future tax deductions arising from the goodwill amortisation associated with partnership acquisitions. This has been offset by a increase in the rate at which deferred tax is recognised from 17% to 19% following the decision of the UK Government to reverse the previously announced reduction to 17%. The deferred tax asset for capital allowances has also been reduced to reflect the utilisation of the allowances to replace previous claims for goodwill amortisation.

EBITDA before non-underlying items/Adjusted EBITDA before non-underlying items

EBITDA before non-underlying items increased by £18.1 million, or 31.2%, from £58.1 million for the year ended 31 March 2019, to £76.2 million for the year ended 31 March 2020. This increase includes the change in treatment of rental and other lease charges which are no longer included in administrative expenses following the transition to IFRS 16. In the year ended 31 March 2020, the impact of this change is £14.1 million. In the year ended 31 March 2019, £14.7m of rental and other lease costs were charged to administrative expenses.

Adjusted EBITDA before non-underlying items increased by £4.0 million, or 6.9%, from £58.1 million for the year ended 31 March 2019, to £62.1 million for the year ended 31 March 2020. This increase is due to the continued growth of both private revenues and DD revenues as well as some overhead savings in {my}dentist. This increase has been partially offset by the decrease in NHS revenue as a result of a decline in UDA delivery.

NHS dentistry services revenue as a percentage of total revenue

NHS dentistry services revenue as a percentage of total revenue decreased 4.9 percentage points, from 62.7% for the year ended 31 March 2019, to 57.8% for the year ended 31 March 2020. This decrease primarily results from the lower level of UDA contract delivery combined with the growth experienced in private dentistry and DD.

Total annual UDA delivery percentage

Our total annual UDA delivery percentage, after temporary and permanent handbacks, for the twelve months ended 31 March 2020 was 81.4%, a decrease of 4.3 percentage points over our total annual UDA delivery percentage of 85.7% for the year ended 31 March 2019. The decrease in UDA delivery percentage is due to a number of factors including a reduction in the number of hours dentists provide for NHS work, a reduction in the volume of contracted UDA's held by dentists, a reduction in the number of handbacks agreed in year by the NHS and the impact of our growth in private revenues. Excluding the impact of handbacks, our total annual UDA delivery percentage was 79.3% down from 80.0% for the year ended 31 March 2018.

Following the Coronavirus outbreak in early March 2020, and the change from carrying out routine procedures to emergency procedures only, the NHS agreed that any shortfall in March 2020 activity performance due to the restrictions placed on practices could be mitigated by substituting the number of March 2019 claims for March 2020 performance. This resulted in the recognition of revenue from 326,000 UDAs in March 2020. This arrangement has been included in calculating the above delivery percentages.

Private dentistry services revenue as a percentage of total revenue

Private dentistry services revenue as a percentage of total revenue increased 1.8 percentage points, from 18.1% for the year ended 31 March 2019, to 19.9% for the year ended 31 March 2020. This increase principally reflects like-for-like growth in private dentistry services of 16.0%.

Like-for-like private revenue growth

Like-for-like private revenue growth was 16.0% for the year ended 31 March 2020, compared to like-for-like growth of 6.5% and 5.0% for the years ended 31 March 2019 and 31 March 2018 respectively. Compared to the year ended 31 March 2018, our like-for-like private revenues have grown by 23.3%. The strong continuing growth in private has been driven by the introduction of the {my}options affordable private dentistry proposition along with the development of our Advanced Oral Health Centres.

Overheads as a percentage of revenue

Overheads as a percentage of total revenue decreased by 4.1 percentage points, from 34.6% for the year ended 31 March 2019, to 30.5% for the year ended 31 March 2020. As discussed above, this includes the change in rental and other lease charges which are no longer included in administrative expenses following the transition to IFRS 16. For other movements, see 'Adjusted overheads as a percentage of revenue' below.

Adjusted overheads as a percentage of revenue

Adjusted overheads as a percentage of total revenue decreased by 1.8 percentage points, from 34.6% for the year ended 31 March 2019, to 32.8% for the year ended 31 March 2020.

This movement is partly due to the revenue growth seen in both private and DD revenues however there have also been reductions in some {my}dentist overheads, specifically equipment and property maintenance, recruitment and travel.

Total number of dental practices

Our total number of dental practices decreased by 6 from 603 at 31 March 2019 to 597 at 31 March 2020. A total of 4 practices were closed during the year, three existing practices were merged into a new site, one practice merged into another existing practice and one new greenfield site was opened.

Liquidity and capital resources

"Liquidity" describes the ability of a company to generate sufficient cash flows to meet the cash requirements of its business operations, including working capital needs, capital expenditures, debt service obligations, other commitments, contractual obligations and acquisitions. Our primary sources of liquidity are provided by cash generated from our operating activities and our third-party financings. Our liquidity requirements arise primarily to meet our debt service obligations, to fund acquisitions and to fund capital expenditures.

We primarily rely on cash flow from operations and borrowings under our Revolving Credit Facility to fund capital expenditures and acquisitions, and to provide funds required for our operations. Our debt service obligations consist primarily of interest payments on the Notes and principal and interest payments on amounts drawn under the Revolving Credit Facility. We expect to fund acquisitions in the future, if any, primarily through drawings under the Revolving Credit Facility and with cash generated by our operations. We expect to fund capital expenditures primarily with cash generated by our operations although certain growth opportunities meeting our return on capital thresholds may be funded from the Revolving Credit Facility. Although we believe that our expected cash flows from operating activities, together with available borrowings under the Revolving Credit Facility, will be adequate to meet our expected general liquidity needs and debt service obligations, we cannot assure you that our business will generate sufficient cash flows from operations to meet these needs or that future debt or equity financing will be available to us in an amount sufficient to meet our liquidity needs, including making payments on the Notes or on our other debt when due. If our cash flow from operating activities is lower than expected, or our capital expenditure requirements exceed our projections, we may be required to seek additional financing, which may not be available on commercially reasonable terms, if at all. Our ability to arrange financing generally and our cost of capital depends on numerous factors, including general economic conditions, the availability of credit from banks, other financial institutions and capital markets, restrictions in the instruments governing our debt and our general financial performance.

In order to maximise liquidity during the Covid-19 pandemic the full available amount under the SSRCF of £73.2 million was drawn down during March. At the year-end the group held around £68.0 million more cash on the balance sheet than normal.

Cash flows

The table below summarises our consolidated cash flow statement for the years ended 31 March 2020 and 2019.

(£ in millions)	**For the year ended 31 March 2020**	**For the year ended 31 March 2019 Restated**
Cash generated from operations	78.3	37.6
Capital expenditure	(27.4)	(24.2)
(Costs of)/proceeds from business and asset disposals	(0.1)	0.4
Contingent consideration paid	(0.5)	(0.3)
Acquisitions	-	(0.2)
Interest received	0.1	-
Financing	16.8	(20.6)
Net increase/(decrease) in cash and cash equivalents	**67.2**	**(7.3)**
Cash and cash equivalents at the start of the year	8.9	16.2
Cash and cash equivalents at the end of the year	**76.1**	**8.9**

The prior year comparatives have been restated to correct the misclassification of an element of contingent consideration paid which should have been reported as an operating cash flow rather than a financing cash flow.

Our cash generated from operations for the year ended 31 March 2020 increased by £40.7 million, or 108.2%, from £37.6 million for the year ended 31 March 2019 to £78.3 million for the year ended 31 March 2020.

The underlying strong cash generation properties of the group's business units has been boosted by a change in classification of cash flows due to the adoption of IFRS 16. Payments under operating leases which were previously included within cash generated from operations, are now presented as cash flows from financing activities, representing repayments of debt.

Cash generated from operations includes favourable working capital movements of £7.9 million (2019: £12.6 million adverse) which principally arise from the movement in the accrual for the UDA shortfall and a decrease in inventories partially offset by an increase in trade and other receivables at the end of March.

The group receives 1/12th of the annual contract value every month through the contract year. Amounts related to UDAs that are not delivered will typically be repaid in the following year and therefore if UDA delivery decreases in the year there will be a working capital inflow as cash is received for UDAs not delivered that will be repaid in the following year. The group has historically negotiated the early repayment of some undelivered UDAs during the year ("handbacks"), however this was significantly lower in the year-ended 31 March 2020 than in previous years. The increase in trade receivables arises from the impact of the Covid-19 pandemic lockdown on many independent high street dental practices. Many practices, especially those that focus on private dentistry closed from mid-March and consequently did not pay invoices due to DD in that month. Post year-end, and as practices have moved into a re-start phase, DD has been able to collect these outstanding debts.

Net cash outflows from capital expenditure increased by £3.2 million, or 12.6%, from £24.2 million for the year ended 31 March 2019 to £27.4 million for the year ended 31 March 2020. This was split between growth capital expenditure of £8.1 million (29.6%) due to investment in site relocations including practice mergers and converting exisiting practices into additional Advanced Oral Health Centres. IT expenditure of £3.9 million included £1.5m of infrastructure and project development at {my}dentist and DD. Maintenance capital expenditure was £14.3 million (52.2%) and includes the replacement of smaller equipment items and £2.8 million of chair replacements.

Cash outflows from acquisitions were £nil for the year ended 31 March 2020, a decrease of £0.2 million from the year ended 31 March 2019. No dental practices were acquired during the year, although one new greenfield site was opened following the award of a new contract (2019: none).

Cash outflow relating to contingent consideration paid on previous years acquisitions increased from £0.3 million in the year ended 31 March 2019 to £0.5m million for the year ended 31 March 2020.

The cash inflow of £16.8 million from financing has resulted from the drawdown of the remaining £73.2 million SSRCF facility in March 2020 in order to facilitate liquidity during the cononavirus pandemic. A £5 million drawdown during Q1 was repaid during the year (year ended 31 March 2019: £20.0 million drawdown). The £100 million SSRCF facility was therefore fully drawn at 31 March 2020. Financing cash flows also include the cash interest costs of £41.4 million (compared to £40.6 million for the year ended 31 March 2019) and lease payments of £15.0 million. Following the adoption of IFRS 16 lease costs are now shown in financing activities (previously these were disclosed within operating activities in the year ended 31 March 2019).

Working capital requirements

Our working capital requirements differ between our DD and {my}dentist divisions. Within DD, net current assets as at 31 March 2020, comprising inventories, trade and other receivables and cash at bank and in hand, less trade and other short term payables, represented approximately 17% of DD revenues prior to intragroup eliminations, for the year ended 31 March 2020.

Within {my}dentist, we do not currently have significant short-term or long-term working capital requirements, as we typically receive payments under our NHS dentistry contracts prior to paying costs related thereto. Payments under our NHS dentistry contracts are made to us by NHS England, with payment of 1/12th the contract value paid at the beginning of each month. We collect the patient contributions on behalf of the NHS and remit such amounts to the NHS in arrears approximately two weeks thereafter. Three to six months following the contract year-end (31 March), we receive a statement detailing each UDA performance under each contract. If, at the end of the contract year, a practice has not performed all the UDAs allocated under its contract, NHS England may seek to reclaim UDAs paid for but not performed. Any payment of reclamation must be made after the end of the contract year of underperformance, although repayment may be made in year if both parties agree. At 31 March 2020 £70.4 million was held within accruals and deferred income on the balance sheet in respect of UDA receipts which were not delivered during the year to 31 March 2020. We expect to repay the majority of these amounts to the NHS during the course of the year ended 31 March 2021. Changes in our working capital are included in our net cash inflow from operating activities.

Contractual obligations and commercial commitments

The table below sets out our contractual obligations and commitments as at 31 March 2020.

£ in millions	Less than 1 year	1–5 Years	More than 5 years	Total
Senior Secured Fixed Rate Notes	–	275.0	–	275.0
Senior Secured Floating Rate Notes	–	150.0	–	150.0
Second Lien Notes	–	130.0	–	130.0
Super senior revolving credit facility	–	98.2	–	98.2
Contingent consideration	2.0	0.1	–	2.1
Leases	14.3	41.3	38.1	93.7
Total contractual obligations	**16.3**	**694.6**	**38.1**	**749.0**

Contingent consideration

Contingent consideration (including earn outs) is payable in respect of certain of our acquisitions based on the performance of the acquired business typically in one to five years following the acquisition. In the case of certain of our acquisitions, fees paid to selling dentists may represent a significant portion of the future EBITDA generated by such acquired dental practices above an EBITDA target agreed in the consultancy services agreements entered into in connection with such acquisitions.

Leases

The group has contractual obligations under non-cancellable leases, including in respect of premises for rent, vehicles provided to certain members of our management team and various other types of office equipment. From 1 April 2019, following the adoption of IFRS 16, the group has recognised right of use assets for these leases and corresponding lease liabilities. The lease liabilities are initially measured on a present value basis of the remaining lease payments and subsequently adjusted for payments and interest. A small number of short term and low value leases have been excluded from the lease liability and continue to be charged to the income statement on a straight line basis. Both lease liabilities recognised under IFRS 16 and short term and low value leases are included in the above table.

Off-balance sheet arrangements

We are the obligor under a letter of credit issued by Lloyds Bank in the amount of £1.8 million to our clinical directors in respect of liabilities they may incur as partners in certain of our dental practices. The letter of credit is issued under the Revolving Credit Facility Agreement.

Financial risk management

Market risk is the potential loss arising from adverse changes in market rates and consists of risks relating to foreign exchange rates, interest rates and market prices. We are not exposed to market price risk as we do not own assets the value of which is determined by market prices.

DD is subject to foreign exchange risk related to the purchases of consumables and materials in Euros and US dollars. We generate revenue in pounds sterling and, because of this, we are unable to match purchases made using Euros or US dollars with revenue generated in these currencies. The group's policy is to hedge the pound sterling equivalent costs of a proportion of our foreign currency purchases using vanilla foreign exchange derivative contracts, in order to reduce uncertainty over future cash flows.

We are exposed to interest rate risk primarily in relation to our debt service obligations, which consist of obligations under our Senior Secured Floating Rate Notes and obligations outstanding under our Revolving Credit Facility. As at 31 March 2020, we have £280.0 million in financial debt subject to variable interest rates consisting of the Senior Secured Floating Rate Notes and the Second Lien Notes. The Second Lien Notes are subject to a LIBOR floor of 1.00%. £98.2 million was drawn against the Revolving Credit Facility as at 31 March 2020, with a further £1.8 million allocated to a letter of credit to our clinical directors. As at 31 March 2020 the Revolving Credit Facility was fully drawn.

Our Senior Secured Fixed Rate Notes bear interest at a fixed rate. For fixed rate debt, interest rate changes affect the fair market value of such debt, but do not impact earnings or cash flow.

The nature of our contracts with NHS Regions means that consumer credit risk is minimised for a significant proportion of our revenues. Certain of the procedures undertaken by our dental practices may be paid for under payment plans which we contract to V12 Retail Finance. While we are not exposed to the credit risk under such payment plans, we are required to carry a consumer credit license in respect of the provision of consumer credit. Whitecross holds our consumer credit license, and undertakes all work performed pursuant to such payment plans. Similarly, DD has no significant concentration of credit risk due to the high volume of individual customers that we supply. New customers are subject to external credit checks using the main agencies, credit terms are negotiated individually and subsequently monitored closely by the credit control team.

Internal controls

The ultimate source of internal controls is our Board. Our Board has delegated to senior management the establishment and implementation of a system of internal controls appropriate to our business. The Board and senior management maintain a strategic risk register to assist in the monitoring of risk across the group and the further development of internal controls. Key controls include the safeguarding of assets; the maintenance of proper accounting records; the reliability of financial information; and compliance with appropriate legislation, regulation and best practice, and are overseen by our independent auditors and our Audit Committee. At the dental practice level, internal controls are primarily managed by our practice managers, area managers and directors of region. In general, the implementation of our internal controls is manual and focused on the prevention of fraudulent UDA claims and the theft of cash. We have previously suffered from breaches of our internal controls that were immaterial to our overall results, including misclaimed UDAs, the theft of petty cash and fraud related to the acquisition of a dental practice.

In DD, controls are focused on the management of inventory, provenance of materials and equipment, including controlled drugs and medicines, and the credit-worthiness of customers.

Critical accounting policies and estimates

Our financial statements have been prepared in accordance with IFRS. The preparation of these financial statements requires us to make estimates and assumptions that affect the amounts of assets and liabilities we report. We continually evaluate our estimates and assumptions and base them on historical experience and other factors, including expectations of future events that we believe are reasonable under the circumstances. Actual results may differ from these estimates. Whilst we do not believe that any of such estimates and assumptions have material implications for our results of operations or financial condition or are material due to a high degree of subjectivity or judgement, the following are significant accounting policies which are determined, to the extent described above, on the basis of estimates and assumptions.

Revenue recognition

Revenue derived from NHS dentistry contracts in England and Wales is recognised on the volume of dental activity delivered in the financial period. Amounts received from the NHS in advance of dental activity being delivered are held on the Balance Sheet within accruals. Revenue from all private dental work and NHS patients in Scotland is recognised on the completion of each piece of treatment carried out, with the exception of orthodontic treatment, which is recognised based on the stage of completion reached during the course of treatment. Revenue generated from the sale of goods by DD is recognised upon despatch and revenue generated from the installation or repair of equipment, or from other services, is recognised upon completion of the service.

From early March 2020, due to the coronavirus outbreak NHS dental practices were restricted to emergency procedures only. The NHS confirmed that for the contract year-ended 31 March 2020, any shortfall in March 2020 activity performance due to the restrictions placed on practices could be mitigated by substituting the number of March 2019 claims for March 2020 performance. This resulted in the recognition of revenue from 326,000 UDAs in March 2020.

Work required for refurbishments

Any refurbishment of properties in our property portfolio is subject to multiple quotes from external third parties. Additionally, all properties in our property portfolio must meet required regulatory standards. Our property portfolio is managed internally by a property management team and supported by external consultants who review our practices and recommend improvements in meeting regulatory compliance in connection with our properties. Part of our internal central property management support function involves regulatory compliance in connection with our properties. Our property management team also manages a defined capital expenditure cycle and dilapidation schedule in respect of our leased and freehold properties.

Goodwill

Goodwill represents the excess of the fair value of consideration paid on acquisition of a business over the fair value of assets, including any intangible assets identified, liabilities and contingent liabilities acquired.

Goodwill is not amortised but is tested for impairment at least annually. We use forecast cash flow information and estimates of future growth to determine the discount rate for assessing any impairment of goodwill. If our results of operations in future periods are adverse to the estimates used for impairment testing an impairment charge may be triggered.

The fair value of the consideration includes both actual and deferred consideration. Where the deferred consideration is contingent upon the future trading performance of an acquired asset, an estimate of the present value of the likely consideration is made. The contingent deferred consideration is reassessed annually and a corresponding adjustment is recorded in the income statement.

Defined benefit scheme

Details of the principal actuarial assumptions used in calculating the recognised liability or surplus for the defined benefit pension scheme are given in note 33 to the audited financial statements for the twelve months ended 31 March 2020, which are included in this Annual report. Changes to the discount rate, mortality rates and actual return on plan assets may necessitate material adjustments to this balance in the future.

Deferred income tax balances

Deferred income tax is provided using the balance sheet liability method, providing for temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for taxation purposes.

The following temporary differences are not provided for: the initial recognition of goodwill; the initial recognition of other assets or liabilities that affect neither accounting nor taxable profit; nor differences relating to investments in subsidiaries to the extent that they are unlikely to reverse in the foreseeable future. The amount of deferred income tax provided is based on the expected manner of realisation or settlement of the carrying amount of assets and liabilities, using tax rates enacted or substantially enacted at the balance sheet date.

A deferred income tax asset is recognised only to the extent that it is probable that future taxable profits will be available against which the asset can be utilised. Deferred income tax assets are reduced to the extent that it is no longer probable that the related tax benefit will be realised.

Deferred income tax assets and liabilities are offset when there is a legally enforceable right to offset current income tax assets against current income tax liabilities and when the deferred income tax assets and liabilities relate to income taxes levied by the same taxation authority on either the taxable entity or different taxable entities where there is an intention to settle the balances on a net basis.

Deferred income tax is provided on temporary differences arising on investments in subsidiaries and associates, except for on deferred income tax liabilities where the timing of the reversal of the temporary difference is controlled by the group and it is probable that the temporary difference will not reverse in the foreseeable future.

Results of operations for the three months ended 31 March 2020 and 31 March 2019

The following tables set out the key line items from the consolidated income statement and consolidated cash flow statement for the three months ended 31 March 2020 ("Q4 FY2020") and 31 March 2019 ("Q4 FY2019").

Consolidated income statement

(£ in millions)	For the three months ended 31 March 2020	For the three months ended 31 March 2019
Revenue	**154.2**	**144.7**
Cost of sales	(87.4)	(79.7)
Gross profit	**66.8**	**65.0**
Distribution costs	(4.9)	(4.2)
Administrative expenses	(146.0)	(77.7)
Other operating income	0.2	0.5
Other gains/(losses)	0.5	(0.5)
Operating loss	**(83.4)**	**(16.9)**
Finance costs	(12.7)	(10.9)
Finance income	-	-
Loss before income tax	**(96.1)**	**(27.8)**
Income tax credit	(13.4)	3.6
Loss for the year	**(109.5)**	**(24.2)**
Attributable to:		
Owners of the parent	(109.5)	(24.2)
Non-controlling interests	-	-
	(109.5)	**(24.2)**

Consolidated cash flow statement

(£ in millions)	For the three months ended 31 March 2020	For the three months ended 31 March 2019
Cash flows from operating activities		
Cash generated from operations	16.5	14.0
Tax paid	–	–
Net cash inflow from operating activities	**16.5**	**14.0**
Investing activities		
Acquisitions (net of cash acquired)	–	(0.1)
Contingent consideration paid	–	–
Purchase of property, plant and equipment	(5.1)	(7.0)
(Costs of)/proceeds from business and asset disposals	(0.1)	(0.5)
Net cash outflow from investing activities	**(5.2)**	**(7.6)**
Financing activities		
Drawdown of bank loans	73.2	10.0
Bank and bond interest paid	(14.8)	(14.6)
Lease cash payments	(4.4)	–
Net cash outflow from financing activities	**54.0**	**(4.6)**
Net increase in cash and cash equivalents	**65.3**	**1.8**
Cash and cash equivalents at the start of the period	10.8	7.1
Cash and cash equivalents at the end of the period	**76.1**	**8.9**

Key performance indicators

	Q1 FY 2020	Q2 FY 2020	Q3 FY 2020	Q4 FY 2020
Other profit and cash flow data				
Revenue (£m)	139.0	151.7	155.5	154.2
EBITDA calculated under IFRS 16 (£m)	15.0	19.4	19.4	22.4
Rent adjustment (£m)	3.5	3.5	3.7	3.5
Adjusted EBITDA (£m)	11.5	15.9	15.8	18.9
LTM adjusted EBITDA (£m)	57.4	59.7	60.1	62.1
Operating profit/(loss) (£m)	(2.5)	1.9	0.6	(83.4)
NHS dentistry services as a percentage of dental practice revenue	74.1%	73.5%	73.8%	76.2%
Private dentistry as a percentage of dental practice revenue	25.9%	26.5%	26.2%	23.8%
Non-dental practice revenue as a percentage of group revenue	20.0%	22.2%	23.3%	23.5%
Like-for-like private revenue growth	14.1%	23.4%	19.4%	8.8%
Like-for-like private revenue growth per working day	16.0%	21.5%	19.4%	7.1%
Gross profit margin %	43.4%	42.6%	42.2%	43.3%
Adjusted overheads as a percentage of revenue	35.5%	32.4%	32.4%	31.6%
Adjusted EBITDA margin	8.3%	10.5%	10.2%	12.3%
Number of dental practices	604	604	601	597
Capital expenditure (£m)	8.4	6.7	7.0	5.1
Cash conversion after capital expenditure	121.0%	133.7%	47.3%	69.3%
Estimated pro forma LTM adjusted EBITDA (£m)	58.4	60.2	60.3	61.3

Three months ended 31 March 2020 compared to the three months ended 31 March 2019

During the quarter, we closed four loss making dental practices, for a total of 597 dental practices in our estate as at 31 March 2020.

Revenue

Revenue for the three months ended 31 March 20120 ('Q4 FY 2020') has increased by £9.5 million, or 6.6%, from £144.7 million for the three months ended 31 March 2019 ('Q4 FY 2019') to £154.2 million. This was predominantly due to the growth in DD revenue with a smaller increase in private revenue at {my}dentist.

The table below further analyses the movements in our revenues between Q4 FY2020 and Q4 FY2019:

Revenue (£ in millions)	For the three months ended 31 March 2020	For the three months ended 31 March 2019	Movement
NHS revenue	80.7	81.9	(1.2)
Private revenue	26.1	23.8	2.3
Dental practices	**106.8**	**105.7**	**1.1**
Orthodontics	11.0	10.8	0.2
Practice disposals	-	0.2	(0.2)
Non-dental practice revenue	0.1	0.1	-
Total {my}dentist revenue	**117.9**	**116.8**	**1.1**
DD revenue	41.8	34.8	7.0
Eliminations	(5.5)	(6.9)	1.4
Group revenue	**154.2**	**144.7**	**9.5**

Revenue generated from base dental practices excluding disposals and orthodontic revenue increased by £1.1 million, or 1.0%, from £105.7 million for the year ended 31 March 2019 to £106.8 million for the year ended 31 March 2020. The increase principally reflects an increase in private revenues of £2.3 million. Private revenue was limited to a like-for-like increase of 8.8% (7.1% per working day), lower that the increase achieved through the first three quarters of the year due to the restrictions placed on practices during March 2020 as part of the response to the Covid-19 outbreak. This effectively stopped private treatments and therefore revenue from mid-March. NHS revenue was £1.2 million lower than in Q4 FY2019 at £80.7 million due to lower UDA delivery in January and February 2020 with March activity replaced by the March 2019 as apart of the NHS contract arrangements during the pandemic. Orthodontic revenues have increased by £0.2 million from £10.8 million for the three months ended 31 March 2019 to £11.0 million in the three months ended 31 March 2020.

DD has shown strong growth in revenue of £7.0 million or 20.1%, from £34.8 million for the three months ended 31 March 2019 to £41.8 million in the three months ended 31 March 2020. This was driven by the demand for medical aesthetics, and improved customer service in wholesale, engineering and equipment. However, volumes in high street consumables continued to be lower than in the prior year as practices continued to be acquired by dental corporates.

Cost of sales

Cost of sales increased by £7.7 million, or 9.7%, from £79.7 million for Q4 FY 2019, to £87.4 million for Q4 FY 2020. Gross profit margin decreased by 1.7 percentage points, from 45.0% for Q4 FY 2019 to 43.3% for Q4 FY 2020.

{my}dentist gross margin was 48.6%, compared to 48.7% for the same period last year. This slight decrease is predominantly due to changes in sales mix with increasing private revenues and changes in orthodontic contracts.

The gross margin in DD was 24.7%, a decrease of 2.8 percentage points from 27.5% for Q4 FY 2019 reflecting the lower margins associated with toxin sales.

Overheads

Overheads, including administrative expenses, distribution costs, amortisation and impairment of intangible assets, depreciation, grant income and other non-underlying items were £151.0 million for Q4 FY 2020, an increase of £69.1 million from £81.9 million in the three months ended 31 March 2019. This increase relates to an increase in impairment charges relating to goodwill and other assets of £62.0 million from £16.3 million in Q4 FY 2019 to £78.3 million in Q4 FY 2020. The impairment includes £77.6 million recorded against the carrying value of goodwill in {my}dentist, £0.2 million recognised relating to permanent contract cuts agreed with the NHS in the quarter and £0.5 million recognised against the right of use asset. The carrying value of goodwill in {my}dentist has been impaired based on a revised forecast due to an increase in uncertainty arising from the Covid-19 pandemic which required more pessimistic assumptions to be used in impairment modelling. There is a £7.9 million decrease in impairment of assets and disposals recognised in Q4 FY 2020 (£10.6 million) compared with Q4 FY 2019 (£18.5 million).

Following the adoption of IFRS 16 on 1 April 2019, rental and other lease charges are not included in overheads, however depreciation (relating to the right of use lease asset) has increased by £2.5 million.

Overheads excluding amortisation and impairment of intangible assets, depreciation, grant income and other non-underlying items were £44.7 million, or 29.0% of revenue, compared to £48.6 million, or 33.6% of revenue, in Q4 FY 2019. As discussed above, this decrease includes £3.5 million relating to the change in classification of rent charges in Q4 FY 2020.

The group's largest overhead is the cost of staff working in dental practices, in operational management and at the divisional support centres. In the quarter ended 31 March 2020, staff costs were £32.5 million, an increase of £1.0 million from £31.5million in Q4 FY 2019. Dental equipment and practice property maintenance costs for Q4 FY 2020 were £2.0 million, a decrease of £0.9 million from £2.9 million in Q4 FY 2019.

The calculation of adjusted EBITDA includes the recognition of cash rental and other operating lease charges of £3.5 million in overheads for Q4 FY 2020.

EBITDA before non-underlying items/ Adjusted EBITDA before non-underlying items

EBITDA before non-underlying items increased by £5.5 million, or 32.4%, from £16.9 million for Q4 FY 2019, to £22.4 million for Q4 FY 2020. Adjusted EBITDA before non-underlying items increased by £2.0 million, or 11.8%, from £16.9 million for Q4 FY 2019, to £18.9 million for Q4 FY 2020.

Non-underlying items

The practice portfolio is being monitored closely for practices which are no longer deemed viable due to reasons such as low UDA contract values , geographical issues or recruitment issues. During Q4 FY 2020, 4 dental practices were closed (Q4 FY 2019: 2 sold, 3 closed) resulting in a £9.9 million loss being recognised in the income statement (Q4 FY 2019: £2.2 million).

Other non-underlying items of £2.2 million principally relates to business development costs of £1.1 million, restructuring costs across the group totalling £0.5 million, dilapidation provision costs of £0.3 million and other legal costs of £0.3 million.

Finance costs

Finance costs increased by £1.9 million from £10.9 million for Q4 FY 2019, to £12.7 million for Q4 FY 2020. This increase is principally due to the interest on lease liabilities recognised under IFRS 16.

Cash flow, liquidity and net debt

At 31 March 2020, net debt was £569.9 million, compared to £561.3 million at 31 March 2019. This increase principally reflects the £73.2 million drawn from the SSRCF during the year and the amortisation of loan arrangement fees offset by a £65.3 million increase in cash.

Net cash flow for the quarter was an inflow of £65.3 million. This arises from cash generated from operations of £16.5 million and a drawdown of £73.2 million from the SSRCF, offset by expenditure of £14.8 million for the servicing of finance, lease payments of £4.4 million and capital expenditure of £5.1 million.

Cash generated from operations of £16.5 million was £2.6 million, or 18.5% higher than Q4 FY 2019. This increase is principally as a result of the adoption of IFRS 16, whereby the payments made in relation to leases are now shown within financing activities as opposed to operating activities as in the previous year.

Capital expenditure of £5.1 million included pro-active refurbishment, preventative maintenance and equipment replacement across the dental practice estate.

Industry

Overview of the UK healthcare system

The provision of healthcare in the United Kingdom is dominated by the National Health Service (the "NHS"), a public sector body, and its affiliates. The NHS was founded in 1948 under the principles of universality and equality, to provide publicly funded access to medical care to all residents of the United Kingdom. Despite numerous political, administrative and organisational changes, the NHS remains a universal service that provides healthcare on the basis of need and not on ability to pay. The NHS is funded through taxation and national insurance contributions. Private health insurers and independent providers of healthcare play a comparatively small role in the healthcare sector in the United Kingdom. Excluding certain prescribed drugs and primary eye and dental care, which require patient contributions (other than for certain exempt groups) all public healthcare services provided by the NHS are free to the patient at the point of delivery.

Healthcare and health policy for England is the responsibility of the UK Government, whereas in Scotland and Wales it is the responsibility of the respective devolved governments. In England, the NHS is supervised by the Department of Health.

The UK healthcare system

The UK healthcare system is divided into the primary and secondary care subsectors. Primary care consists of routine medical care, check-ups and outpatient medical services. Primary care service providers include general practitioners ("GPs"), dentists, opticians, pharmacists, NHS walk-in centres and the NHS's online and telephone health advice and information service. These services are delivered by a wide range of independent contractors on behalf of the NHS, including GPs, dentists, pharmacists and optometrists. Care that goes beyond primary care is referred to as "secondary care" (also known as "acute care"), which consists of hospital-based care and specialised consultative healthcare accessed through referral from a primary or community health professional, such as a GP. Secondary care services include emergency and urgent care, acute care, ambulance services and mental health and elder care services.

Dentistry is essentially a primary care discipline in so far as the vast majority of patient care takes place in an outpatient surgery setting and most treatments are routine and are provided by generalists. Dental treatments beyond the primary level include, amongst others, orthodontics, restorative and paediatric treatments and complicated surgical extractions (both in-patient and out-patient). Primary care dentistry makes up the majority of the total dental market and is weighted towards NHS dentistry services.

NHS

In an effort to reduce costs and modernise the healthcare system, independent healthcare service providers have been permitted to compete and offer their services in certain subsectors of the NHS. Due to capacity and capital constraints, private sector involvement in the NHS has grown. The extent of private sector involvement is determined by the need and willingness of the NHS to outsource these services.

Clinical Commissioning Groups ("CCGs") and NHS Regions share the responsibilities for commissioning services for their local communities, with NHS Regions acting on behalf of NHS England (in England) in respect of dental services. The NHS England National Board has regional and local teams to facilitate relationships with providers, but operates as one national body.

NHS Regions play a key role in the oversight of commissioning, maintaining a focus on addressing unequal access to healthcare and ensuring the right balance between consistency and the adoption of national frameworks and localisation. They also support the coordination of some of NHS England's nationwide initiatives. The NHS Regions in England have direct commissioning responsibilities for GP services, dental services, pharmaceutical services, and certain aspects of optical services, and as such represent the interface for the majority of services at a local level, though the contracting party for such services is NHS England.

NHS Regions and CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities or private sector providers. They must, however, be assured of the quality of the services they commission, taking into account both National Institute for Health and Care Excellence ("NICE") guidelines and CQC data regarding service providers.

Budget environment

For the year ended 31 March 2020, the UK Government budget for the NHS in England was £123.4 billion. Budgeted expenditure for NHS England for the year ended 31 March 2021 is £129.7 billion, an increase of 5.1% over the previous year. During 2018, the NHS was set a five year revenue funding settlement by the Government, averaging 3.4% growth a year in real terms and reaching £20.5 billion extra a year in real terms by 2023/24.

Scotland

The Scottish parliament has responsibility for dental care and healthcare and has full legislative competence, involving the power to pass both primary and secondary legislation regarding these matters. Other "reserved matters" remain the charge of the UK Government. Public healthcare in Scotland is provided by NHS Scotland, a completely separate body from the NHS in England and Wales. Primary and secondary care are linked and integrated, and services are provided by 14 regional health boards.

As in the rest of the United Kingdom, dental care in Scotland is provided through the GDS, the Salaried Dental Service and the Hospital Dental Service. There are differences in how these services are organized and managed in comparison with England, Wales and Northern Ireland.

Scotland operates a form of the GDS contract, within a remuneration model of fee-per-item of service, capitation payments and continuation fees.

The UK dental service market

Introduction

The dentistry services market in the United Kingdom is critical to ensuring the oral health of the UK population, with over one million patient contacts per week according to Mintel occurring within NHS dentistry services alone. Oral health is not only important to a patient's appearance and sense of well-being, but also to overall physical health. According to the World Health Organization, oral diseases are the most common of the chronic diseases worldwide and are important public health problems because of their prevalence, their impact on individuals and society, and the expense of their treatment. Cavities and gum disease may contribute to many serious conditions, such as diabetes, cardiovascular diseases and respiratory diseases, and lead to serious infections.

Residents of the United Kingdom are entitled to receive all clinically necessary dental treatment from the NHS. Primary care NHS dentistry services are available to adults and children without registration in England and Wales from dentists who are contracted to provide NHS dentistry. In Scotland, adults and children must be registered with a dentist to receive treatment.

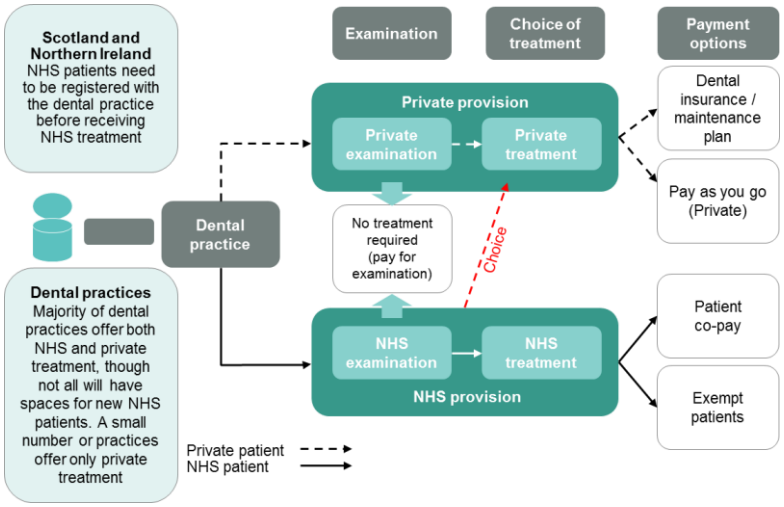
Dental treatment in the United Kingdom can be either fully funded or part-funded by the NHS or privately funded by the patient (whether directly or through the use of a dental payment plan or insurance). Free NHS dental treatment is available for specified groups of patients who are exempt from payment, such as children, new and expectant mothers, and individuals on certain benefits. Patients not exempt from payment pay a contribution toward the cost of NHS dentistry services. Patients with low incomes who do not fall into any of the specified groups of patients who are exempt from payment may be entitled to reduced patient contributions. In Scotland, all dental examinations are free to the patient.

Any treatment needed to keep mouth, teeth and gums healthy and free of pain may be made under NHS dentistry services. In England, this includes dentures, root canals, extractions, crowns and bridges, any preventive treatment needed such as a scale and polish, an appointment with a dental hygienist, fluoride varnish or fissure sealants, the removal of wisdom teeth if necessary, silver-coloured (amalgam) fillings or white fillings where clinically appropriate, and orthodontics for under-18s if considered clinically necessary.

Patients have the option of choosing private dentistry services, NHS dentistry services or a combination of private and NHS dentistry services depending on their preferences. NHS dentistry services are almost exclusively provided by the private sector with the vast majority of dentists practising in primary care settings offering NHS dentistry services or a combination of NHS and private dentistry services, with around 18% of dentists carrying out private dentistry services only. LaingBuisson estimated in 2017 that approximately 18% of patients received wholly private dentistry care. In contrast to NHS dentistry services, private dentistry services differ in that:

- treatment prices are set by the dentist and are typically more expensive than NHS prices;
- there are no subsidised patients, and patients typically pay the full amount for their treatment at the time of their visit;
- patients receive faster service and the range of treatments, technologies and materials available is unrestricted; and
- private dentists' patient lists are typically half the size of those in NHS practices.

The following diagram presents a typical patient journey for NHS dentistry services and private dentistry services:



Market overview

The market value for dental care in the United Kingdom was estimated by Mintel to be £10.0 billion having generated £3.7 billion in spending on NHS dentistry services, £3.5 billion on private dentistry services and £2.8 billion on private cosmetic dentistry services, in each case in the twelve months ended 31 March 2019. The NHS funding of NHS dentistry services represents less than 3% of the overall UK Government health expenditure on the NHS.

Between 2015 and 2019, UK expenditure on dental care has risen by just over 10% according to Mintel. There is now a stronger industry focus on customer benefits, including sharper pricing, value for money, loyalty rewards and the highest quality customer experience. This movement towards consumerism and a more retail-like environment is expected to boost growth. NHS still accounts for the largest proportion of the sector however this has seen a declining trend from 40% of the market in 2015 to 37% in 2019. Cosmetic dentistry has seen the greatest growth in expenditure with an increase of 25% between 2015 and 2019.

Historically economic downturns have though softened demand for full price private dentistry, for example in the twelve months ended 31 March 2008 and 2009 as recessionary impacts held back consumer purchasing, patients shifted from private to NHS dentistry to save on costs. NHS funding for dentistry has not shown a strong correlation to the macroeconomic environment underpinning the stability of the sector throughout economic cycles.

NHS activity, as measured by UDA volumes has been on the decline in England in recent years with the largest fall of 3% in 2017/18. UDA activity has also shifted across bands as restorative activity has narrowed while check-up examinations have continued to grow. This change in UDA band mix away from higher value band 2 (3 UDAs) and band 3 (12 UDAs) treatments, is a result of a reduction in the number of exempt patients.

The government introduced a prototype trial process, which commenced in April 2016 as the next stage in the proposed reform of the dentistry contract. Under the proposed changes to the current contract frameworks, NHS dentistry contracts could combine aspects of the existing UDA-based system, fixed payments for a given level of care time, number of patients treated, clinical outcomes, patient experience and patient safety. We believe that these changes, if they occur, will generally prove revenue neutral, and that we will be able to leverage our scale to derive a competitive advantage in terms of patient recruitment and delivery of quality care under any new NHS dentistry contractual framework. The timing of any change to the contract if any, remains uncertain.

Since the introduction of the UDA-based contracts in 2006, UDA values have been steadily adjusted upwards with, most recently, a price increase of 1.34% for the contract year ending 31 March 2016, 0.7% for the contract year ending 31 March 2017, 1.14% for the contract year ending 31 March 2018, 1.67% for the contract year ending 31 March 2019 and 2.42% for the contract year ending 31 March 2020. The contract uplift for 2021 is yet to be announced.

Supply and demand

According to the General Dental Council ("GDC"), there are approximately 42,000 dentists registered to practice dentistry in the United Kingdom. Dental practices are typically either small or medium-sized private businesses owned either by an individual or a partnership of dentists, or are owned by a dental body corporate. Compared to other European countries, the United Kingdom has one of the lowest rates of dentists per capita, with just over 500 dentists per one million members of the population. This compares to approximately 650 in France and over 850 in Germany.

According to NHS Digital, only 52.4% of the population accessed NHS dentistry services during the 24 months to 30 June 2018 and down from 53.0% in the 24 months ended 30 June 2017. This would suggest that there remains significant unsatisfied demand for NHS dentistry which, in recent years, has been driven by an ageing population and an increased public understanding of the importance of good dental hygiene. However, as the UK economy has strengthened in recent years, the industry has also seen significant growth in private dentistry, with some patients moving away from using NHS dentistry services.

The UK remains a net importer of dentists, with approximately 23% of the dentists registered with the GDC having qualified in parts of the EEA and approximately 12% qualified through the Overseas Registrant Exam or from outside Europe, according to the GDC Annual Report 2019.

Highly regulated market

As with other healthcare sectors, the UK dental market is a highly regulated market in which dental professionals must be registered with the regulatory body, the General Dental Council, in order to work in the United Kingdom. Since April 2011, the activity of dentists in England has also been subject to regulation by the CQC, which is responsible for ensuring that the care and treatment provided by all dental practices in England meet government standards of quality and safety. See "Business—Regulation". Under the current contract system, the provision of

NHS dentistry services is subject to more regulatory oversight than private practice due to the nature of the tendering process and the importance of strong relationships with NHS England.

We believe that the highly regulated nature of the provision of NHS dentistry services provides a competitive advantage to existing market participants, due in part to:

- *Evergreen GDS NHS contracts*. The majority of NHS dentistry contracts are evergreen GDS contracts with no contracted end date, resulting in a limited number of new NHS dental contracts being put out for competitive tender. NHS contracts are unlikely to be moved to another supplier unless there is significant underperformance. See "Business—NHS framework contracts".
- *Ability to attract and retain qualified dentists*. Dental qualifications are required to work within a practice and overseas dentists need to go through UK registration processes before they can practice in the United Kingdom. We believe this works to the advantage of larger market participants, like us, who are better able to absorb talent sourcing and retention costs, including in respect of overseas sourcing when necessary.
- *NHS relationships*. The process for awarding UDAs can be lengthy and is often done by tendering to the general market. However, we believe that preferred and existing suppliers with track records of delivering UDA targets have historically been more successful in winning contract tenders. Large-scale suppliers of NHS dentistry services also tend to have strong relationships with NHS England.

Market trends

We believe that there is significant scope for growth in demand for dental services in the United Kingdom as the market remains underdeveloped in terms of both spending and the supply of dentists. Structural growth factors have driven real growth in NHS dental spending over the last decade, and provide strong prospects for continued future growth.

The sector benefits from a number of favourable long-term trends in healthcare generally and dentistry in particular, including, amongst others, an ageing UK population, increased dental health expectations and increasing public understanding of the importance of good dental hygiene, as well as technological advances facilitating access to new treatments to more patients at lower costs.

NHS dentistry is considered a key front-line service of the UK Government. Despite recurring cycles of macroeconomic volatility, NHS volumes and values have both remained relatively stable. Almost half of the UK population does not visit the dentist on a regular basis, with the majority of this population base receiving dental treatment irregularly and a small proportion never visiting a dentist. In the 24 months ended 31 December 2019, 49.6% of adults and 58.4% of children were seen by an NHS dentist.

The highly fragmented UK dental market provides considerable scope for consolidation for nationwide operators with the platform and resources to drive consolidation, although rising practice valuations in recent times could slow this process. The consolidation trend in the UK primary care dentistry market is expected to continue over the long term, as existing corporate groups continue to expand.

With around 50% of dental practices, closed to new NHS patients due to capacity constraints and full private treatment plans considered to be expensive, we believe there is a demand in the market for an affordable private programme. We have developed {my}options as an affordable range of treatments with transparent pricing, easy appointment times and shorter waiting lists to meet this demand.

The UK dental supplies market

The UK dental supplies market represents an estimated £400-500 million in spending per year and consists of a few key distributors supplying dental consumables and materials to dental practices throughout the UK. Products supplied range from dental consumables, specialist products including orthodontics, oral hygiene, implant products and dentistry equipment such as dental chairs and cabinetry to digital imaging systems. In addition, services offered include equipment installation and maintenance. These distributors primarily sell through field based sales representatives, online and telesales order services.

Business

Overview

We are Europe's largest vertically-integrated dental business and the United Kingdom's number one dental practice chain, with a focus on delivering the best possible patient care, highest clinical standards and a comprehensive choice of treatments through our UK dental practice network. We operate our business through two divisions: {my}dentist and DD. We are the leading provider of dental services in the United Kingdom through {my}dentist, with 548 NHS dentistry contracts across our network of 597 dental practices throughout England, Scotland, Wales and Northern Ireland. As at 31 March 2020, {my}dentist had a market share of approximately 6% in terms of revenue and a market share of approximately 5% in terms of number of practices and held contracts for approximately 14% of all units of dental activity ("UDAs") commissioned in England and Wales. Our dental practices, operating under the "{my}dentist" brand, offer a broad range of primary care dental services, including dental examinations, fillings and extractions, as well as more specialised dental services such as cosmetic dentistry and orthodontics. We are also a leading provider of private dentistry services in the United Kingdom, which has grown quickly over the last five years. We operate in the UK dental market, which benefits from stability in terms of volume and pricing and from favourable systemic trends, including continued government focus on improving access to dental services, favourable demographic trends and an increasing overall spend on dentistry. Through DD, we are a leading supplier of dental and other medical consumables, materials and services (including installation and servicing of specialised dental equipment), selling dental supplies and services to at least 8,000 dental practices, including {my}dentist's dental practices, with an estimated market share of 25% in the United Kingdom, by revenue. In the twelve months ended 31 March 2020, the group recorded revenue of £600.5 million and generated adjusted EBITDA before non-underlying items of £62.1 million.

{my}dentist

For the twelve months ended 31 March 2020, {my}dentist generated revenue of £466.7 million (constituting 77.7% of our total revenue after intercompany eliminations) and adjusted EBITDA before non-underlying items of £60.4 million, constituting 97.3% of our adjusted EBITDA before non-underlying items after intercompany eliminations. {my}dentist's core business is the provision of primary care dental services under long-term contracts with various NHS bodies across the UK, which we refer to as "NHS dentistry services." NHS dentistry services accounted for 57.8% of our group revenue for the twelve months ended 31 March 2020 and 74.4% of {my}dentist divisional revenue. The majority of our dental practices also provide private dentistry services, including general dentistry, hygienist, and cosmetic services, with a smaller number offering specialist services, such as sedation, implants and orthodontics. Private dentistry services accounted for 19.9% of our group revenue and 25.6% of {my}dentist divisional revenue, for the twelve months ended 31 March 2020. Over recent years we have observed an increase in demand for private dentistry and revenue from our private dentistry services has grown accordingly, with like-for-like growth of 7.0%, 5.0%, 6.5% and 16.0% for the twelve months ended 31 March 2017, 2018, 2019 and 2020, respectively. The growth in FY2020 has been driven by the roll-out of our {my}options affordable private proposition and the expansion of our network of Advanced Oral Health Centres to 14 locations. {my}options is currently available in 490 practices (20 practices as at 31 March 2019).

Of our dental practices, 86% are located in England, with 5% in Scotland, 8% in Wales and 1% in Northern Ireland.

We provide NHS dentistry services in England and Wales pursuant to contracts competitively tendered with the NHS specifying targeted annual volumes of UDAs for the contracted dental practice or entity. We refer to these contracts as "NHS dentistry contracts." Unlike other UK health subsectors, such as care homes, there is no single NHS dentistry contract. Instead, our individual dental practices enter into separate NHS dentistry contracts with NHS England (or, in the case of Wales, with Welsh health boards). As at 31 March 2020, our dental practices were contracted under 548 such NHS dentistry contracts. Each NHS dentistry contract in England and Wales for UDAs specifies a fixed UDA volume per year target, and each UDA delivered under an NHS dentistry contract is assigned a fixed value in a given year, with the number of UDAs per treatment varying based on the treatment provided. The volume of UDAs under a given contract does not change year-to-year, and the value assigned to a contract has historically increased year-to-year.

Approximately 93% of our NHS dentistry contracts, covering 49% of our group revenue in the twelve months ended 31 March 2020, consist of general dentistry services ("GDS") contracts, which we refer to as "evergreen" as they have no fixed term and roll over indefinitely except in cases of cumulative UDA underperformance of more than 4% (or 5% in Wales), at which point the number of UDAs under an individual contract may be rebalanced or, in extreme cases, the GDS contract may be terminated. None of our GDS contracts have ever been terminated. UDA rates are set annually and historically have benefited from annual price increases ("contract uplifts"), with the contract uplift for the contract year ending 31 March 2020 constituting a 2.42% increase over the prior contract year for England (with an uplift of 2.50% in Wales and 2.50% in Scotland). The uplift for the contract year ending 31 March 2021 has not yet been announced, however in the last 15 years, NHS England has never reduced prices.

Between the contract years ending 31 March 2011 and 31 March 2015, our five-year average for UDA delivery rates (that is, the percentage of contracted services actually delivered) under NHS dentistry contracts was 96.8%. However, in the contract years ending 31 March 2016 through to 31 March 2020, our UDA delivery rates decreased to 92.4%, 90.4%, 86.1%, 85.7% and 81.4% respectively. The decline in the number of UDAs delivered is due to disposals of loss making sites, a reduction in the number of hours dentists provide for NHS work, a reduction in the volume of contracted UDAs held by dentists, and the impact of growth in private revenues. We have been making progress in clinician recruitment and retention and growing clinical hours remains a key focus. There does however continue to be significant recruitment challenges across the sector. During the year ended 31 March 2020, the business continued to develop new recruitment channels in order to accelerate dentist recruitment from both UK and overseas channels. The total number of dentists engaged by the group increased by 163 over the year, including over 100 newly-qualified dentists and added 3,900 weekly hours of clinical time.

We are paid for our NHS dentistry services in equal monthly instalments of our annual contracted value. This results in a well-matched cash flow and cost profile as we typically receive payments on our NHS dentistry contracts prior to paying related costs. Any underperformance in terms of UDA delivery must be repaid, where requested, to the NHS after the contract year end, or repaid over subsequent contract years. We have never had to make a repayment of more than £2 million to the NHS in respect of any of our individual contracts. During the year ended 31 March 2020, a number of small permanent contract handbacks have been agreed with the NHS Regions, principally in areas where there has been insufficient patient demand for NHS dentistry for a number of years. These permanent handbacks equate to approximately 0.6% of the total number of UDA's contracted by {my}dentist as at 31 March 2019. Private dentistry services are typically paid for by the patient at the point of treatment.

A typical dental practice for us has four dental chairs on average, with three or four self-employed, independently contracted dentists offering primary care dental services under an NHS dentistry contract, supported by nurses employed by us. As at 31 March 2020, approximately 2,800 self-employed, independently contracted dentists worked in our dental practices, supplemented by approximately 280 dentists not assigned to a single practice, which we refer to as "locums," and supported by approximately 6,300 dental and central support staff. In addition, 640 hygienists work across our dental practices.

We own the NHS dentistry contracts and infrastructure of our dental practices and employ the dental support staff, whilst contracting with self-employed dentists for provision of dental services. We believe our business model is attractive to dentists as we enable dentists to focus on dentistry by taking on the administrative, regulatory and compliance burdens associated with running a dental practice, along with monitoring the dentist's performance and adherence to GDC and NHS standards and other regulatory requirements. Amongst our most significant costs are dentist fees and costs for laboratory work and materials, all of which are directly linked to volumes of sales and activity. In part as a result of the establishment of our DD division, we centralise and insource the procurement of equipment and materials used in {my}dentist's dental practices to generate economies of scale and lower our costs. Our dental practices purchase their dental consumables, materials, equipment installation, maintenance and engineering work, as well as any other products that DD's offers, internally.

DD

DD is one of the two leading suppliers in the United Kingdom's fragmented dental consumables, materials and services markets, with an estimated market share of 25%. For the twelve months ended 31 March 2020, DD revenue of £160.8 million, constituting 26.8% of our total revenue (£133.8 million after intercompany eliminations, constituting 22.3% of our total revenue). Adjusted EBITDA before non-underlying items of £6.4 million, constituting 10.3% of our adjusted EBITDA before non-underlying items.

DD provides support to {my}dentist's dental practices, as well as providing a wide range of products and services to the wider UK dental and healthcare sectors, including at least 8,000 dental practices in the United Kingdom. The integration of {my}dentist's dental practices with its supply chain and service providers in DD has resulted in significant cost savings and synergies, as we capture margin that would otherwise be paid to third-party suppliers and benefit from certain VAT exemptions. DD also provides us with an additional avenue for growth beyond the acquisition of dental practices.

We have consolidated DD Products and Services Ltd (formely Billericay Dental Supply co. Limited) and Med-FX Ltd to distribute their catalogue of approximately 27,000 products from a central logistics platform through an online and telesales order service. The products offered by our DD businesses include dental consumables, specialist products including orthodontics, oral hygiene and implant products and dentistry equipment ranging from dental chairs and cabinetry to digital imaging systems. Med-FX specializes in the supply of medical aesthetics and operates a registered pharmacy. BF Mulholland supplies a similar range of dental consumables, materials and equipment to those offered by DD, but to the Northern Irish and Irish markets, and therefore extends our geographic reach, and increases our purchasing power. DD also carries out services such as the installation and maintenance of specialised dentistry equipment (for example, hand piece repairs) and training and membership services.

History

The predecessor company of our group was founded by a practising dentist in 1996. It listed on the Alternative Investment Market of the London Stock Exchange in 2002 and delisted in 2004. In 2006, it was acquired by Legal & General Ventures and was subsequently sold to Merrill Lynch Global Private Equity in 2008. On 11 May 2011, we were acquired by Carlyle and Palamon and were simultaneously merged with Associated Dental Practices, which owned 133 dental practices at that time. Associated Dental Practices was founded in 1985 by a group of dentists and experienced rapid expansion through both organic growth and acquisitions. Associated Dental Practices was acquired by Kaupthing Capital Partners in 2007 and was subsequently sold to a consortium led by Palamon in 2009.

In 2013 we formed our practice services division (as it was then known) with the acquisition of dbg, which was followed by the acquisitions of DD in 2014, Med-FX in 2015, PDS Dental Laboratory (sold in October 2018), Dolby Medical in 2016, and BF Mulholland in 2017. The division is now known as DD. We have expanded significantly through both acquisitions and organic growth, and we have gradually consolidated our position as the leading provider of dental services and a leading supplier of dental and other medical consumables, materials and services in the United Kingdom.

{my}dentist

We are the leading provider of dental services in the United Kingdom. Our dental services consist primarily of primary care NHS dentistry and private dentistry services. We are not currently active in the secondary care dental services market. Our NHS dentistry and private dentistry services accounted for 57.8% and 19.9%, respectively, of our revenue in the year ended 31 March 2020. As at 31 March 2020, we had a network of 597 dental practices in the United Kingdom, which provide both NHS and private dentistry services. More than 80% of our dental practices have three dental chairs or more and on average we have approximately four dental chairs per dental practice. A typical dental practice for us has three to four self-employed, independently contracted dentists offering primary care dental services under an NHS dentistry contract, supported by nurses employed by us. In addition, 640 hygienists work across our practices, the majority of whom are self-employed, independent contractors. {my}dentist focuses on leveraging its economies of scale and offering services and support to its dentists and dental practices by assuming many of the administrative responsibilities associated with running a dental practice as well as centralising and insourcing those administrative responsibilities to our central support function.

NHS dentistry services

We provide the majority of our dental services to NHS patients through NHS dentistry services. In the year ended 31 March 2020, revenue generated by our NHS dentistry services was £347.1 million, or 57.8% of our total group revenue. We provide primary care dental services such as dental examinations, periodontal treatment, amalgam fillings, endodontics and extractions, as well as fitting bridges, crowns and dentures. Our dentists also provide advice on how to care for teeth and gums in order to prevent oral health problems.

Our dentists have a duty of care to offer and carry out all treatments that are within their professional capabilities, and they refer patients to appropriate specialised dentists both within and outside of {my}dentist dental practices if a specific dental service is outside their capabilities. However, during the course of a treatment, NHS patients can choose to receive private dentistry services offered by the same dentist.

Our NHS dentistry services are funded by the NHS, and by fixed patient contributions depending on whether or not such person is exempt, and varying in amount based on the type of treatment. The patient contribution is set by the NHS and revised annually. Patients contribute to the cost of NHS dentistry services on the basis of the type of services they receive, with the balance of payments paid by NHS England, so there are no material billing requirements vis-à-vis NHS dentistry payments. The full amount is contributed by the NHS where patients are exempt from payment. Exempt patients include students under 19 years of age, the unemployed, new and expectant mothers and pensioners. In addition, certain low income patients may be entitled to partial exemptions, depending on their income. Exempt patients tend to receive treatments with a higher UDA band mix greater than that for non-exempt patients.

Private dentistry services

We provide our private dentistry services to both NHS patients and non-NHS patients. In the year ended 31 March 2020, revenue generated by our private dentistry services was £119.3 million, or 19.9% of our group revenue. All NHS patients can elect to receive private treatment, and private dentistry services may be provided as enhancements or add-ons to NHS dentistry services. In general, we provide our private dentistry services in the same dental practices where we provide our NHS dentistry services. We work to expand patient choice by broadening our offering of private dentistry services. Whilst dentists working in our dental practices may educate patients as to our private dentistry services, the choice of private dentistry services lies solely with the patient.

Certain cosmetic and advanced dental treatments can only be offered as part of our private dentistry services. The most common treatments that patients opt for privately include white fillings, advanced crowns and bridges, advanced dentures, implants, teeth whitening, facial aesthetics, hygienist services, orthodontics and treatments by specialised dentists. Other specialist dentistry services offered in some of our dental practices include sedation dentistry services, oral surgery, domiciliary services (that is, the treatment of patients outside of their dental surgery and at their residence), and oral pathology and maxilla facial surgery, which includes the diagnosis and treatment of oral lesions such as oral cancer. We also provide private periodontal services (that is, the advanced care of gum diseases) and advanced endodontic dental services (such as root canal therapy).

Typically, appointments for private dentistry services can be made in a few days whereas appointments for NHS dentistry services can take several weeks, making private dentistry services attractive to patients with greater disposable income. On average, follow-up appointments for private dentistry services can be arranged sooner and with more convenience than for NHS dentistry services. Our private dentistry services are entirely funded by our patients whether through fee-per-service payments or the patient's dental insurance plan. Private dentistry services are typically paid at the time of treatment. The prices of private dentistry services are set by the individual dentist working within guidelines determined by us including minimum fee levels. The cost to the patient of private dentistry services (such as a white filling) is higher than the cost of a comparable NHS primary care dental service (such as an amalgam filling), with higher prices for more-complex procedures.

As the UK economy has strengthened, we have observed an increase across the market in demand for cosmetic dentistry, including, facial aesthetics, tooth whitening, veneers and dental implants.

During the previous year the group carried out a significant review of dentist involvement and determined that while dentists still appreciate the opportunities provided by NHS dentistry, as they progress in their career they wish to develop their skills by providing a wider range of treatments, some of which are not available on the NHS. In concentrating on NHS services, {my}dentist has not previously provided the opportunities for experienced dentists to develop their practice through offering additional private sessions and this has led to a decrease in the number of hours the group can make available to patients. Following clear feedback from dentists, the group initially introduced a limited affordable private dentistry offering "access {my}dentist" in early FY2019 however, the demand for this service led the group to develop a full service affordable offering "{my}options" which offers patients choice of private treatment with transparent pricing options. This offering is currently available in 490 practices and is being rolled-out across the group.

Provision of services to our dental practices

Whilst dentists working in our dental practices and the hygienists, nurses and other staff that support them provide services to patients, we provide services such as procurement and estate management to our dental practices through a management contract between two of our operating subsidiaries, PTPL and Whitecross, and our dental practices.

DD

Provision of consumables, materials, equipment and services

DD sells dental consumables, materials and other supplies and services, both to our own dental practices and to third-party dental practices. DD has one of the largest engineering teams in the United Kingdom, which carries out installations of surgery, equipment and digital imaging systems. The same engineering team also provides planned and reactive maintenance services to many brands of dental equipment and related types of equipment. In addition, DD holds dealership agreements with a number of prominent dental equipment manufacturers and operates a handpiece repair business that services both {my}dentist's dental practices and third-party customers.

We have integrated dbg and DD with each other, as well as with our other operations, including Med-FX and Dolby Medical. This integration has included the development of customer and category plans, the consolidation of warehousing, distribution and logistics facilities and the recruitment of a senior divisional management team.

DD distributes a catalogue of approximately 27,000 products from its central logistics platform through its online and mail order service, including dental consumables, specialist products including orthodontics, oral hygiene,

implant products and dentistry equipment ranging from dental chairs and cabinetry to digital imaging systems. DD also carries out services such as the installation, maintenance and repair of equipment and has a handpiece repair business. We believe that each of the acquisitions will deliver increased capability, significant cost savings and synergies to us and will allow us to drive economies of scale in terms of purchasing and other efficiencies that will benefit all customers of DD (including our dental practices).

Central support function

Our business model focuses on leveraging our economies of scale and offering services and support to our dentists and dental practices by assuming many of the administrative responsibilities associated with running a dental practice and centralising, and insourcing them to our central support function. In addition to managing the performance of our dental practices, our central support function also provides the following services: IT, compliance, regulatory, legal, finance, human resources, health and safety, risk management, talent sourcing, training, insurance, property oversight, the administration of patient records, acquisitions, payroll, marketing, information sharing and logistics functions. For the year ended 31 March 2020, the {my}dentist central support function resulted in costs of £27.7 million, which constituted 5.9% of {my}dentist revenues for the year.

NHS framework contracts

Overview

{my}dentist provides NHS dentistry services to patients under various types of framework contracts. Our individual dental practices enter into separate NHS dentistry contracts with NHS England (or Welsh health boards in Wales). The NHS Regions administer the NHS budget on behalf of the NHS and NHS England tenders contracts on behalf of the NHS to dental care providers such as us. Under the current NHS system, which was introduced in 2006, the value of the framework contracts is primarily based on volume, specifically UDAs. Accordingly, our dental practices are remunerated based on the number of UDAs they complete in a contract year.

Payments under the framework contracts are made to us by NHS England, with payment of 1/12th of the contract value paid at the beginning of each month. We collect patient contributions on behalf of the NHS, and typically remit such amounts to the NHS in arrears within two-to-six weeks thereafter. Three to six months following the contract year-end (31 March), we receive a statement detailing UDA performance under each contract. If, at the end of the contract year, a practice has not performed all the UDAs allocated under its contract, NHS England may seek to reclaim UDAs paid for but not performed. Any reclamation of payment must be made after the end of the contract year of underperformance, although repayment may be made in-year if both parties agree. We also receive mid-year UDA performance statements and, if a dental practice has failed to meet 30% of its annual target by 30 September, the NHS Region may adjust payments made under such contract for the remainder of such contract year to correspond to an annual performance of two times of what the dental practice has achieved to 30 September. Dental practices are only paid for exceeding the number of UDAs contracted on a case-by-case basis upon approval by NHS England.

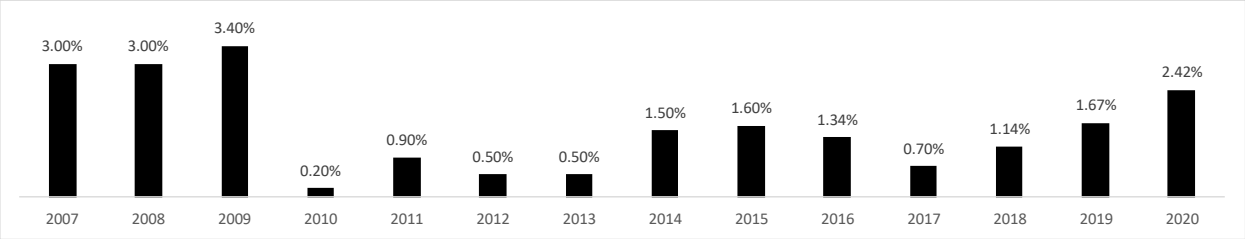
In general, UDA values differ across the United Kingdom and amongst our dental practices. We estimate that the average value of a UDA in England for our practices is currently approximately £28. The number of UDAs awarded for a particular treatment depends on the type of treatment provided. Dental treatments are split into four bands based on the type of treatment, the number of UDAs applicable to such treatment and the patient contribution. The patient contribution in respect of each treatment type during the year ended 31 March 2020 is set out in the table below:

	Treatment included	Number of UDAs	Patient charge	
			England	Wales
Band 1	Examination, prevention and advice, radiographs and scale and polish	1	£ 22.70	£ 14.30
Band 2	Band 1 plus all fillings, root canal therapy and extractions	3	£ 62.10	£ 46.00
Band 3	Band 1 and 2 plus any medical device constructed by a lab including crowns, bridges and dentures	12	£ 269.30	£ 199.10
Band 1a	Urgent treatment to include advice, 1 filling and 2 extractions	1.2	£ 22.70	£ 14.30

Patients treated at our Scottish and Northern Irish dental practices pay 80% of the gross cost of each course of treatment up to a maximum of £384, other than exempt patients, whose treatments are paid for by the regional Scottish, or Northern Irish, Health Boards.

The value per UDA to date has been subject to annual contract uplifts as recommended by the Review Body on Doctors' and Dentists Remuneration ("DDRB") and promulgated by the Department of Health, which may or may not accept the DDRB's recommendation. The contract years ended 31 March 2016, 2017, 2018, 2019 and 2020 saw contract uplifts of 1.34%, 0.70%, 1.14%, 1.67% and 2.42% respectively. The contract rate uplift for the year ending 31 March 2021 is yet to be announced. Historically UDA values have never declined in nominal terms since their introduction in 2006.

The following table presents the contract uplifts for each of the contract years (ending 31 March) since 2007:



Types of NHS dentistry contracts

There are two primary types of NHS dentistry contracts:

- General Dentistry Services ("GDS") contracts are evergreen contracts with no end date that automatically roll over upon the achievement of targeted UDA volumes. Generally, the volume of UDAs contracted under GDS contracts cannot be reduced unless volume targets are not met. Absent the termination events described under "—Key terms of NHS dentistry contracts", a GDS contract may only be terminated if there is cumulative UDA underperformance of more than 4% (or 5% in Wales) and the cumulative effect of breaches of such NHS dentistry contract would be prejudicial to the efficiency of the services to be provided under the contract, and even then the more likely scenario is amendment of the contract rather than cancellation. Volumes of UDAs under the contract can only be varied by mutual consent. For the year ended 31 March 2020, approximately 49% of our revenue was generated under GDS contracts.
- Personal Dentistry Services ("PDS") contracts are fixed-term contracts, usually with terms of three to five years. However, if the PDS contract covers mandatory services (i.e. general dental and not specialist), the service provider has the right to apply to NHS England to convert the PDS contract into a GDS contract. The majority of the group's PDS contracts are for the provision of specialist orthodontic services. Like GDS contracts, the volume of UDAs contracted under PDS contracts cannot generally be reduced unless volume targets are not met. For the year ended 31 March 2020, approximately 5% of our group revenue was generated under PDS contracts. The NHS is currently in the process of competitively re-tendering the majority of orthodontic PDS contracts across England, which includes the majority of PDS contracts held by {my}dentist.

In Scotland and Northern Ireland, non-salaried dentists are compensated on the basis of the number of patients registered with them and for procedures performed. Scottish dental practices may also receive additional practice allowances to assist in the upkeep of their premises. Scotland and Northern Ireland do not employ volume targets, and earnings of dental practices are uncapped. For the year ended 31 March 2020, 3.2% of our total group revenue was generated in Scotland and 0.6% in Northern Ireland.

In addition to general dental services, we provide specialised dental services that a general dentist may not be able to carry out. These services may be added on to our GDS or PDS general dentistry services contracts, or may be subject to separate framework contracts with NHS England.

- Orthodontic treatments are subject to a system similar to the UDA system, with the value of the framework contracts primarily based on units of orthodontic activity ("UOA"). Each orthodontic treatment equals 21 UOAs - that is, one UOA attributed to the examination and 20 UOAs attributed to the fitting of the brace and the ongoing related dental care of the patient. Payments under these framework contracts are made to us on a monthly basis, with any shortfalls trued up following the contract year-end.
- Sedation dentistry services are contracted and paid in a manner similar to UOAs.
- Oral surgery, which includes the extraction of difficult to remove teeth that a general dentist may not be able to perform, are contracted based on a target number of patients or visits or by types of treatment, and depend on referral volumes. Payments under these framework contracts are made to us on an equal monthly basis, with any shortfalls trued up following the contract year-end.

- Domiciliary services, which include the treatment of patients outside of a dental surgery (usually at a patient's residence), are contracted based on a target number of patients or visits. Payments under these framework contracts are made to us on a monthly basis, with any shortfalls trued up following the contract year-end.
- Oral pathology and maxilla facial surgery services, which include the diagnosis and treatment of oral lesions such as oral cancer, are mostly carried out as secondary care, and paid by the NHS based on a course of treatment.

Key terms of NHS dentistry contracts

The specific terms of any given NHS dentistry contract vary depending on the NHS Region and the outcome of negotiations at the time the contract is awarded by NHS England. In addition to the terms related to contract duration, volumes and prices described above, all our NHS dentistry contracts include a general quality of care requirement. Failure to meet this quality of care requirement could result in loss of the applicable contract. NHS dentistry contracts also include limitations on assignment and, in most cases, a change of control absent consent of NHS England. Our NHS dentistry contracts are also generally terminable by NHS England upon certain insolvency events, if the contracted entity's financial situation is such that NHS England considers that NHS England is at risk of material financial loss or on grounds the contracted party is unsuitable for reasons such as disqualification, sanction or criminal activity. For other breaches of such contracts, such as underperformance in terms of UDA volumes, the contracts are only terminable by NHS England after service of notice on the contracted party of the breach and a provision of time for the contracted party to cure such breach. In our experience, NHS England has been willing to renegotiate contracts for lower volumes of UDA in lieu of terminating contracts due to underperformance. Out of our 548 NHS dentistry contracts, none of our GDS contracts have been terminated.

Tendering of new contracts

The majority of NHS dental contracts in England and Wales were allocated in 2006. Because most of these are GDS contracts with no fixed end date, a limited number of new NHS dental contracts are issued for competitive tender each year. In practice, new dental contracts tend to be issued for tender only if:

- the NHS Region has identified a shortfall in the existing supply of NHS dental treatment compared with the estimated need for dental services in that geographic locality;
- a dentist holding an existing NHS dentistry contract dies, retires or decides to abandon his or her contractual rights; or
- NHS England terminates a dental practice's contract in accordance with its terms.

Tenders are advertised through various channels which we monitor. Tenders for contracts are competitive, and winning bids tend to be those determined by the NHS Region to offer the best price, quality of service and care, compliance and timetable, along with other localised factors. However, the majority of contracts to deliver NHS orthodontic dentistry services are time-limited PDS agreements. PDS contracts typically have a duration of between three and five years and are therefore subject to periodic competitive re-tender by the NHS.

The NHS Regions have over the last two years run a competitive re-tendering process for the majority of its PDS contracts to deliver orthodontic dentistry services across England. The early tender results in the South of England identified a clear trend in terms of reductions in rate for orthodontic services and a smaller overall contract size as the NHS looks to increase the number of treatment locations. With the trend for smaller contracts, it is likely that the overall size of our orthodontic practice NHS contracts will reduce in size. In mitigation, the group is exploring options to provide more private orthodontics including using products such as clear aligners for the treatment of adults. However, the contract process is "paused" at present in certain regions due to the volume of legal challenges raised on contract awards and inconsistent bid marking.

There is a risk that we may be unsuccessful in retaining some, or all, of our orthodontic dentistry contracts as a result of this re-tender exercise, or that we retain volumes, or win additional volumes, but at a lower price per UOA. In light of this risk, we have created a new division within {my}dentist, "{my}orthodontist" to manage the 36 specialist orthodontic practices in our portfolio and we are currently reviewing our operational models to maximise our efficiency.

In the event that we are awarded additional contracts through this tender exercise, in locations where we do not currently have a dental practice, we may need to invest significant amounts of capital expenditure to procure and fit-out premises from which we can deliver any such new contracts. Any such capital investment would be funded through a combination of operating cash flows and utilisation of the cash balance held on balance sheet following the drawdown of the full SSRCF.

New framework agreement proposals and pilot/prototype programmes

The UK Government has proposed changes to the current model of contracting NHS dentistry services that would move away from a strictly volume of services metric (namely, UDAs) to an approach that takes into account preventative treatment and increased access to dentistry services. The proposed changes would replace the UDA system with remuneration based on capitation (that is, the number of patients treated and the treatments provided), and an activity measure (yet to be determined). The precise timing of any change remains uncertain.

In order to test the proposed payment models prior to implementation across the UK dental market, the Department of Health began a pilot programme in May 2011, which was expanded and revised in April 2013 and ended in January 2016. Three pilot payment schemes were tested; a guaranteed income model; a weighted capitation and quality model; and a model which allowed for complex care.

After ending the pilot programme in January 2016, the Department of Health introduced the first phase of a new prototype contract programme beginning in April 2016. The second phase of the programme was tested in 2017 and 2018 and, if adopted, the revised payment plan based on the prototype programme will gradually be introduced. The new prototype programme uses two different approaches to determining remuneration, blending patient numbers and types of dental activity. The prototypes also involve active performance management by NHS England, which includes monitoring of operational key performance indicators, such as clinical effectiveness, best practice, patient experience, safety and data quality.

We were involved in the development, testing and review of various pilot programmes on behalf of the NHS and we have engaged with the Department of Health and the BDA in relation to the prototype roll out and development, with four of our practices (three of which previously participated in the pilot programmes) participating as prototypes. We believe that our involvement in the development of these pilot programmes and prototypes will provide us with a competitive advantage by allowing us to prepare for coming changes and by giving us a voice in their implementation. However, as the actual policy changes have not yet been finalised by the UK Government and the exact timeline of the implementation has not yet been set, and as high-level changes in relevant UK Government administrative roles have changed since the Steele Review in 2008, no assurance can be given that the new framework agreements will be implemented in the manner we expect, or at all. The terms of any new NHS dentistry contract are uncertain and the final terms of any NHS dentistry contract could be different from those we expect, which could have undesirable consequences for us and could result in material changes to our business.

We believe that changes to the current model of contracting NHS dentistry services, if any, present an opportunity for us. As the leading provider in the market, we have the capacity, scale and resources to quickly adapt to change. Specifically, we believe that capitation requirements will make the recruitment of patients more important, and that our IT systems, developing CRM capabilities and sales and marketing resources provide us competitive advantages in patient recruitment. The proposed focus on preventative care and increased responsibilities for hygienists and nurses could help us operate more efficiently, with dentist time being spent delivering more critical treatments. We may also benefit from any standardisation of UDA rates. Any change would affect the provision of dental services throughout England and potentially Wales, so we believe that the UK Government will try to ensure that any such change is essentially revenue neutral, or positive, for NHS dentistry as a whole so as not to disrupt the provision of dental services or encourage a migration of dentists into private dentistry services.

Dental professionals

Dental professionals in, or affiliated with, our workforce consist of highly trained dentists who are self-employed, independent contractors, and a team of dental staff which includes practice managers, highly skilled dental nurses, hygienists, dental therapists and dental assistants.

Dentists

Dentists working in our dental practices are self-employed, independent contractors known as dental surgeons, and we enter into contracts with our dentists using our standardised associate agreement which has been reviewed by the BDA and which we understand to comply with HMRC requirements for independent contractors. We provide the dentist with the facilities, equipment, staff, materials and patient list in exchange for notional monthly licensing fees paid by dentists to us. We individually negotiate the compensation arrangements in the standardised associate agreements with each dentist working in our dental practices, and so are able to vary the compensation paid to dentists based on prevailing rates in the applicable local markets for dentists. Under the associate agreements with dentists, dentists receive a fixed percentage fee per UDA delivered, in the case of NHS dentistry services, and a percentage of fees paid for private dentistry services delivered. Contracts with dentists in our dental practices typically are evergreen, but terminable by either party upon four months' notice and include non-compete terms that prevent dentists from competing against us within a certain geographic radius of our dental practice after such contracts' termination. We also have arrangements with dentists, some of whom are our employees, that are not assigned to any single dental practice but provide services where they are most needed, including in response to

local shortages or areas in the United Kingdom that do not have full-time dentists. A small number of our dentists are employees.

To legally practice dentistry in the United Kingdom, a dentist must be registered with the General Dental Council (the "GDC"), the regulatory body for dentistry, must abide by regulations promulgated under the CQC and, in the case of NHS Dentistry, must abide by the Performers' list regulations. Of our dentists, approximately half are British. Given our current need to recruit additional clinicians in order to deliver our NHS dentistry contracts, we have continued to develop our dedicated recruitment team during the year and are actively recruiting dentists both from UK and overseas channels, including both EEA and non-EEA countries. The distribution of NHS dentists can vary widely across regions, and historically the sourcing of dental graduates and dentists has been particularly difficult in southwest England.

Between 2002 and 2010, significant efforts were made by the UK Government to improve the supply of dentists to address historical shortages, including opening new UK dental schools, expanding enrolment, and attracting more EEA-qualified dentists into the United Kingdom. Despite a dip in the dental student intake between 2010/11 and 2016/17, numbers have increased back up to previous levels of approximately 1,000 students in 2017/18 and 2018/19.

Because dentists working in our dental practices are self-employed, independent contractors, we do not contribute to their pensions, provide holiday pay, make employer National Insurance contributions or take other actions that would be necessary if dentists working in our dental practices were our employees. Dentists working in our practices have the freedom to treat a patient in the manner determined in their professional opinion to the best of their medical skill. As a result, dentists are solely liable for any medical negligence liability that occurs as a result of their performance of dentistry services. Dentists are required as a matter of professional conduct to carry their own medical negligence liability insurance coverage.

Providing quality care for our patients is our first priority, and to that end we focus on making training opportunities available to our dentists, for which they pay training fees. We have an in-house training academy for our dentists, hygienists, therapists and dental nurses in order to allow our dentists, paying by subscription, to choose to stay abreast of the latest medical and technological developments in the provision of dental services. Our academy is the first major private post-graduate dental training facility owned by a dental body corporate in the United Kingdom, and it demonstrates our ongoing commitment to our dentists and support staff. This underlines our retention strategy, which is designed to encourage high performers to remain with {my}dentist.

Other dental professionals

Dental staff and employees support the work of dentists in our dental practices, and they include dental nurses and technicians working in dental laboratories and dental therapists. The clinical role of these non-dentists and dental professionals has expanded in recent years, allowing nurses to take on greater responsibility in their respective practices, thereby increasing the time dentists are able to spend on more complex tasks. Like the dentists themselves, many of our dental employees are required to register with the GDC.

Dental nurses provide support to dentists in surgery and other clinical environments and are responsible for, amongst other duties, dental instrument sterilisation, operative care, the preparation of treatment materials and various clerical duties such as updating patient records. A nurse is required to be present whenever a dentist is treating a patient. We have historically experienced relatively high rates of turnover amongst our nurses, and we have introduced initiatives, including increased salaries, career planning and training, to reduce such churn.

Dental hygienists are predominantly self-employed and perform a number of procedures, such as providing local analgesics, scaling and polishing teeth and providing general oral health advice. Following legislative changes, dental hygienists are able to book and carry out certain limited procedures without a referral from a dentist. Most of our 640 dental hygienists, as at 31 March 2020, are independent contractors and are reimbursed on the basis of work performed.

Dental therapists perform a wider range of procedures which include all that a hygienist can carry out as well as fillings for adults and children and extractions on children.

Clinical dental technicians are able to provide and manufacture full dentures for edentulous patients and, following a consultation and design from a dentist, provide partial dentures.

Dental technicians manufacture dental appliances such as braces, crowns, dentures and bridges.

Patients

Our patient base is broad, and generally reflects the diversity of the UK population, with a slight bias toward patients from less-privileged socioeconomic groups.

Sales and marketing

{my}dentist

We have implemented a variety of targeted marketing efforts that are aimed at attracting new patients and increasing visit frequency from existing patients. This is in addition to the patients that the dentists bring to treat in our dental practices. IT is a key focus in our marketing strategies. We are focused on online marketing efforts through a branded and interactive website with improved search engine capabilities that enable users to customise their searches for appointments, education and general questions about our business and the dentistry industry.

Each of our local dental practices has its own page on our main website. In addition, certain practices, particularly those offering specialist services, have individually tailored marketing programmes which typically include bespoke brochures and leaflets. Where appropriate, individual practices may also undertake their own marketing programmes as part of the normal patient re-call process, including through the use of specific posters, leaflets or banners displayed outside the relevant practices.

We have developed a patient management system to improve our ability to analyse the approximately four million active patient records we hold. The primary aim of this system is to enable us to direct tailored marketing initiatives and offers at our patient base to encourage more frequent visits, as well as the use of specialist services and attendance at events such as kids' clubs for fluoride treatment and teeth whitening for adults.

{my}dentist's marketing and sales efforts are also directed at minimising the number of patients lost due to failure to attends, excessive waiting room times and difficulties or delays in booking appointments and receiving information. Patients can receive text message reminders of their appointments and can also provide feedback in this way. We also have instituted a programme to contact lapsed patients who have missed appointments and re-book them into appointments. We are very keen to receive feedback from patients and now operate both paper and SMS patient feedback surveys across all of our dental practices. We use this data to calculate a 'recommendation score', that is the proportion of patients who would be extremely likely, or likely, to recommend our services. This methodology is consistent with that used by the NHS website. In addition, we are increasingly focused upon collecting and analysing more qualitative information from patients which will enable us to continue to develop the quality of our services and the experience that we offer to patients. Our teams monitor feedback provided on practices via Google or on the NHS website and respond to specific customer issues in order to improve the customer service provided.

All of the foregoing initiatives are important elements of the group's sales and marketing strategy. However, we believe that our best marketing tool is maintaining a strong reputation for excellence in the provision of dental services, as such services are often dependent on local word-of-mouth and referrals, both from current patients to other patients and from general dentists to specialists. We are therefore also pursuing new marketing platforms, such as the use of social media campaigns, to leverage our reputation for excellence in dental services and raise awareness amongst a greater number of potential patients. In addition, we believe that a significant number of NHS patients are directed to one of our practices by the NHS website, which enables users to search for local practices based on postcode or area and also to provide ratings and feedback for individual practices, thereby underlining the importance of maintaining our focus on high quality patient care and operational excellence.

The launch of {my}options during the year was backed by a phased marketing campaign to build awareness of the treatments available and the transparent nature of the costs associated with different treatments. Focus groups, specific customer feedback and surveys were all used as part of the {my}options pilot process, the launch and then through each phase of the roll-out to ensure that a consistent approach was followed. Feedback was sought from patients, clinicians and staff in order to tailor the treatment range to the strategic plan.

During the Covid-19 pandemic, a significant amount of management time has been put into communication with patients, clinicians and other stakeholders to provide information, guidance and advice based on the evolving publications provided by the NHS and public health bodies across the UK.

DD

Our sales and marketing strategy in DD is to drive sales through three channels: web sales, telesales and direct marketing. The various websites used by the business units within DD are important transactional and marketing portals for its customers. Over the past few years, we have invested in these websites to improve their functionality and, in the longer term, to encourage customers and members to place more orders via such websites rather than through the inbound telesales operations.

The centralised sales force of DD is comprised of direct sales staff and telesales staff, supported by a management system to monitor sales performance and yield. DD also has both outbound telesales and regional sales managers who actively visit third-party practices within their territories in order to keep such practices apprised of the various supplies and services we can provide, as well as to provide technical support for previously sold items.

DD's telesales team currently manages inbound calls as their primary focus and take the opportunity to offer customers additional products while taking their original orders. We have invested in a new CRM and scheduling system, along with associated reporting tools, which enables us to track customer purchasing activity across all channels, whether via the web, telesales or through its sales force. This should in turn enable DD to target marketing and sales activities to maximise the value offering to existing customers to drive loyalty and to identify and win new business.

Quality of care

We are focused on providing services that achieve high quality and strong patient satisfaction rankings. In addition to requirements under our NHS dentistry contracts to meet certain standards of quality of care, we are overseen and regulated by the CQC, which inspects and rates all health and social care providers, including dental care providers, in England.

We have consistently maintained high quality ratings across our dental services, and as at 31 March 2020, 100% of our practices met the essential standards set by the CQC.

We continue to work closely with the Royal Society for Prevention of Accidents ("RoSPA"), implementing its Quality Safety Assessment (QSA) management system audit across the company. The QSA process helps ensure measurable standards of performance are being constantly improved and maintained throughout the business. In 2020, {my}dentist was awarded a Gold Award by RoSPA for the sixth consecutive year in recognition of high levels of Health and Safety standards.

Clinical governance

We have a dedicated team of clinical directors devoted to clinical excellence led by our Group Clinical Director. As part of our clinical governance efforts, our clinical directors manage the clinical aspect of our dental practices, investigate patient complaints, respond to regulatory inquiries, help shape policies and procedures and conduct periodic audits and site visits of our dental practices. They work closely with and advise each operational Director of Region on issues of clinical governance and quality of care within their region. We also employ approximately 28 dentists who serve as clinical support managers on a part-time basis. The clinical services team also works closely with NHS England, NHS Regions, the CQC and professional bodies and universities to raise our profile and update our clinical practices and ensure we provide consistent, high-quality care to our patients.

Acquisitions and portfolio management

Overview and strategy

We have historically grown by pursuing selective acquisitions to expand our network of dental practices and NHS dentistry contracts. During the period beginning 12 May 2011 and ended 31 March 2018, we acquired 237 dental practices and invested approximately £238.0 million in dental practice acquisitions. Our acquisition strategy is to target dental practices with three or more dental chairs (the average practice acquired since 12 May 2011 has had four chairs) that benefit from GDS NHS dentistry contracts. We also focus on the historical UDA delivery rates of potential acquirees and the retention of key personnel.

In recent times, valuations being attributed to dental practices by prospective vendors have increased substantially and, together with our high levels of debt have lead us to be very selective on potential dental practice acquisitions, given greater potential returns on other investments.

In the previous financial year we concluded our portfolio review where we identied dental practices which were no longer viable due to structural issues such as very low UDA rates or difficutly to recruit dentists due to geographical location. This review resulted in the closure of 40 dental practices and sale of 31 dental practices over the previous three financial years.

The group has continued to review on a practice by practice basis the portfolio of NHS contracts held by practices and the services available to be provided in the practice. This resulted in the decision to close a further 4 dental practices during the current year.

A pilot programme has also been implemented during the year to move smaller 1-2 chair practices into larger premises in higher footfall, “High Street” locations. Overall during the year-ended 31 March 2020, 1 greenfield site was opened, 1 practice merged into another existing practice and 3 existing practices merged into one new practice.

Legal structure of acquisitions

We structure the acquisition of a dental practice in one of four ways depending on a number of factors including the legal status of the target dental practice. Typically, our NHS dentistry contracts prohibit assignment without the consent of the applicable NHS Region and contain change of control provisions.

Assignment

In limited circumstances, an NHS Region may consent to the assignment of the applicable NHS dentistry contract. In such a case, we assign such contracts to our trading company, Whitecross Dental Care Limited, in place of the seller of the acquired practice.

Acquiring an incorporated dental practice

Some of the dental practices we acquire already hold their NHS dentistry contract in an incorporated entity. In such situations we acquire the shares of the incorporated entity and it becomes a subsidiary.

Incorporation

In a situation in which the NHS Region does not consent to assignment of the contract and we are acquiring a practice from a sole proprietor or partnership, we may request that such sellers incorporate their practice into a limited company and obtain consent from the NHS Region for the NHS dentistry contract to be reissued in the name of that company. Assuming such consent is obtained and there are no change of control provisions in the newly issued contract (or consent is obtained to the change of control), we then acquire the shares in the limited company. This route of acquisition is rarely used now as a result of the formulation of the partnership structure described below which does not, we are advised, require the consent of the NHS Region at any stage.

Partnership

In a situation in which the NHS Region does not consent to assignment of the contract and we are acquiring a practice from a sole proprietor or a partnership, we add two or more of our clinical director employees to become partners with the sole proprietor or join in partnership with the existing partners (as applicable). There is an obligation to notify the NHS Region of such admissions but obtaining their consent to the change in status of the contractor is, we are advised, not required. In the case where our clinical directors join an existing partnership, legally, their admission to that partnership effectively dissolves the existing partnership and creates a new one. However, notwithstanding the dissolution of the existing partnership and equally, where a new partnership is formed with a sole proprietor, we believe, after consultation with external counsel, that existing law provides that the new partnership continues to hold and benefit of the NHS dentistry contract previously held by the predecessor partnership or sole proprietor (as applicable). Typically, the original partners or sole proprietor retire from the

partnership shortly after the completion of the acquisition. As at 31 March 2020, 20% of our dental practices were organised as partnerships.

We have in the past experienced an increased unwillingness on the part of NHS Regions to assign contracts, and most of our recent acquisitions have therefore been undertaken pursuant to the partnership structure described above.

Acquisition opportunities

Whilst the UK dental market is highly fragmented, with approximately 11,725 high street dental practices (according to the 2019 LaingBuisson report on Dentistry), only a small number of high-quality acquisition targets meeting our criteria come up for sale in any given year.

Competitors

We compete in the UK dental services market, a highly fragmented market consisting of a variety of for-profit and not-for-profit groups. According to LaingBuisson, the UK dental services market is made up of 11,725 high street dental practices. {my}dentist is the leading provider of dental services in the United Kingdom with 597 dental practices as at 31 March 2020. The remainder of the market is made up of smaller corporate groups, independent practices and dentists working as sole practitioners. Our market share in terms of revenue was approximately 6% for the twelve months ended 31 March 2020. Our next largest competitor, Bupa Dental has over 470 dental practices in the UK and the Republic of Ireland. Whilst we do not compete with any one competitor in each of the local markets for dental services in which we operate, we do generally experience significant competition at the local level from independent dental practices for such services, and that competition may be intense. We compete with other dental practices in both tendering for new NHS dentistry contracts through the NHS tender and in driving customer demand and thereby UDA delivery rates.

DD also competes with a number of other providers in the market for the provision of supplies and services to third-party dental practices. This market is also highly fragmented, particularly as many of the larger dentistry practices prefer to purchase from multiple suppliers. The most significant competitor in this area is Henry Schein, which, together with DD, is a leader in the market. Our {my}dentist dental practices purchase their dental consumables, materials and services from DD exclusively, except in cases where DD does not offer the required consumables, materials or services.

Regulation

We are subject to regulation by the UK Government (and the Scottish Government in relation to our practices located in Scotland) and we are particularly impacted by laws relating to the provision of dental services and quality of care, as well as the regulations of the Department of Health. Discussed in more detail below are some of the key laws and regulations under which we operate.

As a provider of primary healthcare services within the NHS we are subject to a complex legislative framework designed to ensure that people who use healthcare services such as those provided by us are protected and certain standards of quality and safety are met.

The CQC is an independent body which regulates the provision of health and social care services in England. Its main objective is to protect and promote the health, safety and welfare of those using such healthcare services. The CQC's functions include the registration of healthcare service providers and the ongoing monitoring of such providers through inspections, data analysis and other checks to ensure that standards of quality and safety are met and to encourage ongoing improvements by such providers. The results of such reviews and inspections are published by the CQC and are available for public inspection.

The services provided by our dental practices fall within the scope of regulated activities under healthcare legislation and like all relevant service providers we must be registered with the CQC. The regulations stipulate that where the service provider is a body corporate, an individual must also be registered and shall be responsible for supervising the management of the carrying on of the provision of the services by that provider. There are various registration requirements which include providing a statement of purpose setting out the aims and objectives of the service provider and details of the locations at which the services will be provided. All our dental practices are duly registered with the CQC and we have a dedicated team who deals with our CQC registrations and the provision of information to the CQC.

The CQC maintains a public register of all registered service providers and the activities carried out by them, and we are obliged to notify the CQC of certain changes affecting the carrying on of the services (for example, where the service provider is a partnership, it must notify the CQC of any changes in the membership of the partnership) and the occurrence of certain incidences in the provision of such services, which might include allegations of abuse, matters reported to, or investigated by the police and physical damage to the premises which may have a detrimental

effect on the care provided. Failure to register with the CQC or non-compliance with the registration requirements may result in both criminal and civil sanctions. The CQC is also empowered to take enforcement action if a registered service provider fails to comply with relevant regulations. The regulations provide that all service providers are required to take proper steps to assess and monitor the quality of services being provided and ensure the proper care and welfare of patients. For example, service providers are required to consider the safety and suitability of the premises and equipment used, ensure that appropriate standards of cleanliness are met, have effective complaints procedures in place and maintain accurate patient records. Further, service providers must ensure that they have sufficient levels of staffing and recruit staff with the necessary qualifications, skills and experience. Our CQC registrations manager and clinical directors, amongst others, oversee the provision of services at our dental practices to ensure that our practices meet all applicable CQC standards.

An important part of the CQC regulatory framework is the maintenance of up-to-date registrations. This is particularly relevant to us when we acquire practices and need to ensure that adequate time is allowed for the transfer of registrations from the vendor to us. We continuously review our processes and controls in order to minimise the risk of any such incidents occurring and to ensure that the highest levels of CQC compliance are maintained.

There are specific regulations governing dental services contracts. The regulations applicable to both GDS and PDS contracts set out the conditions which must be met by a service provider before a contract for the provision of dental services will be provided by an NHS body. Where applicable conditions are satisfied, a GDS contract may be provided to an individual dental practitioner, partnership, dental corporation or limited liability partnership ("LLP") and a PDS contract may be provided to an individual dental practitioner, a dental corporation, a company limited by shares or an LLP. The regulations also prescribe the terms to be included in such contracts, which include: the services to be provided and the manner in which they are to be provided to patients (including the practice address and surgery hours); the type and duration of the contract; the applicable fees and charges; conditions to be met by those who perform the services and provisions regarding complaints; patient records; the provision of information and rights of entry and inspection; and sets out procedures for dispute resolution and the variation and termination of the contract.

Generally, under a GDS contract, the service provider will be required to provide a range of dental services and, in most circumstances, on an ongoing basis subject only to specific termination provisions set out in the legislation. A GDS contract generally provides greater flexibility by allowing the service provider to form partnerships and change the membership of partnerships. PDS contracts are typically granted for a fixed term and do not include any provision for the service provider to form partnerships. However, if mandatory (i.e. general dental and not specialist) services are provided under the PDS contract, the service provider has the right to apply to NHS England to convert the PDS contract into a GDS contract.

Since we also operate dental practices in Scotland, Wales and Northern Ireland, we are subject to regulation relating to the provision of dental care in those jurisdictions, which may differ from regulation relating to the provision of dental care in England.

DD is subject to regulatory oversight by the UK's Medical & Healthcare products Regulatory Agency in respect of the purchase, storage, sale and distribution of controlled drugs and medicines. Failure to comply with these regulations could result in fines or penalties, including the denial of the ability to supply certain or any controlled drugs or medicines.

Environment, health and safety

We are subject to numerous separate laws and regulations relating to the protection of the environment and human and occupational health and safety, including those governing the handling, transportation and disposal of hazardous and medical waste. These laws and regulations are enforced either at the national level (particularly in the case of health and safety) or at local level. Fire safety laws are enforced by the local fire inspectors and environmental laws enforced by local authorities.

The most significant occupational health and safety law is the Health and Safety at Work etc Act 1974 (the "Health and Safety Act"). The Health and Safety Act imposes a duty of care upon us, not only to our employees but also to our patients and to any visitors to our facilities. We are required to take care to prevent serious accidents and to eliminate from our facilities conditions that could lead to such accidents. Our business activities are, in particular, exposed to significant risks, relating, for example, to the transmission of infections (including blood-borne infections, such as HIV) and other risks associated with medical practices generally and dental practices specifically. There are also similar and specific risks associated with our DD business, particularly its warehouses and dispensaries, and in the supply of equipment. We have experienced in the past, and likely will experience in the future, violations of health and safety regulations. We have a dedicated team of experienced health and safety experts to meet our health and safety requirements and address any violations that may occur.

With regard to environmental legislation, the most significant law is the Environmental Protection Act 1990–Part II as amended (the "Environmental Protection Act"). The Environmental Protection Act mandates that all waste is disposed of through a licensed waste disposal agent and that all hazardous and non-hazardous waste disposals be supported by approved documentation. In that respect, we ensure that we only use approved and licensed waste carriers and recyclers.

Failure to comply with such laws and regulations in the future could subject us to, amongst others, civil and criminal fines and penalties, enforcement actions, the suspension or termination of our licenses to operate or third-party claims. See "Risk factors—Risks related to our business—Our business activities are exposed to significant health and safety risks, and we may also be subject to future liability due to unforeseen health and safety risks."

We are also committed to reduce the impact of our business on the environment. As a major dental care service provider, we produce a considerable volume of clinical waste at the dental practice level. We have partnered with a waste management company to ensure this waste is collected, processed and disposed in line with all relevant environmental regulations.

Immigration

We have historically relied on foreign dentists (both from within and outside the EEA) to the extent required to address shortfalls in UK dental graduates and UK-qualified dentists to fill vacancies in our dental practices. In such cases, and even though our dentists are independent contractors not employed by us, we must comply with relevant immigration laws for non-EEA workers. In particular, the Immigration, Asylum and Nationality Act 2006 (the "IANA") imposes civil and/or criminal penalties on the provision of work to adults who are subject to immigration controls and have not been granted leave to enter or remain in the United Kingdom or whose leave is invalid, ineffective or subject to conditions preventing them from accepting employment ("illegal workers"). Under this legislation, an employer is subject to civil fines of up to a maximum of £20,000 per worker if it employs an immigrant in a job for which he or she is not authorised. Changes to the law made as at February 2008 created a criminal offence of knowingly employing an illegal worker. From July 2016, this offence has been widened such that it is a criminal offence if the employer knows, or has reasonable cause to believe, they are employing an illegal worker. Employers prosecuted under the IANA can establish a defence by proving that they checked, copied and retained specific types of documents as specified by the UK Government prior to the commencement of employment. In addition, NHS Regions review the immigration papers of foreign dentists as part of their approval process.

Suppliers

The primary equipment and materials required to conduct our business include dental practice equipment such as dental chairs, diagnostic equipment, general dentistry materials, such as the amalgam, other components for fillings and bridges, radiology equipment, hygiene equipment and other general dental care products.

Dental appliances such as crowns, dentures and bridges are supplied to {my}dentist's dental practices by third-party laboratories and the costs of such supplies are shared equally between us and the self-employed dentists working in that practice.

In part as a result of the establishment of DD, we centralise and insource the procurement of equipment and materials used in {my}dentist's dental practices to generate economies of scale and lower our costs. {my}dentist's dental practices purchase their dental consumables, materials, equipment installation, maintenance and engineering work, as well as any other products that DD offers internally. We also negotiate volume discounts with our external suppliers of non-dental supplies, including for DD.

We generally do not enter into long-term supply commitments with our suppliers and actively look to negotiate volume discounts with them. Whilst we believe that the large amount of supplies purchased by DD are readily available from a large number of suppliers, some of the more specialised items, such as handpieces, may only be available from a few suppliers, and any disruption or loss of such suppliers could negatively impact our ability to supply {my}dentist and impact DD's ability to supply its third party customers.

The group has an anti-slavery and human trafficking policy which reflects our commitment to acting ethically and with integrity in all our business relationships and to implementing and enforcing effective systems and controls to ensure slavery and human trafficking is not taking place anywhere in our supply chains. Relevant staff undergo training to ensure that they possess a high level of understanding of the risks of modern slavery and human trafficking occurring within our supply chains and our business and to ensure they are aware of how to report any concerns they may have. In addition, the group is developing a system for supply chain verification, whereby the organisation evaluates potential suppliers before they enter the supply chain. We are also reviewing our existing suppliers and, where necessary, contacting them to ensure that they agree to comply with the requirements of the Modern Slavery Act 2015 and the group's policies.

Billing and payment

We have no material billing requirements in respect of patients of our NHS dentistry services. Patients contribute to the cost of NHS dentistry services depending on the type of dental care service they receive, with the balance of payment paid by NHS England. The patient contribution is set by the NHS and revised annually. The full amount is contributed by the NHS when patients are exempt from payment. Exempt patients include students under 19 years of age, the unemployed, new and expectant mothers, and pensioners. In addition, certain low income patients may be entitled to partial exemptions, depending on their income. Our private dentistry services are entirely funded by our patients, whether through out-of-pocket payments or certain dental insurance or payment plans. Private dentistry services are typically paid as of the time of treatment. Whilst most patients opting for private dentistry services pay out-of-pocket, we also accept payment under certain dental insurance plans.

Payments under our NHS dentistry contracts are made to us by NHS England, with payment of 1/12th of the contract value paid at the beginning of each month. We collect patient contributions on behalf of the NHS and remit such amounts to the NHS in arrears approximately two to six weeks thereafter. Three to six months following the contract year-end (31 March), we receive a statement detailing each UDA performance under each contract. If, at the end of the contract year, a practice has not performed all the UDAs allocated under its contract, NHS England may seek to reclaim UDAs paid for but not performed. Any payment of reclamation must be made after the end of the contract year of underperformance although repayment may be made in-year if both parties agree. We also receive mid-year UDA performance statements and, if a dental practice has failed to meet 30% of its annual target by 30 September, the NHS Region may adjust payments made under such contract for the remainder of such contract year to correspond to an annual performance of two times of what the dental practice has achieved to 30 September. Dental practices are only paid for exceeding the number of UDAs contracted on a case-by-case basis upon approval by NHS England.

Real and personal property

We lease our executive offices, which are located at Europa House, Europa Trading Estate, Stoneclough Road, Kearsley, Manchester, M26 1GG, United Kingdom. At 31 March 2020 we were also party to 654 other property leases, which includes 597 active dental practices in various locations throughout the United Kingdom, 20 leased or licensed car parks, DD's central warehouse and eight other leased properties used by DD. We typically lease dental surgeries on behalf of our dental practices pursuant to long-term leases. In some cases we also lease space for our dental practices from NHS Regions.

Rates (UK business property taxes) paid in respect of a dental practice are reimbursed to us by NHS England in proportion to such dental practice's proportion of NHS dentistry services performed to private dentistry services and, as a result, the majority of the rates paid in respect of our dental practices are reimbursed. Our property portfolio is managed internally by a property management team and supported by external specialists where appropriate. Part of our central property management support function involves regulatory compliance in connection with our properties. Our property management team also manages a defined capital expenditure cycle and dilapidation schedule in respect of our leased and freehold properties.

We are also party to certain operating leases in respect of approximately 204 vehicles leased by us for use by certain members of our management team, including certain of our clinical directors, area development managers and sales and engineering staff within DD, as well as operating leases in respect of office equipment, such as copier machines.

Intellectual property

Whilst our know-how, copyrights, business processes and other intellectual property rights are important to our business, we do not consider any single piece of intellectual property to be of material importance in relation to our business as a whole. We are not currently engaged in any material intellectual property litigation, nor do we know of any material intellectual property claims outstanding. We believe we have registered all relevant trademarks associated with the "{my}dentist" brand.

Information technology systems

IT systems impact virtually all aspects of our business, including record-keeping, patient information processing and storage, data security, marketing and sales, compliance logistics and practice and performance management. Our IT strategy is driven by the dual goals of promoting growth of our business whilst ensuring data security.

We have implemented a centralised IT platform for {my}dentist that brings together many of our IT functions in one data warehouse based at our support centre and managed by an experienced team of information specialists. Our practice performance management IT systems are critical to the management of our business, and we have implemented unified practice management software across our entire estate of dental practices and dashboard capabilities for our Area Development Managers and Directors of Region working in our dental practices to monitor

performance. In addition, we are developing backup and recovery databases for use in our support centre and dental practices. These systems back up our data several times a day to make sure that the abundance of sensitive patient information we have stored at our many dental practices is safely managed in one central location.

Our IT systems have been updated in order to comply with the requirements of the European data privacy regime under the European General Data Protection Regulation ("GDPR"), which became applicable from May 2018. GDPR will further increase the regulatory requirements as well as introduce the potential for large fines for non-compliance. In addition, we continue to prepare for any potential changes to data retention and regulation that could be introduced as part of changes to the NHS dentistry contract framework.

We operate a separate, bespoke IT infrastructure for DD that manages warehouse operations, inventory control and logistics. A web portal system has been implemented which allows practice managers and dentists from across {my}dentist to review an e-catalogue and order products for their practices via this web portal. The use of such an e-catalogue provides our dental practices with access to a select list of product lines suitable for both the provision of NHS and private dentistry services while enabling us to keep the cost of materials used by our practices within agreed parameters.

We also leverage our IT systems in its sales and marketing strategy by, for example, search optimisation and improved website functionality.

Independently contracted dentists and employees

Dentists working in our dental practices are self-employed and independent. As at 31 March 2020, we had approximately 2,800 dentists working in our 597 dental practices, either part-time or full-time. We also have arrangements with approximately 280 dentists, which we refer to as locums, who as at 31 March 2020 were not assigned to a single practice, but can fill dentist vacancies on an as-needed basis to provide dental services where they are most needed. We also have approximately 87 practising dentists who are our employees and are referred to as regional dentists and foundation dentists. We individually negotiate the associate contracts with dentists working in our dental practices, and so are able to vary the compensation paid to dentists based on prevailing rates in the applicable local markets for dentists. Under our associate contracts with dentists, dentists receive a fixed percentage fee per UDA delivered, in the case of NHS dentistry services, and a percentage of fees paid for private dentistry services delivered. Contracts with dentists in our dental practices typically are for a term of two years and include non-compete terms that prevent dentists from competing against us for our NHS dentistry services patients within a certain geographic radius of our dental practice.

We also employ highly skilled dental support staff who provide a broad range of clinical and administrative support services for our dentists, including 28 clinical technicians (all of whom are self-employed, independent contractors) in our practices across the UK. In addition, as at 31 March 2020, 640 hygienists worked across our practices, the majority of whom were self-employed, independent contractors.

The following table sets out the number of our dentists and dental support and central staff, as at 31 March 2020:

	As at 31 March 2020
Self employed dentists, including locums	3,021
Self employed hygienists	640
Dental, support and central staff, including employed dentists and hygienists	6,312
DD staff	563
Total	10,536

Insurance

Our operations are subject to various actual and potential claims, liabilities, hazards and disasters. We carry a variety of insurance policies, including policies in respect of property and material damage, business interruption, combined commercial liability, and directors' and officers' liability. We believe that our insurance coverage is adequate and customary for a business of our size in our industry. Our self-employed, independently contracted dentists are obliged by professional licensing standards to carry their own medical negligence insurance, and we are typically not subject to medical negligence liability claims.

Legal proceedings

In the normal course of our business, we may be involved in legal, arbitration or administrative proceedings. Additionally, we operate in a closely regulated industry. As such, in the ordinary course of business, we are subject to national and local regulatory scrutiny, supervision and control. Such regulatory scrutiny often includes inquiries, investigations, examinations, audits, site visits and surveys, some of which are non-routine.

We are currently, and have in the past been, subject to employment tribunal claims brought by former employees.

On the basis of current information, we do not expect that the actual claims, lawsuits and other proceedings to which we are subject, or potential claims, lawsuits and other proceedings relating to matters of which we are aware, will ultimately have a material adverse effect on our results of operations, financial condition or liquidity.

From time to time we are subject to claims and disputes related to the recoupment of amounts paid under NHS dentistry contracts and other disputes with NHS Regions and NHS England. Each of the claims arises from allegations of overstated contract payments, or patient charge collection claims.

Risk factors

Investors should carefully consider the risks described below together with all of the other publicly available information regarding IDH before making an investment in the Notes. The risks below are not the only risks we face. Additional risks and uncertainties not currently known to us or that we currently consider immaterial may also materially and adversely affect our business or operations. Any of the risks described herein could have a material adverse effect on our results of operations and financial condition and our ability to service our debt, including the Notes. In such a case, investors may lose all or part of their investment in the Notes.

Risks related to our business

Our business and industry has been, and will continue to be, severely impacted by the effects of the Covid-19 pandemic and the resulting economic slowdown.

In late 2019, a novel strain of coronavirus, Covid-19, was first detected and in March 2020, the World Health Organization declared Covid-19 a global pandemic. Since the outbreak of the Covid-19 pandemic, governments of many countries, including the United Kingdom, have taken preventative measures to try to contain its spread, including mandatory closure of businesses, social distancing requirements and travel restrictions. These measures have severely diminished the level of economic activity around the world and in the United Kingdom and resulted in a global economic slowdown. The Covid-19 pandemic has had, and we expect it will continue to have, a significant impact on our patients, our clinicians and employees and our suppliers, particularly in the event of any recurrence of outbreaks and consequent lockdown measures whether at the local or national level. The severity of the economic effect, levels of unemployment, and the speed and nature of the recovery will all impact our performance in the near term.

In March 2020, we began providing emergency cover only with no aerosol generating procedures (AGP), operated a telephone-only triage service and were not able to provide private treatments. Dental practices were permitted to re-open to routine treatments in England in early June 2020 and phased re-openings in Scotland, Wales and Northern Ireland were permitted later in June and July 2020 subject to certain revised operating procedures. Within {my}dentist, the revised operating procedures required for healthcare settings, including additional personal protective equipment (PPE) requirements, the higher costs of PPE, limits on performing certain procedures and fallow period requirements between patient appointments, have impacted and will continue to impact productivity and the potential revenue an individual clinician and surgery can generate. Furthermore, if the measures we have undertaken in response to the COVID-19 pandemic are not effective, or if patients do not perceive our response to be adequate, we could suffer damage to our reputation and our brand, which could materially adversely affect our business. There is also uncertainty over the speed at which patients will choose to return to medical settings, particularly for elective procedures. In addition, we may experience a lack of availability of clinicians and staff due to quarantine measures, illness or if they have medical conditions that prevent them from returning to practice. Economic conditions affecting the profitability of dental practices will also affect their ability to afford services and materials provided by DD. While shortfalls in delivery due to the COVID-19 pandemic have to date been supplemented by NHS support payments, our future performance may depend on continuing support from the NHS.

In addition, the Covid-19 pandemic and resulting economic slowdown has caused us to modify our business practices, particularly with respect to our liquidity position and near-term cost structure. We have fully drawn our revolving credit facility to increase our cash position, utilised the Coronavirus Job Retention Scheme to furlough staff, reviewed our fixed and variable cost base and halted certain capital expenditures. In the event that the business interruptions caused by Covid-19 require us to seek other sources of liquidity, there can be no guarantee that additional liquidity will be readily available or available on favorable terms and in an amount sufficient to fund our needs. Our ability to meet our obligations under our outstanding debt may also be impacted, which may require us to seek covenant relief and there can be no assurance that such relief would be available on acceptable terms or at all. Furthermore, financial markets and economies worldwide have been negatively impacted by the Covid-19 pandemic and economic slowdown, and could result in a global recession. Any deterioration in financial markets could impair our ability to obtain financing in the future, including our ability to incur additional indebtedness to fund our ongoing operations or other liquidity needs, or to refinance our indebtedness.

The full impact of Covid-19 on our business and industry remains uncertain and will ultimately depend on a number of factors that cannot be accurately predicted at this time and are beyond our control, including, but not limited to, the duration including the extent of any future outbreaks and resulting containment measures, the timing and ability of vaccination and other treatments, unemployment rates and the length of time it takes for normal economic and operating conditions to resume. While we are undertaking measures to minimise the impact on long term performance, the Covid-19 pandemic will reduce short term profitability and we cannot make any assurances that the measures we have undertaken will be successful. If the measures are not successful, our business, financial condition and the results of our operations could be materially adversely affected, and it could result in materials changes to our business, financial condition and results of operations or prospects. To the extent the Covid-19

pandemic adversely affects our business, financial condition, results of operations and prospects, it may also have the effect of heightening many of the other risks described herein.

We may fail to deliver UDA volumes under our NHS dentistry contracts, or we may reach those volumes over a longer period of time than originally expected, which could have a negative impact upon our results of operations and the financial performance of our business.

Many of our NHS dentistry contracts require the dental practice holding the contract to reach certain volumes within a certain period of time. If, whether due to underperformance, poor management, lack of demand or any other reason, a dental practice suffers cumulative UDA underperformance of more than 4% (or 5% in Wales), volumes under the contract may be reduced, or, if the cumulative effect of breaches are prejudicial to the services to be provided under such NHS dentistry contract, the entire contract may be lost. The long term effect of the Covid-19 pandemic may be to make it harder for us to deliver our UDA volumes whether through changes in customer sentiment, lower numbers of clinicians willing to practice in the United Kingdom or through lost productivity from increases in appointment times or turnaround times between appointments.

In addition, as we are paid each month for 1/12 of the contract value under NHS dentistry contracts, any underperformance in terms of UDA delivery must be repaid to the NHS after the end of the contract year of underperformance. In certain instances, the underperformance can be repaid during the contract year. Significant underperformance could thereby result in large repayments to the NHS, and we may not have cash or financing available at such times to make such repayments, which could adversely impact our financial condition.

Industry-wide factors have resulted in a decrease in our UDA delivery rates, which negatively impacts our revenues from NHS dentistry services.

During the twelve months ended 31 March 2020, we continued to experience a decline in UDA delivery rates with respect to the NHS dentistry services provided by {my}dentist. Our UDA delivery rate, after temporary and permanent handbacks, for the contract year ending 31 March 2020 was 81.5% compared to 85.7% for the year ended 31 March 2019, 86.1% for the year ended 31 March 2018, 90.4% for the year ended 31 March 2017, 92.4% for the year ended 31 March 2016 and an average UDA delivery rate of 96.8% for the five years ended 31 March 2015. Before handbacks, our UDA delivery rate for the year ended 31 March 2020 was 79.3% compared to 80.0% for the year ended 31 March 2019. The long term reduction in UDA delivery rates in our core business of NHS dentistry services resulted in a decline in revenue and therefore impacted EBITDA before non-underlying items in previous years. The decrease in FY2020 related to a reduction in the number of in-year handbacks.

We believe that this decline in our UDA delivery rates is a result of a number of factors leading to dentists wanting to reduce the number of UDAs they are willing to complete in a year and the number of hours they are willing to provide for NHS services. There has also been a decrease in the number of exempt patients we treat in each year. These factors, along with the steps we have taken to improve patient choice which has contributed to growth in our private revenues have reduced the volume of UDAs completed. In order to deliver the same volume of NHS treatment, {my}dentist needs to recruit more dentists. There is no guarantee that we will be able to recruit sufficient dentists to address the decline, or that we will continue to be able to recruit dentists at a sufficient rate to replace leavers. The Covid-19 outbreak may make the United Kingdom a less attractive option for overseas dentists in the future.

Moreover, the decrease in the number of exempt patients, such as students under 19 years of age, the unemployed, new and expectant mothers and pensioners, exempt from payment ("exempt patients"), has resulted in a decline in the mix of UDA bands delivered, since exempt patients typically receive services requiring a high number of UDAs per course of treatment.

While we are undertaking measures to recover UDA performance, we cannot make any assurances that such measures will be successful, or that the loss of revenues from UDA delivery rates will be offset by increases in the provision of private dentistry services or NHS dentistry contract price uplifts. Furthermore, we may face continued NHS scrutiny in the future that may offset any measures we take to address UDA delivery rate declines. See "Management's discussion and analysis of financial condition and results of operations—Significant factors affecting results of operations—{my}dentist—Industry-wide factors affecting UDA delivery rates." In addition to its impact on revenue, a drop in UDA delivery also increases the risk that NHS Regions may seek to renegotiate the number of UDAs contracted under certain of {my}dentist's NHS dentistry contracts or even, in an extreme scenario, terminate certain NHS dentistry contracts. A continuation of the decline in UDA delivery rate over an extended period of time may have a material adverse impact on our financial condition.

We may be subject to claims for recoupment of amounts paid under NHS dentistry contracts.

We are paid for NHS dentistry services under each of our 548 NHS dentistry contracts in equal monthly instalments of our annual contracted value. As such, we may receive payment for services not yet rendered, or for services that

will not be rendered. Following the close of the contract year, or in some cases, after renegotiation with the NHS in year, we may be subject to claims for recoupment of amounts paid under NHS dentistry contracts where we were overpaid in respect of underperformance of UDA delivery. If we are found to have been overpaid in respect of a NHS dentistry contract, such sums may be subject to recoupment by NHS England. Although management has conducted a thorough analysis of the impact of such claims, amounts claimed in respect of such recoupment may be significant, and if we do not have cash or financing available at the time the recoupment is required, it may be difficult for us to repay such amounts. In addition, if a dentist working in one of our dental practices fraudulently claims UDAs in respect of services not actually performed, we may be liable for reimbursing NHS England for amounts received in respect of such NHS dentistry contract, and we may be unable to effectively recoup our losses from the fraudulent dentist.

We could be unsuccessful in re-tendering for some, or all, of our NHS orthodontic dentistry contracts, or we may only retain our existing contracts at reduced unit prices or volumes.

The majority of our contracts to deliver NHS orthodontic dentistry services are time-limited PDS agreements. In previous years, PDS contracts have typically had a duration of between three and five years and, therefore, we were periodically required to competitively re-tender for these contracts. The NHS Regions have also over the last two years run a competitive re-tendering process for the majority of its PDS contracts to deliver orthodontic dentistry services across England. The early tender results in the South of England identified a clear trend in terms of reductions in rate for orthodontic services and a smaller overall contract size as the NHS looks to increase the number of treatment locations. With the trend for smaller contracts, it is likely that the overall size of our orthodontic practice NHS contracts will reduce in size. In mitigation, the group is exploring options to provide more private orthodontics including using products such as clear aligners for the treatment of adults. However, the contract process is suspended at present in certain regions due to the volume of legal challenges raised on contract awards and inconsistent bid marking.

We may be unsuccessful in retaining some, or all, of our orthodontic dentistry contracts as a result of this re-tender exercise. Alternatively, we may retain some, or all of our existing contracts, but for a lower volume of UOA's, or at a lower price per UOA. Any loss of revenue that results from us failing to retain an existing contract, or retaining an existing contract but with a lower volume, or at a lower price per UOA, will have a corresponding impact upon our financial condition and results from operations.

Furthermore, loss or reduction of a contract may lead to a conclusion that the affected dental practice may no longer be viable. As a result, we may need to take the decision to close or sell the affected practice, or practices, with the risk that we cannot recover the carrying value of the associated assets and that we may incur significant additional closure related costs. Both of these factors could have an impact upon our results from operations and financial condition.

In the event that we are awarded additional contracts through this tender exercise, in locations where we do not currently have a dental practice, there is a risk that we are unable to deliver these contracts if, for example, we are unable to find suitable premises, or if we are unable to recruit sufficient new dentists with the appropriate skills, in time to enable us to open the new practices by the contract start date. This could adversely impact the reputation of our business, as well as our results from operations and financial condition.

Furthermore, developing the facilities to deliver a new contract may require significant capital expenditures. If we do not generate sufficient cash flow from our operations or have funds available for future borrowing under our existing credit facilities to cover these capital expenditure requirements, we may not be able to make such capital expenditures, which may negatively impact our revenues and profitability and, ultimately, we may breach the terms of any new contracts.

Our inability to attract and retain dentists, hygienists, nurses, practice managers and other key dental professionals could adversely affect our business, financial condition and results of operations.

The success of our dental practices depends on attracting and retaining qualified, skilled and experienced dentists, therapists, hygienists and nurses. Our success also depends on our ability to attract and retain qualified practice, area development and regional managers, in addition to senior management at the group level.

Over the past five financial years, we have experienced a reduction in our UDA delivery rates, as a result of disposals of loss making sites, a reduction in the number of hours dentists provide for NHS work, a reduction in the volume of contracted UDAs held by dentists, and the impact of growth in private revenues. When combined, these factors have led to localised shortages of dentists within some of our practices, as the availability and distribution of NHS dentists can vary widely across regions. As a result, we need to recruit additional dentists in order to fulfill our NHS contracts. In addition to the actions we have taken to increase UDA performance by working with dentists to increase their productivity, we have increased recruitment, both from within the UK and overseas, to increase capacity. Although we see an increase in the net number of dentists the recruitment of additional dentists will take

time, as the clinical recruitment cycle can take a minimum of four months due to notice periods and the time taken to complete regulatory registrations. It can take significantly longer (between six and nine months) to recruit an overseas based dentist for NHS services. Furthermore, it takes time for newly appointed dentists to settle into the business and for their productivity to increase to normal levels. There can be no guarantee that we will be able to recruit sufficient dentists to address the shortage we currently have, either on acceptable terms, or at all.

We have previously experienced similar periods in which a shortage of qualified dentists in the United Kingdom and our inability to fill vacancies had a negative adverse effect on our operations, and we may experience similar periods in the future. In particular, our ability to attract and retain dentists could be negatively affected by any adverse change in our reputation, and this risk may be exacerbated by our brand. Vacancies, whether localised or on a national scale, result in lower rates of UDA delivery and may partly reflect variable levels of spending on NHS dentistry by the NHS, and thereby affect our ability to perform under our contracts and our results of operations. Furthermore, our plans for future talent sourcing and retention of highly trained dental professionals may not materialise or may be more expensive than expected. We have historically experienced a high rate of turnover among our dental nurses. Increases in the national living wage in the United Kingdom may result in an increase to our staff costs, or may result in additional turnover among our dental nurses as the pay for other types of work will increase. The impact of the Covid-19 pandemic may reduce the number of people applying to train as a dentist or as a dental nurse as they wish to avoid clinical settings, this could reduce the pool of available workforce for us and increase the cost of future talent.

Our business depends on personal relationships and the professional reputation of our dentists, whose patients refer other patients to our dental practices. Dentists who have left our practices and who have strong relationships with their local health community may draw business away from us. If we lose, or fail to attract and retain, skilled dentists, hygienists, nurses and other key dental professionals, our revenue and earnings could be adversely affected.

When it has been necessary in the past, we have attempted to overcome shortages in the supply of dentists, hygienists and nurses in the United Kingdom by recruiting dentists, hygienists and nurses from outside the United Kingdom, particularly from South Africa and Eastern Europe. If shortages in the supply of dentists, hygienists and nurses in the United Kingdom continue, or occur again in future, we may be unable to fill vacancies if immigration processing and obtaining NHS and GDC approvals (including language tests) becomes more difficult, particularly for dental professionals who are not citizens of the EEA. Such difficulties may be exacerbated by the United Kingdom's withdrawl from membership of the European Union, particularly if such withdrawal results in greater restrictions on the movement of people between the European Union and the United Kingdom. An inability to fill vacancies with non-UK citizens during times of shortage of dental professionals in the United Kingdom could result in underperformance in our contracts and a corresponding loss of revenue or, if such underperformance is significant and persistent, decreased volumes under, or losses of, our NHS dentistry contracts.

We spend substantial resources and time training our staff, and any increase in staff turnover in an industry where shortages in the supply of qualified dentists is common could increase our operating costs and impact the quality of the services we provide.

Our business activities are exposed to significant health and safety risks, and we may also be subject to future liability due to unforeseen health and safety risks.

Health and safety risks are inherent in the services that we provide and are always present in the dental practices that we operate. Our business activities are, in particular, exposed to significant risks, relating, for example, to the transmission of infections (including blood-borne infections, such as HIV) and other risks, to dentists, employees and patients, associated with medical practices generally and dental practices specifically. Furthermore, we sell dental equipment and supplies, as well as, through Med-FX, facial aesthetic products, and have warehouses and logistic systems which are also subject to health and safety regulations and standards. If an incident occurs because of a failure to comply with health and safety regulations by us or our employees or as a result of a defective product sold by us, we may be held liable or fined, and any registration certificates or licenses we require to operate our business or our dental practices could be suspended or withdrawn for such failure. This may have a material adverse impact on our reputation, business, financial condition, results of operations and prospects. From time to time we have experienced health and safety incidents.

Our operations are subject to licensing and regulation under national and local laws and regulations in the United Kingdom relating to the protection of human and occupational health and safety, including those governing the handling and disposal of medical samples and biological, infectious and hazardous waste, as well as regulations relating to the safety and health of dental professionals and staff. Our dental practices are also required to comply with specific regulations for dentists, including sterilisation and decontamination rules. In addition, we must meet extensive requirements relating to workplace safety for personnel in dental practices who could be exposed to various biological risks such blood-borne pathogens (including HIV), which require work practice controls,

protective clothing and equipment, training, medical follow-ups, vaccinations and other measures such as needlestick prevention.

Moreover, we could incur substantial costs and sanctions, including civil and criminal fines and penalties, enforcement actions, or the suspension or termination of our licenses to operate as a result of violations of our responsibilities under these laws and regulations, which could have a material adverse effect on our business. We also may become subject to claims from employees or other persons, such as those alleging injury or illness resulting from exposure to materials they handle or to which they are exposed or to patients with whom they come into contact.

Health and safety regulations are likely to become more stringent over time, and our costs to comply with these requirements are likely to increase.

We handle personal data including sensitive patient data in the ordinary course of our business, and any failure to maintain the confidentiality of that data could result in legal liability for us and reputational harm to our business.

We receive, generate and store significant volumes of personal data including sensitive information, such as patients' medical information. We are therefore subject to privacy laws and regulations and related security protocols with respect to the use, transfer and disclosure of protected health information intended to protect the confidentiality, integrity and availability of such information, and the privacy of the individuals.

Privacy regulations and related security protocols establish a complex regulatory framework on a variety of subjects, including:

- the circumstances under which the use or disclosure of protected health information is permitted or required without the specific freely given consent of the patient;
- a patient's rights to access, amend and receive a statement of certain disclosures of protected health information;
- requirements to notify patients of privacy practices for protected health information;
- administrative, technical and physical safeguards required of entities that use or receive protected health information; and
- the protection of computing systems that store protected health information.

The European data privacy regime under the European General Data Protection Regulation ("GDPR"), incorporated into UK law by the Data Protection Act 2018, came into effect from 25 May 2018, and further increases the regulatory requirements as well as increasing the potential for large fines for non-compliance and introducing the payment of compensation to affected individuals.

Even if such data was not subject to the strict regimes imposed by the Data Protection Act 2018, and the GDPR, a failure to comply with equivalent standards could harm our reputation and reduce the number of patients willing to seek treatment with us, or customers willing to purchase supplies from us. Furthermore, as DD sells supplies to dental practices with which {my}dentist competes directly, we need to maintain strict information barriers within the group and any breach of such barriers could lead to fewer customers being willing to transact with us.

If we do not adequately safeguard confidential patient data or other protected personal data, including health information, across all of our operations, or if such information or data is wrongfully used by us or disclosed to an unauthorised person or entity, our reputation could suffer and we could be subject to significant fines, penalties and litigation, either from the ICO, or directly, by any affected individual.

We are exposed to litigation risks, including litigation risks related to medical negligence and disputes with employees.

From time to time we are subject to various actual and potential claims, lawsuits and other proceedings relating principally to breaches of contract, breaches of employment legislation, common law causes of action for civil damages, negligence and personal injury, and other claims. Some of the claims, lawsuits and proceedings against us may involve claims for substantial monetary damages and the cost of defending against such claims has been and may be significant. Moreover, such claims could divert our senior management's attention from our day-to-day operations and negatively affect our business. If we fail in defending such claims, or, in the case of product liability claims related to supplies we sold, we are unable to successfully seek redress against the original manufacturer under any indemnification agreement that might be in place, it may result in substantial monetary damages, which may materially and adversely affect our financial condition and results of operations. Whether or not we are successful in defending against them, such claims may also cause significant damage to our reputation and result in decreased demand for our dental services, thereby making it more difficult to attract dentists, or to retain existing, and/or tender for new, NHS dentistry contracts.

Although we believe that our dentists are solely liable in the case of claims alleging medical or professional negligence, which may be covered by a dentist's professional insurance, claimants may attempt to bring us into proceedings in respect of such claims.

Failures of our information technology systems, including cyber attack, other major incident, or failures resulting from system conversions under the new NHS dentistry contract, could disrupt our operations and cause the loss of UDA claims, customers, patients or business opportunities.

IT systems are used extensively in virtually all aspects of our business, including reporting, billing, patient information processing and storage, logistics and the management of systems monitoring our performance as well as the website through which customers order a substantial portion of the consumables and materials supplied by DD. Our operations depend on the continued and uninterrupted functioning of our IT systems. As part of our efforts to increase our operational efficiency and leverage our economies of scale, upon each acquisition we have centralised and insourced a number of functions previously carried out by individual dental practices, including IT, compliance, regulatory, legal, finance, human resources, health and safety, risk management, talent sourcing, training, marketing, insurance and logistics functions. Whilst we believe centralisation and insourcing of these functions have made our operations more efficient, such activities have to a certain extent also made such functions more vulnerable to a catastrophic failure at the site, or sites, at which the IT systems underlying such functions are physically located. In addition, there is the risk that the process of centralisation and insourcing disrupts the normal functioning of our IT systems, resulting in losses of information or disruption to our operations. IT systems are vulnerable to damage from a variety of sources, including telecommunications or network failures, human acts and natural disasters. Moreover, our IT systems may be subject to cyber attack through physical or electronic break-ins, computer viruses and other similarly disruptive problems.

We record and claim UDAs via our IT systems. If possible changes to the NHS dentistry contract are implemented we could be required to update our IT systems to address changes under the new regime. UDAs may only be claimed under the contracts from which they arose if such claims are made within 60 days of the service giving rise to the UDA claim. If, whether due to our inability to update our IT systems upon changes to the new NHS dentistry contract or to a failure of our information systems or otherwise, we are unable to claim UDAs by the required deadline, such UDAs may be lost and the patient fees retained by the NHS, and we may underperform on the applicable contract. The result of such underperformance may include reduction in UDA volumes or even the loss of such contracts, which could have an adverse effect on our business, financial condition and results of operations.

We also sell a substantial portion of the consumables and materials supplied by DD through the division's various business websites, and any failure of the IT systems underlying these websites could have an adverse effect on the business, financial condition and results of operations of DD.

Failure to continue to comply with quality of care standards could adversely impact our reputation.

We are subject to a high level of regulation and oversight. The CQC is our primary regulator in England, with the equivalent regulators in Scotland, Wales and Northern Ireland being Healthcare Improvement Scotland ("HIS"), Healthcare Inspectorate Wales ("HIW") and the Regulation and Quality Improvement Authority ("RQIA"), respectively. The CQC, HIS, HIW and RQIA set quality of care standards and registration requirements that we are required to meet. Some of these standards are stringent, and require significant costs for us to comply with them. By law, our dental practices in England, Scotland, Wales and Northern Ireland must be registered and licensed with the CQC, HIS, HIW or RQIA, as applicable, to show that they are meeting certain essential standards of quality and safety. Non-compliance with such standards may result in a range of enforcement actions taken by the CQC, HIS, HIW or RQIA, ranging from fines and public admonition to facility closure, and could materially and adversely affect our business, financial condition and results of operations.

Furthermore, those legal entities of the group which sell dental supplies to {my}dentist's and third party practices must be properly accredited in order to sell such products. In addition to the cost of compliance and fines or disruptions to our business, non-compliance, or alleged non-compliance, may lead to unfavourable national press coverage, which could have the effect of damaging our reputation with our patients and with NHS England, NHS Scotland, Health in Wales and Health and Social Care in Northern Ireland and which could materially and adversely affect our business, financial condition and results of operations. This effect could be exacerbated because the majority of our dental practices now trade under the "{my}dentist" brand.

We may not be able to continually enhance our dental care practices with the most recent technological advances in dental care equipment, which could affect our growth prospects and our reputation.

Technological advances in dental care equipment can be rapid and requires a substantial investment of resources by dental practices. Such equipment costs represent significant capital expenditures for us. Rapid technological advances could render existing equipment obsolete earlier than anticipated and result in assessed impairment charges, which may have a material effect on our results of operations. If we are unable to purchase the necessary equipment, our reputation could be negatively affected, which could have a material adverse effect on our business, financial condition and results of operations.

Our inability to retain reputational control of our '{my}dentist' brand, particularly given the increasing use of social media, could adversely affect our reputation, financial condition, business and results of operations.

With the majority of our dental practices operating under a single brand identity, the risk of damage to our business resulting from our inability to retain reputational control of our brand has significantly increased. This is exacerbated through the increasing usage of social media. Our failure to retain reputational control over our brand could significantly impact our business, financial condition and results of operations.

Any change to the legal classification of contracts under our operating partnerships could have a material adverse effect on our business, financial condition and results of operations.

Certain of our clinical directors act as partners in dental practices which we acquire through partnership structures. This allows us to both exercise control over the partnership and maintain the NHS dentistry contract without assigning it to another party, which would require NHS England's consent. If our clinical directors were no longer willing to be identified as partners in our dental practice partnerships, due to, for example, the risks and liabilities associated with acting as partner (for example, in 2015, one of our partnerships was fined and involved in a criminal proceeding due to the inadvertent loss of registration of a partnership due to a technical error), and we were unable to replace them, we could effectively lose the benefit of the relevant NHS dentistry contract with the affected partnership.

The death of one or more of the partners in our dental practice partnerships may result in the surrender of the NHS contracts held by such partnership, and result in the re-tendering of such contracts.

We rely on relevant NHS regulations that permit the transferability of NHS dentistry contracts between partners in a partnership to transfer contracts to our clinical directors. If such regulations were modified it could render us unable to transfer, and thereby benefit from, NHS dentistry contracts held by our partnerships. If we lost NHS dentistry contracts held by our dental practices organised as partnerships because of the death of the partners within those partnerships, which dental practices constituted approximately 20% of our practices as at 31 March 2020, or were unable to transfer such contracts, it could materially and adversely affect our revenues, and therefore our financial condition and results of operations.

Our ability to significantly grow our business relies upon our acquisition strategy and there can be no guarantee that we will resume our acquisition strategy or that sufficient or appropriate acquisition opportunities will be available to us, that financing will be available on acceptable terms or that, once acquired, new businesses will be successfully integrated into our operations.

To date, growth in our dental practice estate has been largely attributable to the acquisition of other small and medium-sized independent dental practices and their integration into our existing network. In recent times, valuations being attributed to dental practices by prospective vendors have increased substantially and, together with our current high levels of gearing and performance decline, have led us to pause our dental practice acquisition programme. As a consequence, we anticipate only limited practice acquisitions activity until market conditions normalise and our gearing levels start to reduce.

The success of our acquisition strategy depends on the ability of our senior management to identify suitable acquisition candidates, to accurately assess the value, strengths, weaknesses, contingent or other liabilities and potential profitability of such acquisition candidates, to obtain any necessary permits or approvals from bodies such as the NHS and the Competition and Markets Authority (the "CMA") to operate such acquisition candidates, attract suitable associate dentists at appropriate rates, and to integrate the operations of such businesses once they are acquired. Our success in making additional acquisitions depends on the availability of, and competition for, suitable acquisition candidates. Successful integration of acquired practices will depend on our ability to effect any required changes in operations or personnel, and may require renovation or other capital expenditures or the funding of unforeseen liabilities. The integration and operation of any future acquisitions may expose us to certain risks, including the following: difficulty in integrating the acquired businesses in a cost-effective manner, including the establishment of effective management information and financial control systems; unforeseen legal, regulatory,

contractual, labour or other issues arising out of the acquisitions; significant unexpected liabilities or contingencies arising from the acquisitions; potential disruptions to our ongoing business caused by our senior management's focus on the acquired companies; and post-acquisition performance not meeting our expectations or plans. There can be no assurance that we will resume our acquisition strategy, or that our future acquisitions will be made on appropriate terms or at an acceptable cost or can be successfully integrated. A failure to identify appropriate acquisitions or to properly integrate them once acquired could have a material adverse effect on our business, results of operations, financial condition or prospects.

In addition to acquiring small and medium-sized chains of independent dental practices, from time to time we may also enter into acquisitions of a larger scale or in complementary markets to our current operations. If we were to undertake such additional acquisitions, the risks associated therewith would be similar in nature to, but of a substantially greater magnitude than, those associated with our more routine acquisitions.

We are subject to competition legislation that affects our ability to acquire dental practices. Whilst the UK dental market is as a whole highly fragmented, we have a high market share of dental practices and UDAs in certain localities. The CMA, the UK's competition regulator, may review acquisitions we make for purposes of compliance with competition law. This could limit our ability to acquire new dental practices and grow, particularly in markets we find attractive. If we do not comply with competition laws, we may be subject to significant sanctions.

We have historically financed acquisitions of dental practices through a variety of sources, including our own cash reserves and debt financing. Whilst we intend to continue to finance acquisitions from these sources in the future, we may have insufficient cash reserves to fund acquisitions and adverse market conditions or other factors may prevent us from obtaining debt finance on acceptable terms or at all.

If we are unable to implement our acquisition strategy, obtain sufficient financing or integrate acquired businesses successfully, our business and prospects for growth could be negatively affected.

The operations of DD are subject to a significant level of competition and regulatory oversight, and are reliant upon transport and warehousing infrastructure in order to generate revenues.

Our DD operations are subject to intense competition from other suppliers and distributors of dental and medical products and equipment. This competition can result in pricing and margin pressures or loss of customers as a result of competitor actions. There is also substantial competition for the services of experienced sales staff, the loss of whom could adversely impact our ability to retain customers. Any significant loss of customers is ultimately likely to have a materially adverse impact upon our revenues and results of operations.

DD is subject to regulatory oversight by the Medicines and Healthcare Products Regulatory Agency ('MHRA') in respect of the purchase, storage, sale and distribution of controlled drugs and medicines. Failure to comply with these regulations could result in fines or penalties, including the risk that we may no longer be able to supply certain or any controlled drugs or medicines. This could have a significant adverse impact upon our revenues and results of operations and could also result in the loss of customers to our competitors due to our inability to provide a complete range of the products and services they require. In addition, to the extent that we inadvertently supplied products that did not meet with regulatory requirements, we could be subject to warranty or compensation claims from our customers. Such claims could have a substantial adverse impact upon our business, results of operations and financial condition and there could be no certainty that we would ultimately be able to recoup such losses from our suppliers.

Our warehousing, supply and distribution operations are also subject to the risk of disruption which could adversely impact our ability to fulfil customer orders and therefore adversely impact our results of operations. Disruption could result from a major incident, such as a fire, at our warehouse which is concentrated in a single location, or disruption to transport infrastructure, both in respect of goods arriving from suppliers, some of which are located overseas, and the delivery of goods to our customers. Such disruption could ultimately also result in the loss of customers to competitors and adversely impact our business, results of operations and financial condition.

Our competitors may not be willing to also be customers of DD.

In the past several years, we have acquired a substantial presence in the dental practice service and supply market, primarily through a number of acquisitions which now form our DD business unit.

However, there is a risk associated with this vertical integration, since certain of our competitors could cancel their contracts with DD which would result in a decrease in our EBITDA. Following the acquisition of DD, we initially experienced a loss of contracts with our competitors. To the extent a significant proportion of DD's third-party dental practice customers cease conducting business with us, it could have an adverse impact on the business, results of operations, financial conditions or prospects of DD.

We are exposed to currency fluctuation risks that could adversely affect our profitability.

DD is subject to a certain degree of foreign exchange risk related to purchases of consumables and materials in Euros and US dollars. We generate revenue in pounds sterling and, because of this, we are unable to match purchases made using Euros or US dollars with revenue generated in these currencies. Significant changes in the value of the pound sterling relative to the Euro or US dollar could adversely affect the results of operations of DD. Although the group's policy is to hedge the pound sterling equivalent costs of a proportion of our foreign currency purchases using vanilla foreign exchange derivative contracts, in order to reduce uncertainty over future cash flows, there can be no certainty that significant fluctuations in foreign exchange rates will not have a materially adverse impact upon our results of our operations.

We rely on continued patient demand for dental care, and a decrease in patient demand, or an adverse change in the UDA band mix that patients demand, could adversely impact our business, results of operations and financial condition.

Our future growth depends on our ability to maintain our existing high-quality services and, through successful sales and marketing activities, increase demand for our dental services. Any number of factors such as health and safety incidents, problems in our dental facilities, negative media or social media coverage, or general patient dissatisfaction, whether legitimate or not, could lead to a deterioration in our reputation and the public perception of the quality of our dental services, which in turn could lead to a loss of business support for our operations. Any impairment of the value of our brand and registration could similarly have a material adverse effect on our business, results of operations, financial condition or prospects. Additionally, the possible transition to a new NHS dentistry contract and a business model that will focus more on patient numbers will make our revenue generation more reliant on patient retention. Demand for our services, particularly for our private dentistry services, is also dependent on macroeconomic factors. To the extent the demand for NHS dentistry services changes in such a way that it reduces the UDA band mix of services we provide, it could impact our UDA delivery rates and, therefore, our revenues. For example, as the UK economy has improved, over the past three years we have experienced a decrease in exempt patients who typically demand higher UDA band treatments since services are provided to such patients without a patient contribution. This change in the UDA band mix, amongst other factors, has impacted our UDA delivery rates and revenues from NHS dentistry services. There can be no guarantee that demand for our services will grow or continue, and any decrease in demand and any such failure could have a material adverse effect on our business, results of operations, financial condition or prospects.

Our costs of operations are subject to price inflation, but UDA values, which make up a majority of {my}dentist revenues, are subject to UK Government determination which may not reflect the actual inflation rate, resulting in increases to our cost of doing business that we are unable to pass on, which could adversely affect our results of operations and financial condition.

We are subject to price inflation in the purchase of our materials and services and to inflation in respect of the fees paid to our dentists and the wages paid to staff. At the same time, a significant portion of our revenue is paid under NHS dentistry contracts with prescribed annual adjustments for UDA values for inflation. Historically, the annual UDA contract uplift was in line with that recommended by the Review Body on Doctors' and Dentists' Remuneration (the "DDRB"), an independent review body that makes recommendations to the Department of Health. However, although the annual UDA contract uplifts have not always followed the DDRB's recommendation, as the contract rates have been set by the UK Government, in recent years the DDRB recommendation was used as an input to a formula to determine the UDA contract uplift in conjunction with expected cost inflation in other key dental practice expenditures such as laboratory fees, materials and other overheads. If increases under our NHS dentistry contracts do not meet the price inflation and fee and wage inflation we experience in our business, the result would be an erosion of our profitability as the price we are paid for our services would decline in real terms. Depending on the quantum of inflation we experience, this could have an adverse effect on our business, financial condition and results of operations. Government finances have been placed under significant strain by the Covid-19 pandemic and in the years following the banking crisis, contract increases were substantially below inflation levels.

The introduction of a national living wage in April 2016 and the apprenticeship levy in April 2017 has increased our staff costs, as will any future increases in minimum wages, wage inflation or wage/apprentice levies.

The national living wage took effect in the United Kingdom in April 2016, initially raising the minimum hourly wage for workers aged 25 and over to at least £7.20 per hour. This increased to £7.83 per hour from April 2018, £8.21 from April 2019, it rose further to £8.72 per hour from April 2020. Staff under age 25 continue to receive the national minimum wage. These increases have been rolled out across our staff, and primarily affect wages paid to our dental nurses and support staff, which increases our staff costs. While the payment of the national living wage is

expected to benefit our retention among these groups, our staff costs have increased at a faster rate than the UDA rate uplifts we have received in respect of our NHS dentistry contracts.

In addition, from April 2018 we have been required by legislation to contribute an additional 0.5% of our total wage bill to the apprenticeship levy. The impact of the apprenticeship levy across our business for the year ended 31 March 2020 was approximately £0.5m. Our results of operations could be adversely impacted to the extent that further increases in wages or wage levies are mandated, or to the extent that wages increase with, or in excess of, inflation.

Certain of our operations are capital intensive and require significant capital investment and planning to support successful growth.

Our existing dental practices require expenditures on maintenance to repair ordinary wear and tear, to upgrade outdated equipment and to standardise the suite of dental equipment across our estate. For the twelve months ended 31 March 2020, our capital expenditure including for growth projects was approximately £27.3 million (2019: £24.3 million). Our central support functions, particularly our IT systems, also require regular capital expenditure. Similarly, acquisitions of dental practices also require a certain amount of upfront capital expenditure, with the average three-chair practice acquired requiring approximately £50,000–£100,000 in capital expenditure. When we grow organically through new contract acquisition and new builds, or merge together existing practices, considerably more capital expenditure, up to £500,000 or more, is required. If we do not generate sufficient cash flow from our operations or have funds available for future borrowing under our existing credit facilities to cover these capital expenditure requirements, we may not be able to make such capital expenditures, which may negatively impact our competitive position and, ultimately, our revenues and profitability. Moreover, to the extent that our investment in capital expenditure does not generate the expected levels of returns in terms of efficiency or improved cost profile, or it takes longer to achieve such expected levels, there could be an adverse effect on our business, financial condition, results of operations and prospects.

We operate in a highly fragmented and competitive environment in certain geographic regions, and an inability to compete successfully with our competitors in these regions could result in a loss of market share, contracts or patients.

The dentistry industry in the United Kingdom is highly fragmented and competitive, particularly in certain geographic areas. Whilst we do not compete with any one competitor in each of the local markets in which we operate, our competitors include other national Dental Bodies Corporate ("DBCs") as well as regional and local independent dental practices, and we face current and prospective competition for patients and contracts from these competitors. In recent times, we have seen increased competition in the market for dental practice acquisitions which has caused the average cost of each acquisition to increase, making it harder for us to make cost effective acquisitions. As a result of this, together with the challenging trading conditions we have recently experienced, we have paused our acquisition growth strategy until transaction prices normalise and trading conditions improve.

DD operates in competition with certain national and regional companies including specialists in certain areas. In particular, some of our competitors, have developed a strong presence online and have sought to provide a "one-stop-shop" solution for customers, which could allow them to expand their market share. If we are unable to compete effectively, our business, financial condition and results of operations may be materially and adversely affected.

Our inability to retain senior management could adversely affect our operations.

We rely upon the experience of our senior management team to maintain relationships with key players in the dentistry industry, understand the technical and strategic elements of our business, manage our portfolio of practices effectively, and to identify acquisition opportunities. Whilst we have attempted to establish policies and remuneration schemes designed to retain and properly incentivise our management team, no assurance can be given that these strategies will be effective in retaining key members of management. If one or more of our executives or other key personnel are unable or unwilling to continue in their present positions, we may not be able to replace them easily, and our business may be disrupted, which may materially and adversely affect our results of operations and financial condition. In addition, if any of our executives or other key personnel joins a competitor or forms a competing company, we may lose know-how and other key members of management, which may also have an adverse effect on our business, financial condition and results of operations.

The United Kingdom's withdrawal from the European Union may have a negative effect on global economic conditions, financial markets and our business.

The United Kingdom formally left the European Union on 31 January 2020 however, this was the start of a transition period (due to end on 31 December 2020) where months of negotiation will occur in order to set new trade

deals. The withdrawal from the EU has created significant uncertainty about the future relationship between the United Kingdom and the European Union, including with respect to the laws and regulations that will apply as the United Kingdom determines which European Union-derived laws to replace or replicate. Depending on the terms of the withdrawal, the United Kingdom could lose access to the single EU market and to the global trade deals negotiated by the European Union on behalf of its members which could affect the attractiveness of the United Kingdom as a global investment centre and detrimentally impact UK growth. Volatility in the value of the pound against the Euro and the US dollar following the referendum held in June 2016 has had, and could continue to have, a negative impact on the cost of sales for DD because a significant proportion of DD's supplies are purchased on a wholesale basis in Euros and US dollars. The withdrawal of the United Kingdom from the European Union may also make it more difficult for us to source dentists from outside the United Kingdom as a result of changes to UK border and immigration policy. In addition, in response to the United Kingdom's decision to leave the European Union, the regional government in Scotland have argued strongly for a second referendum to be held on independence from the United Kingdom, although these plans are currently on hold until after the European Union exit process has finished. A vote by Scotland to leave the United Kingdom could present risks for our dental practices in Scotland. Any of these risks could have an adverse effect on our business, financial condition, results of operations and prospects.

Weakness in economic conditions could adversely affect demand for our services, which could in turn adversely affect our business, financial condition and results of operations.

An economic downturn in the United Kingdom or new UK Government austerity measures due to the Covid-19 pandemic would increase the risks associated with our business, including the risk of reduced levels of government funding for the NHS and the risk of a lack of demand for our dental services generally. Most patients, unless exempt, are responsible for contributing to the cost of the dental services they receive. Even if government funding for dentistry is not significantly affected, macroeconomic weakness and high unemployment rates may result in non-exempt patients who are unable or unwilling to make their required contributions to the cost of their dental services, thereby driving down demand for dental services and affecting our UDA delivery rates. More generally, a decrease in household disposable incomes, or the perception thereof, in times of economic downturn can lead to a reduction in individuals' healthcare expenditure, which has had and could have in the future a negative impact on more discretionary spending, such as spending on either our NHS or private dentistry services.

A downturn in the overall dental sector, or wider UK healthcare market, could also impact the operations of DD by reducing demand for the products and services we supply. A reduction in demand could adversely impact our revenues and results of operations either through us reducing our sales prices, and therefore our margins, to maintain volumes, or through reduced sales volumes or through a combination of both.

Loss of our ability to use certain properties subject to long-term leases through reclamation by the landlord could adversely affect on our business.

The majority of our dental practices and warehouses are situated in leased properties. A typical lease has a term of approximately 15 years in length. As with all leases, the landlord is entitled to serve notice to reoccupy the property at the end of the lease term. If landlords in respect of such properties choose to exercise their rights under such clauses, our dental practices may have to relocate to an alternative site and find other surgery space, perhaps upon short notice. In particular, this risk could materialise in situations where the landlord is also a dentist who previously sold the practice to us. He or she may exercise his or her right to reclaim the leased surgery space and it may be difficult for us to reopen the dental practice in a timely manner and we would have the additional challenge of a competing dental practice in the space where our dental practice previously traded in the event the dentist secures an NHS dentistry contract.

Our business and results of operations are subject to seasonal factors, and extreme weather conditions can affect our levels of activity and hence our revenue.

Historically, our revenue has been somewhat seasonal as dentists typically push to reach their contracted UDA levels by working more intensively during the fourth quarter of each financial year. Our patients are less likely to attend or make dental appointments during inclement or severe weather conditions, particularly when transportation is disrupted. During such periods, we tend to experience a decrease in demand for our dental services and a reduction in our revenue, particularly in UDA delivery rates. If such weather events occur near the end of the contract year, we may experience difficulty achieving our annual UDA delivery targets.

In addition, DD's warehousing and logistics facilities are at risk from localised instances of extreme weather or natural disasters.

Our insurance may be inadequate to cover future liabilities and our insurance premiums may increase substantially.

We may be subject to significant losses from claims, liabilities, hazards and disasters. Whilst we currently maintain insurance which we believe is adequate and consistent with industry practice, we may experience losses in excess of our insurance coverage or claims not covered by our insurance. Furthermore, there can be no assurance that we will be able to obtain insurance coverage in the future on acceptable terms or at all. Any such losses not covered by insurance may have a material adverse effect on our financial condition and results of operations.

A substantial portion of our assets are represented by goodwill and intangible assets, and we may never realise the full value thereof or we may be required to write down the value of our goodwill and intangible assets.

We have recorded a significant amount of goodwill and intangible assets. Total goodwill, which represents the excess of cost over the fair value of the net assets of the businesses we acquire, was £142.1 million as at 31 March 2020, or 18% of our total assets. At 31 March 2020, intangible assets were valued at £295.6 million.

We perform goodwill impairment testing on an annual basis, or more frequently, where indicators of impairment are identified. During the year ended 31 March 2020, an impairment of £77.6 million was recorded against the carrying value of goodwill within {my}dentist to reduce the book value to the fair value. The reduction in the fair value calculation is due to an increase in uncertainty arising from the Covid-19 pandemic which required more pessimistic assumptions to be used for impairment modelling. We have also recorded impairment charges totaling £1.4 million against the intangible assets and goodwill allocated to the {my}dentist division in relation to permanent contract handbacks which have been agreed with NHS Regions during the year. In addition, impairment charges totalling £10.0 million have been recorded against the goodwill, intangible assets and other tangible assets of dental practices which have been closed during the year.

If we were to conclude in future that any further write-down of our goodwill or intangible assets is necessary, we would have to record the appropriate charge, which could result in a material adverse effect on results of operations. A write-down of our goodwill or intangible assets may result from, amongst other things, further deterioration in our performance, a decline in expected future cash flows, or decisions being taken to close or sell additional dental practices.

Changes in tax laws or challenges to the group's tax position could adversely affect the group's results of operations and financial condition.

We are subject to complex tax laws. Changes in tax laws could adversely affect our tax position, including our effective tax rate or tax payments. We often rely on generally available interpretations of applicable tax laws and regulations including guidance specific to our industry published by HMRC on their website. Changes in NHS regulations and interpretations have in the past required changes in the group structure which could subsequently lead to an adverse tax position. In certain instances we have secured clearance from HMRC on the application to tax law within the group. There cannot be certainty that HMRC will always be in agreement with our interpretation of these laws. If our tax positions are challenged by HMRC, the imposition of additional taxes could require us to pay taxes that we currently do not collect or pay or increase the costs of our services to track and collect such taxes, which could increase our costs of operations or effective tax rate. The occurrence of any of the foregoing tax risks could have a material adverse effect on our business, financial condition and results of operations.

Recent changes in tax law related to the deductibility of certain types of interest may result in increased tax costs.

From 1 April 2017, the UK Government has introduced new rules, known as the Corporate Interest Restriction, to limit the corporate tax deductibility of interest expense. These changes introduced, amongst other things, a fixed ratio rule, limiting corporate tax deductions for net interest expense to 30% of a group's UK tax EBITDA. In addition, a group ratio rule, broadly based on the external net interest to EBITDA ratio is available should this be less restrictive than the 30% cap. The application of these rules may reduce the amount of interest for which a corporate tax deduction can be claimed.

Any future changes to the law in this area could further reduce the amount of interest expense incurred on our indebtedness for which we can claim a tax deduction, which would effectively increase the amount of taxes we pay on our taxable profits.

Under UK law, until 1 April 2017, interest payments in respect of indebtedness were generally deductible from taxable profits. In the event that a company was considered to be thinly capitalised—that is, if it had more debt than it either could, or would, borrow acting in its own interests—the deductibility of interest on amounts of debt considered "excessive" (or greater than would arise if the company was acting at arm's length from the lender) may

have been treated as distributions of equity instead of interest in respect of indebtedness for tax deductibility purposes. The determination of whether a company was thinly capitalised was made on the basis of a company's self-assessment, discussed with HMRC, of its true, arm's length borrowing capability, as if it were borrowing on a stand-alone basis from a third-party lender. Amounts of interest paid on debt in excess of such borrowing capability were treated as distributions on equity and were not deemed to be deductible for tax purposes.

We have discussed the application of the UK transfer pricing/thin capitalisation rules with HMRC to establish the amount of indebtedness that is supportable under UK transfer pricing principles and interest arising on that amount may be deducted for UK corporation tax purposes. We have an agreement in place with HMRC in respect of tax year 2012-2013. The position in respect of tax years 2013-2014 through to 2016-17 is supported by self-assessment analysis. From the tax year 2017-18 onward, returns are subject to the new Corporate Interest Restriction rules.

We may not be able to tender for new NHS contracts if we do not comply with applicable laws.

The UK Government has implemented a procurement policy requiring potential suppliers of goods and services to the government, including us as providers of NHS dentistry services, to self-certify their recent tax compliance history as part of contract tender processes, and to comply with health and safety equality and other laws. If we do not comply with such laws, we may not be able to participate in tenders for new NHS dentistry contracts, which could adversely affect our results of operations and prospects.

In addition, public sector procurement rules have been extended to include provisions that require suppliers of goods and services to the government, such as ourselves through our NHS dentistry contracts, to be responsible for reviewing and determining the employment status of all contractors providing services to us. Previously, the contractor held this responsibility. In the event that we were judged by the NHS, or another government body, to have incorrectly determined any such contractors to be self-employed, we could lose our contracts and be unable to tender for future contracts. In addition, we may become liable for any retrospective employment taxes that may become due, which could adversely affect our business model, results of operations and prospects.

We could be adversely affected by violations of anti-bribery laws or violations of other government regulations by our employees.

Anti-bribery laws generally prohibit companies and their intermediaries from making improper payments to public officials for the purpose of obtaining or retaining business. Our internal policies mandate compliance with these anti-bribery laws. We operate a large number of dental practices throughout the United Kingdom and rely on our management structure, regulatory and legal resources and effective operation of our compliance programme to direct, manage and monitor the operations of our practices and the activities of our dentists and employees.

However, despite our training, oversight and compliance programmes, we cannot ensure that our internal control policies and procedures will always protect us from deliberate, reckless or inadvertent acts of our employees or dentists that contravene our compliance policies or violate applicable laws. Violations of these laws, or allegations of such violations, could result in a material adverse effect on our business, financial condition, results of operations or prospects.

We may be subject to organised action by our dentists or other employees, which could decrease our profitability and negatively affect our results of operations.

Self-employed dentists working in our dental practices could act collectively to demand a higher portion of contracted fees for the services they perform in our dental practices. Whilst none of our employees are currently unionised, no assurance can be made that such employees will not become unionised in the future. Any such collective action or unionisation by our self-employed dentists or employees, whether targeting us specifically or not, could have the effect of increasing our costs, thereby adversely affecting our results of operations.

The interests of our shareholders could conflict with your interests.

A majority of our equity interests are beneficially owned by Carlyle and Palamon. See "Principal shareholders." As a result, Carlyle and Palamon are able to control matters requiring shareholder approval, including the election and removal of our directors, our corporate and management policies, potential mergers and acquisitions, payment of dividends, asset sales and other significant corporate transactions. The interests of both Carlyle and Palamon could conflict with the interests of the holders of the Notes, particularly if we encounter financial difficulties or are unable to pay our debts when due. For example, Carlyle or Palamon could cause us to pursue acquisitions, divestitures, financings, dividend distributions or other transactions which, in their respective judgement, could enhance their equity investments, even though such transactions might involve risks or decrease the market value of the Notes. Such transactions may not trigger a "Change of Control" under the Indenture. Furthermore, Carlyle or Palamon may sell all or any part of their respective shareholding at any time or look to reduce their holding by means of a sale to a strategic investor, an equity offering or otherwise.

Risks related to our industry

Any change in the employment status of dentists in our dental practices could have an adverse effect on our business, financial condition and results of operations.

Our dentists are self-employed, independent contractors. Because of their non-employee status, we do not pay pension contributions, employer National Insurance contributions, holiday pay or medical negligence insurance in respect of our dentists, and our dentists do not have the rights of employees under the Employment Rights Act 1996.

The most common method for a practice owner of engaging with clinicians in the dental industry is for the clinician to operate as a self-employed associate dentist. This enables dentists to retain their clinical freedom over the appropriate course of treatment for patients, to develop their interests in specific specialities by having the flexibility to work across different practices and to have control of the amount they can earn through the hours they make available for appointments. In return, they contribute to the running costs of the practice and are responsible for a share of the laboratory costs relating to their treatment plans. This method of engagement has been recognised historically as the normal approach for the industry through the use of a model contract developed by the BDA. HMRC have published guidance that confirms if an associate is engaged on the terms of the model contract and the terms are followed, then the associate can consider themselves to be self-employed.

In common with many industries where self-employed individuals are utilised widely, HMRC have undertaken an industry review of the engagement terms used and the way these terms are applied in practice. The group utilises the model contract developed by the BDA as its basis of engagement with dentists and has clear policies and procedures about how associates work with employed practice teams. The group, supported by external advisors, has engaged with HMRC in this review, including through discussions with senior operational management and practice teams. The group is aware that HMRC have approached a number of clinicians engaged by the group in order to discuss their self-employed status.

As of the date of this report, HMRC's review is still in progress. HMRC had previously notified the group that they were considering withdrawing or amending the guidance relating to the model contract with effect from 5 April 2020. This action has subsequently been paused. HMRC have stated previously that their view is that they should not now be providing guidance on individual industry-specific contracts. Given the existence of the current guidance, the group considers that any changes will relate to prospective rather than retrospective engagements and that status will need to be considered against HMRC's general guidance for self-employment in the future. Any change this has on the nature of engagement with clinicians is also likely to affect the entire industry.

If HMRC reassessed our business model and objected to the self-employed status of the dentists in our dental practices it could lead to significant costs and tax consequences for our business. In addition, we have in the past been subject to conflicting, non-precedential employment tribunal determinations regarding the employment status of our dentists. To the extent employment tribunals would begin to consistently consider dentists to be our employees, we may also be exposed to new areas of liability under employment law. The occurrence of any of the foregoing would materially and adversely impact our business, financial condition and results of operations.

Changes to Value Added Tax ("VAT") legislation, or the judicial interpretation of VAT legislation, resulting in the application of VAT in respect of the services we provide to our dental practices could have an adverse impact on our results of operations.

VAT is a tax charged on most business transactions in the United Kingdom. A hypothetical VAT-registered business adds VAT to the prices at which it sells its goods and services and reclaims the VAT it pays for the goods and services it purchases. The current standard rate of VAT in the United Kingdom is 20%. Dentistry, however, is a VAT-exempt service under applicable VAT legislation, which means that most dental services are exempt from VAT and charges for supplies amongst groups of dentists are exempt from VAT provided that they relate to the provision of services or facilities that are predominantly medical in nature and are necessary to allow the recipient of such services and supplies to perform dentistry. We have structured our operating subsidiaries such that two of our operating subsidiaries, PTPL and Whitecross, provide services in terms of payroll, the provision of supplies and estate management, amongst others, to the majority of our dental practices, including those operating within partnerships. Under this arrangement, we consider the services provided by PTPL and Whitecross to partnerships to be VAT exempt, in so far as they relate to the provision of services or facilities that are predominantly medical in nature and are necessary to allow the recipient of such services and supplies to perform dentistry. If, however, HMRC successfully challenged our VAT-exempt status, the costs of our operations would effectively increase by an additional 20%, which would materially and adversely impact our business, financial conditions and results of operations. In addition, if VAT rates were to increase our cost base would be negatively affected to the extent of such increase, and we would not be able to recover such an increase in VAT costs.

We are subject to numerous legal and regulatory requirements governing our activities. If we fail to comply with such requirements, we may be subject to substantial fines or sanctions which could have a material adverse effect on our financial condition and results of operations or could impact our ability to conduct our business.

The provision of our dental services is subject to a high level of regulation and oversight. These regulatory requirements relevant to our business cover the entire range of our operations, from the initial acquisition of new practices, which are subject to registration and licensing requirements, to the sourcing of dentists and the recruitment and appointment of dental support staff, occupational health and safety, duty of care to patients, clinical standards, the conduct of our dentists, other dental professionals and support staff, and other stringent requirements. The majority of our operations are regulated by the same body, the CQC, or its equivalent in Scotland (HIS) and Wales (HIW). We are also subject to regulations imposed by the Health and Safety Executive, which is the national UK independent regulator for health and safety in the workplace and some legal entities may be required to hold a license with NHS Improvement, the health sector regulator in the UK.

Furthermore, new legislation, regulations, regulatory systems or regulatory bodies may be introduced and we are unable to predict their content or their effect on our business. There can be no assurance that our operations will not be adversely affected by regulatory developments.

A failure to comply with government regulations or the receipt of a negative report that leads to a determination of regulatory non-compliance or the failure of any of our dental practices to cure any defect noted in an inspection report, for example, could result in reputational damage, fines and/or the revocation of the license of any of our dental practices.

Regulatory action could also result in our management deciding to cease providing dental services in a particular region or to close a particular practice because of negative publicity or regulatory sanction. In addition, regulatory action in relation to one or more of our practices, regardless of the substantive merit or the eventual outcome of such action, may have a material adverse effect upon our reputation and brand and our ability to attract and/or retain patients, expand our business or seek licenses for new dental practices, either nationally or within the regional area in which the dental service which is subject to the regulatory action is located.

Any failure to comply with applicable regulations could have a material adverse effect on our business, financial condition, results of operations or prospects.

Our operations are also subject to regulation from the Financial Conduct Authority ("FCA") in respect of the brokering of consumer credit for high value private dentistry treatments and from the Payment Card Industry Security Standards Council in respect of the receipt of electronic card payments. We are also required to comply with the Data Protection Act 2018 and the GDPR regulations in respect of the handling of personal data. Failure to comply with these requirements could adversely impact our ability to offer certain high value private dentistry treatments and/or to receive electronic card payments which comprise a substantial proportion of our private dentistry revenues, DD revenues and patient charges for NHS treatment.

The terms of any new NHS dentistry contract, are uncertain, and the final terms of any such new NHS dentistry contract could be different from those we expect, which could have undesirable consequences for us and could result in material changes to our business.

The UK Government is currently reviewing the regulatory framework related to NHS dentistry and the NHS dentistry contract, with the goal of making NHS dentistry more efficient, accessible, high quality and focused on preventative care. In April 2016, the government commenced a prototype trial process as the next stage in the reform of the NHS dentistry contract. We currently anticipate that this process will evaluate the proposed contract over the next two to three years, although it is not yet certain if or when a new NHS dentistry contract will be introduced and adopted by an Act of Parliament. As with any significant regulatory change, there exists the risk that we may not be able to adapt to the change, or the change may prove costly or limit our ability to execute our business model and strategy. For example, the UK Government has indicated that, under the prototype trial, a partial move away from compensation based on UDA volumes may be introduced, and instead dentists will be rewarded based on a combination of number of patients registered and the number of Band 2 and/or Band 3 treatments completed. Quality metrics that measure clinical patient outcomes and the quality of the patient experience may also be increasingly used by the NHS as part of contract management. The UK Government and the GDC have also indicated that non-dentist staff such as hygienists will be able to carry out preventative services without a referral from a dentist, potentially adding competition to dental practices by independent hygienists. Since the final terms of any proposed new NHS dentistry contract are uncertain, we cannot anticipate all risks that might arise upon the adoption of any such new NHS dentistry contract, including risks that may specifically target our business model, and we cannot provide assurance that dentistry will remain under the purview of the NHS. If any such new NHS dentistry contract has terms different from those we expect, our business, financial condition and results of

operations could be materially adversely affected, and it could result in material changes to our business, financial condition, results of operations or prospects.

We rely on contracts with publicly funded entities in the United Kingdom such as the NHS for a substantial proportion of our revenues, and changes to levels of funding or funding priorities under such contracts could adversely affect our business, results of operations and financial condition.

NHS dental services accounted for 57.8% of our total revenues for the year ended 31 March 2020. While dental expenditures have not declined in nominal terms, contract uplifts have not kept up with inflation, resulting in a decline in the price paid for our NHS dentistry services in real terms. Any decline in government funding for NHS dentistry services, whether in nominal or real terms, could result in lower overall volumes of UDAs, lower prices per UDA, fewer new contract tenders or other measures that could cause declines in our revenue and materially adversely affect our business, financial condition and results of operations. Such a decline in nominal or real terms of NHS dentistry spending would also have a direct negative impact on DD, as some of the division's largest customers are NHS affiliates, and an indirect impact on DD, as a reduction in revenues for dental practices could cause them to reduce their purchases of non-essential supplies and work to reduce their overall supply costs, including services and supplies purchased from the group.

In addition, approximately 7% of our NHS dentistry contracts, principally providing orthodontic treatments and covering approximately 5% of our dentistry revenue for the year ended 31 March 2020, are Personal Dentistry Services ("PDS") contracts, which are typically fixed term contracts with a period of three to five years. These contracts are therefore subject to periodic competitive re-tender. Our failure to successfully re-tender for these contracts as they expire could adversely affect our revenues and results of operations in the future.

We may become subject to additional regulation by NHS Improvement, the health sector regulator in the UK, which could restrict our future growth through acquisitions because of our high-level of indebtedness, result in additional regulatory oversight, increase our costs and limit our ability to grow.

The Health and Social Care Act 2012 sets out NHS Improvement's core responsibilities as the sector regulator of NHS-funded health care services and tasks NHS Improvement with promoting the provision of health care services that are economic, efficient and effective. The legislation provides that all NHS providers of health care services must hold an NHS provider license issued by NHS Improvement, unless they are exempt.

On 1 April 2014 The National Health Service (License Exemptions, etc.) Regulations 2013 came into force and the regulations set out exemptions to the requirement for a provider of NHS services to hold a license with NHS Improvement. Regulation 5 exempts persons providing "primary dental services" commissioned by (or under delegated authority from) NHS England in accordance with Part 5 of the NHS Act 2006 as NHS England is already well-placed to enforce standards equivalent to those included in NHS Improvement's standard license conditions. This means that where a legal entity is providing private dental services under Part 5 of the NHS Act 2006 (i.e. pursuant to a GDS contract) there is no requirement for that legal entity to hold a license. However, if the legal entity provides other NHS services, it will require a license unless it qualifies for another exemption. For example, Regulation 8 exempts providers whose revenue from supplying NHS services is less than £10 million in a relevant business year from the requirement to hold a license.

The legal entity providing the NHS services is the legal entity that must be licensed. For example, where a provider is part of a wider corporate group, such provider will need to be licensed in its own right if it is the legal entity responsible for providing the services (rather than the parent company) and in the case of partnerships, each partnership which provides NHS services must be licensed unless an exemption applies. The license sets out the conditions the license-holder must meet in order to provide NHS-funded services and examples of standard conditions include obligations about pricing and anti-competitive behaviour. If any legal entity owned by us is regulated by NHS Improvement, we could be subject to potentially significant costs of compliance and monitoring. In addition, based on NHS Improvement oversight of other UK healthcare sectors, regulation by NHS Improvement may entail financial and clinical health checks of our business, and NHS Improvement may prohibit us from participating in new contracts, transferring contracts or acquiring new dental practices because of our high level of indebtedness. If these or other circumstances were to materialise, they could materially and adversely affect our business, financial condition and results of operations.

Risks related to our capital structure

Our substantial indebtedness could have a material adverse effect on our financial health and could prevent us from fulfilling our obligations with respect to the Notes and the Guarantees.

We continue to have a significant amount of outstanding debt with substantial debt service obligations. At 31 March 2020, we had an aggregate principal amount of third-party financial debt of £653.2 million outstanding excluding accrued interest and unamortised debt issuance costs. At 31 March 2020, the group had fully drawn the £100 million Revolving Credit Facility in order to maximise group liquidity during the Covid-19 outbreak. There also remains £1.8 million thereunder allocated to a letter of credit to our clinical directors.

Our significant leverage could have important consequences for our business and operations and for you as a holder of the Notes, which may include, but may not be limited to:

- subjecting us to additional regulation or oversight or limiting our ability to acquire or transfer NHS dentistry contracts;
- making it more difficult for us to satisfy our payment obligations with respect to the Notes, the Revolving Credit Facility and our other debts, liabilities and obligations;
- requiring us to dedicate a substantial portion of our cash flow from operations to payments for the service of our debt, thus reducing the availability of our cash flow to fund investments in our business and for other general corporate purposes;
- limiting the availability of funds for our working capital, capital expenditures, investments, acquisitions and our other general corporate purposes;
- limiting our flexibility in planning for, or reacting to, changes in our business, patient demand, competitive pressures and the patients we serve;
- placing us at a competitive disadvantage compared to any of our competitors that have lower leverage or greater financial resources than we have;
- increasing our vulnerability to general and industry-specific adverse economic conditions;
- negatively impacting credit terms with our creditors; and
- limiting our ability to borrow additional funds and subject us to financial and other restrictive covenants.

Any of these or other consequences or events could have a material adverse effect on our ability to satisfy our debt obligations, including our obligations in respect of the Notes and Guarantees.

Despite our current level of debt, we may still be able to incur substantially more debt in the future, which may make it difficult for us to service our debt, and impair our ability to operate our businesses.

We and our subsidiaries may be able to incur substantial additional debt in the future. Although the Revolving Credit Facility Agreement and the Indenture contain restrictions on the incurrence of additional debt, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances the amount of debt that could be incurred in compliance with these restrictions could be substantial and we may be able to secure such additional debt with Collateral or other assets. Under the Indenture, in addition to specified permitted indebtedness, we are able to incur additional indebtedness so long as, at the time of the incurrence, on a pro forma basis, our fixed charge coverage ratio (as defined in the Indenture) is at least 2.00 to 1.00, and in the event such indebtedness is secured indebtedness, our consolidated senior secured leverage ratio (as defined in the Indenture, which, amongst other things, exclude certain specified permitted indebtedness from the calculation of such ratio) is less than 4.50 to 1.00. Under the terms of the Indenture, we are permitted to incur future debt that may have substantially the same covenants as, or covenants that are more restrictive than, those of the Indenture. Moreover, some of the debt we may incur in the future could be structurally senior to the Notes and may be secured by collateral that does not secure the Notes. In addition, the Indenture and our Revolving Credit Facility Agreement do not prevent us from incurring obligations that do not constitute indebtedness under those agreements. The incurrence of additional debt would increase the leverage-related risks described in this Annual report.

We may not be able to generate sufficient cash to service our indebtedness, including due to factors outside our control, and we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make principal or interest payments when due on our indebtedness, including amounts drawn under the Revolving Credit Facility Agreement and our obligations under the Notes, and to fund our ongoing operations, will depend on our future performance and ability to generate cash which, to a certain extent, is subject to regulatory, general economic, financial, competitive, legislative, legal and other factors, as well as other factors discussed in these "Risk factors", many of which are beyond our control. In addition, upon the maturity of the Revolving Credit Facility, or any replacement credit facility, the Notes or any other debt which we may incur, if we do not have sufficient cash flows from operations and other capital resources to pay our debt obligations, or to fund our other liquidity needs, we may be required to, amongst other things:

- reduce or delay business activities and capital expenditures;
- sell assets;
- obtain additional debt or equity capital;
- restructure or refinance all or a portion of our debt on or before maturity; or
- forego opportunities such as acquisitions of other businesses.

There can be no assurance that any of these alternatives can be accomplished on a timely basis, on satisfactory terms or at all. In addition, the terms of our existing and future debt, including those terms contained in the Indentures and the Revolving Credit Facility Agreement, may limit our ability to pursue any of these alternatives.

If we are not able to refinance any of our debt, obtain additional financing or sell assets on commercially reasonable terms or at all, we may not be able to satisfy our debt obligations, including under the Notes. In that event, borrowings under other debt agreements or instruments that contain cross-default or cross-acceleration provisions may become payable on demand, and we may not have sufficient funds to repay all our debts, including the Notes.

In addition, any failure to make payments of interest or principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which could harm our ability to incur additional indebtedness. For a discussion of our cash flows and liquidity, see "Management's discussion and analysis of financial condition and results of operation—Liquidity and capital resources".

The Senior Secured Floating Rate Notes and drawings under the Revolving Credit Facility Agreement bear, and any future variable interest rate debt we incur will bear, interest at floating rates that could rise significantly, thereby increasing our costs and reducing our cash flow.

The Senior Secured Floating Rate Notes and drawings under the Revolving Credit Facility Agreement bear interest at floating rates of interest per annum equal to GBP LIBOR, as adjusted periodically, plus a spread. The Revolving Credit Facility Agreement also allows for drawings to be made in Euros which will bear interest at floating rates of interest per annum equal to EURIBOR, as adjusted periodically, plus a spread. These interest rates could rise significantly in the future. There can be no assurance that hedging will be available on commercially reasonable terms or at all, or that we will enter into any interest rate hedging. Hedging itself carries certain risks, including that we may need to pay a significant amount (including costs) to terminate any hedging arrangements. To the extent that interest rates or any drawings were to increase significantly, our interest expense would correspondingly increase, reducing our cash flow.

We are subject to restrictive covenants which limit our operating and financial flexibility.

Our Revolving Credit Facility Agreement and each of the Indenture and the indenture governing the Second Lien Notes contain covenants which impose significant restrictions on the way we operate, including restrictions on our ability to:

- incur or guarantee additional debt and issue preferred stock;
- in the case of the indenture governing the Second Lien Notes, layer debt of the Issuer and the guarantors of the Second Lien Notes;
- make certain payments, including dividends or other distributions;
- make certain investments or undertake acquisitions, including participating in joint ventures and undertaking capital expenditure;
- prepay or redeem subordinated debt;

- engage in certain transactions with affiliates;
- create unrestricted subsidiaries;
- agree to limitations on the ability of our subsidiaries to make distributions;
- sell assets, or consolidate or merge with or into other companies;
- sell or transfer all or substantially all our assets or those of our subsidiaries on a consolidated basis;
- complete a change of control;
- issue or sell share capital of certain subsidiaries; and
- create or incur certain liens.

Any future indebtedness may include similar or other restrictive terms. These restrictions could materially and adversely affect our ability to finance our future operations or capital needs or to engage in other business activities or consummate transactions that may be in our best interests.

In addition, the Revolving Credit Facility Agreement requires us, subject to the Revolving Credit Facility being drawn in cash by more than 35%, to maintain a specified maximum ratio of drawn super senior debt to EBITDA before non-underlying items, tested quarterly. Our ability to meet that financial ratio can be affected by events beyond our control, and we cannot assure you that we will meet such financial ratio. A breach of any of those covenants, ratio or restrictions could result in an event of default under the Revolving Credit Facility Agreement. Upon the occurrence of any event of default under the Revolving Credit Facility Agreement, subject to applicable cure periods and other limitations on acceleration or enforcement, the relevant creditors could cancel the availability of the Revolving Credit Facility Agreement and elect to declare all amounts outstanding under the Revolving Credit Facility, together with accrued interest, immediately due and payable.

In addition, a default under the Revolving Credit Facility Agreement could lead to an event of default and acceleration under other debt instruments that contain cross-default or cross-acceleration provisions, including under the Indenture and the indenture governing the Second Lien Notes. If our creditors, including the creditors under the Revolving Credit Facility, accelerate the payment of those amounts, we cannot assure you that our assets and the assets of our subsidiaries would be sufficient to repay those amounts in full, to satisfy all other liabilities of our subsidiaries that would be due and payable and to make payments to enable us to repay the Notes, in full or in part. In addition, if we are unable to repay those amounts, our creditors could proceed to enforce the security interest in any Collateral granted to them to secure repayment of those amounts.

These covenants could affect our ability to operate our business and may limit our ability to react to market conditions or regulatory developments or take advantage of potential business opportunities as they arise. For example, such restrictions could adversely affect our ability to finance our operations; pursue acquisitions, investments or alliances; restructure our organisation; or finance our capital needs.

Management

Board of directors of the Issuer

Board of directors

The Issuer is a public limited company incorporated under the laws of England and Wales. The following table sets out certain information with respect to the current members of the Issuer's board of directors:

Name	Age	Title
Tom Riall	60	Executive Director
Jeremy Perkin (appointed 5 April 2019)	46	Executive Director

Board of directors of the Parent Guarantor and EquityCo

Board of directors

The Parent Guarantor is a private limited company incorporated under the laws of England and Wales. The following table sets out certain information with respect to the current members of the Parent Guarantor's board of directors.

Omar Shafi Khan resigned as Chief Financial Officer on 5 April 2019 and as a Non-Executive Director of Turnstone Equityco 1 Limited on 26 July 2019.

Name	Age	Title
Alan Bowkett	69	Non-Executive Chairman
Tom Riall	60	Executive Director
Omar Shafi Khan (resigned 26 July 2019)	45	Non-Executive Director
Jean Bonnavion (resigned 6 November 2019)	48	Non-Executive Director
Oliver Butler* (appointed 29 March 2019)	35	Non-Executive Director
Barry Cockroft*	69	Non-Executive Director
Louis Elson (resigned 6 November 2019)	57	Non-Executive Director
Karthic Jayaraman*	44	Non-Executive Director

** Director of Equityco only and not of the Parent Guarantor.*

Alan Bowkett was appointed to the board of the Parent Guarantor on 27 July 2020.

Set out below is a brief description of the business experience of the individuals who serve as members of our Board.

Alan Bowkett. Mr. Bowkett joined the Board as non-executive Chairman on 21 March 2017. He has been Chair of a number of international companies inter alia, Avio Spa, Diaverum AG, Metzeler BV, Euromedic BV and Acordis BV. In the UK he was Chair of FTSE 250 housebuilder Redrow and CEO of Berisford plc from 1992-99. Currently, in addition to his IDH role, he is Chair of Cambridge Education Group and Ontic Ltd. From 2009 - 2015, he was Chairman of English Premier League side Norwich City Football Club. Mr. Bowkett holds an MBA from London Business School and a BSc(Econ) from University College London.

Tom Riall. Mr. Riall joined Integrated Dental Holdings as Chief Executive Officer on 8 May 2017. He is the former Chief Executive Officer of Priory Group having held the position from April 2013 to December 2016 and led Priory through its successful sale to Acadia Healthcare Services. Just prior to his appointment, he had served as Chief Executive of Serco's global services business since June 2012, and prior to that its Civil Government and Home Affairs divisions having joined the business in 2005. Serco is a UK listed company that provides a variety of services and products relating to defence, home affairs, aviation, and transport. Mr. Riall has completed the Advanced Management Programme at Harvard Business School, holds an MBA from the City University Business School and a BA from Durham University.

Oliver Butler. Mr. Butler is an Associate Director at The Carlyle Group advising on buyouts, privatizations and strategic minority investments for Carlyle Europe Partners. Since joining Carlyle in 2010, Mr. Butler has been actively involved with Carlyle's investment in current portfolio companies PA Consulting and Praesidiad as well as prior investments in Talaris and Holland & Barrett (through the investment in NBTY). Mr. Butler was also a member of the transaction teams that executed Carlyle's investment in RAC and Addison Lee. Prior to joining Carlyle, Mr. Butler was with Greenhill & Co. Inc. in London. Mr. Butler received a B.A. with honours in natural sciences from Cambridge University.

Barry Cockcroft. Mr. Cockcroft joined our Board in 2015 as a Non-Executive Director. Mr. Cockcroft is a qualified dentist and initially spent more than 25 years in general dental practice where he also represented Coventry, Warwickshire and Solihull on the General Dental Services Committee of the British Dental Association, ultimately becoming the Vice-Chairman of the Committee. In 2002 he joined the Department of Health as Deputy Chief Dental Officer, and was appointed Chief Dental Officer in 2006 and retired in 2015. During this time, he provided clinical and professional advice to NHS England, the Department of Health and Health Education England and contributed to the development of dental care in the United Kingdom. He was awarded a CBE in 2010 as well as honorary fellowships by the University of Central Lancashire, the Faculty of Dental Surgery in England and the Faculty of General Dental Practice and an honorary doctorate in dental science by the University of Plymouth.

Karthic Jayaraman. Mr. Jayaraman is a Partner at TPG Capital based in London, where he co-leads the platform's healthcare group. Prior to joining TPG, Karthic served as a Managing Director/Partner at The Carlyle Group and was a Co-Head of Carlyle Global Partners. Before that, he worked at Credit Suisse in investment banking and at Schlumberger as a field engineer. Karthic received his bachelor's degree in mechanical engineering from The University of Sydney and his MBA from Harvard Business School.

Key members of senior management

In addition to the board of directors discussed above, the following individuals form the key members of the senior management of the Parent Guarantor:

Name	Age	Title
Tom Riall	60	Chief Executive Officer
Nilesh Pandya	49	Chief Financial Officer
Paul Adams	60	Managing Director – DD
Steve Melton	58	Managing Director – {my}dentist
Tom Muir	34	Group Director of Communications
Jeremy Perkin	46	Director of Group Finance
Dr Julian Perry	58	Group Commercial Director
Robert Pilling	44	Director of Business Development
Dr Nyree Whitley	49	Group Clinical Director
Nicky Walsh	52	Director of HR

Set out below is a brief description of the business experience of other key members of senior management of the group not already described.

Paul Adams. Mr Adams joined Integrated Dental Holdings on 30 April 2018 as Managing Director of the DD division. He has more than 25 years' experience in FTSE100 and private equity companies across consumer products, retail, technology, financial cash management and healthcare sectors, including the manufacture and supply of pharmaceutical and medical device products. Mr Adams has strong operations experience, having been Chief Operating Officer of Talaris Ltd, a global cash management company, then owned by private equity house, Carlyle, the current co-owner of the group. In 2012, he became CEO of Talaris, taking the business through a successful sale to Glory Ltd later that year, where he continued as Chief Executive. Most recently, Mr Adams was CEO of Redeem Group Ltd. He has an MBA from Westminster University and is co-author of The Little Black Book of Change published by John Wiley & Sons in 2016.

Steve Melton. Mr. Melton joined Integrated Dental Holdings in October 2017 as Managing Director of the {my}dentist division. Mr. Melton has more than 30 years' experience at Board level across retail, consumer, and healthcare. Most recently, he was Chief Executive at Circle Health, the AIM-listed, employee co-owned hospital group. Prior to this, he was Supply Chain Director for Argos, and held a variety of leadership positions in Scottish Courage, Asda and internationally with Unilever. He graduated with a First Class degree in Chemical Engineering from Queen's College, Cambridge University.

Tom Muir. Mr Muir joined Integrated Dental Holdings as Group Director of Communications in August 2017. He was previously Group Director of Corporate Affairs at the Priory Group, the UK's leading provider of mental healthcare and specialist education services and, before that, Head of Communications for Circle Partnership, the employee co-owned hospital group. He has worked as a Senior Political Adviser at the Conservative Party and was a Global Emerging Markets Research Analyst for Japanese Investment Bank, Nomura. Mr. Muir has a first-class degree from Cambridge University in History and Management Science.

Nilesh K Pandya. Mr Pandya joined Integrated Dental Holdings as Chief Financial Officer on 12 October 2019. He was previously Chief Financial Officer of TDR Group owned International Car Wash Group Limited, where he led the successful sale of the group to Roark Capital Group following an acquisitive growth strategy in the US. Prior to this, he was Chief Financial Officer of Investcorp Technology Partners owned Skrill Holdings, where he led with the management team the organic and inorganic growth and subsequent sale of the group to CVC. Mr Pandya has also held senior positions with M&S Foods, HSBC Investment bank and began his career with KPMG. He has a degree in Politics, Philosophy and Economics from Oxford University and is a member of the Institute of Chartered Accountants in England and Wales.

Jeremy Perkin. Mr. Perkin is the Director of Group Finance and joined Integrated Dental Holdings in December 2008 as Financial Controller of the legacy IDH business. Prior to joining our team, Mr. Perkin held a series of roles with KPMG LLP including the role of Senior Manager in Audit. He has a degree in Economics and Politics from the University of Bath and is a member of the Institute of Chartered Accountants in England and Wales.

Dr. Julian Perry. Dr. Perry joined Integrated Dental Holdings in January 2018 as Group Commercial Director. Dr. Perry has over 30 years' experience in dentistry, including more than 20 years in multi-site ventures. Prior to IDH, he held a series of roles with Oasis Dental Care, now BUPA Dental, including Group Clinical Director and Director of Acquisitions. Dr. Perry played a key role in the successful turnaround and sale of Oasis Dental Care to BUPA in November 2016. Dr. Perry also continues to work part time as a practicing clinician with a special interest in implant dentistry.

Robert Pilling. Mr. Pilling is the Group Director of Strategy for Integrated Dental Holdings and joined the Group in January 2009. He worked closely with the IDH management team during the sale of the business to the Carlyle Group and Palamon in 2011 and has worked extensively in the acquisitive growth and strategic planning within the group thereafter. He was previously a Senior Manager at BDO Stoy Hayward, a global firm of accountants and advisors across 154 countries. His role was primarily working on UK national turnaround business solutions and he also worked on a number of corporate finance matters. Prior to this, Mr. Pilling worked in accountancy roles for the card retailer, Birthdays plc which was later acquired by Clinton Cards. Mr. Pilling is a member of the Chartered Institute of Management Accountants.

Dr. Nyree Whitley. Dr Whitley has more than 20 years' experience of clinical practice and was formerly a Regional Clinical Director at {my}dentist until becoming Group Clinical Director in 2017. Nyree qualified from Guy's Hospital in 1996 and, since then, has held posts in primary and secondary dental care, as a Postgraduate Dental Tutor for the Welsh Deanery, a Clinical Reviewer for the National Clinical Assessment Service (NCAS), an associate Dento-legal Advisor and Local Dental Advisor for Dental Protection and is still a practicing dentist.

Nicky Walsh. Miss Walsh is the Director of HR. She joined Integrated Dental Holdings in January 2015 as Head of HR before being appointed Director of HR in June 2016. Her career in HR spans over 20 years across a number of sectors including retail, financial services, housing and commercial vehicle contract hire. Prior to joining Integrated Dental Holdings, Miss Walsh worked in senior HR management roles at Phones 4U, the mobile phone retailer, and HBOS.

The business address for each of the Board and the senior management team of the group is Europa House, Europa Trading Estate, Stoneclough Road, Kearsley, Manchester M26 1GG, United Kingdom.

Committees

Audit Committee

The role of the Audit Committee is to monitor and review our internal financial controls, risk management systems and audit function, external auditor independence and objectivity, and the effectiveness of the external auditor review process. The Audit Committee will also develop and implement our policy on the engagement of, and make recommendations to the board in relation to the appointment of, external auditors. The Audit Committee meets at least twice every twelve months.

Remuneration Committee

The responsibilities of the Remuneration Committee include determining the remuneration and performance targets for senior executives and any employees who earn a salary greater than £110,000 per year, the award of rights under equity incentive plans and the setting of all management bonus schemes.

Compensation of directors and senior management

The aggregate salary and fees, performance-related remuneration and bonuses, pension contributions and other benefits paid to the directors and senior management listed under "—Board of directors of the Parent Guarantor" and "—Key members of senior management" in the year ended 31 March 2020 was £2.7 million excluding severance and other transition payments to directors and senior management that have left us during such period.

Management employment agreements

Our senior management is compensated by way of a fixed annual salary and an annual bonus. The annual bonus is typically determined based on the proportion by which our EBITDA before non-underlying items exceeds budget and certain personal objectives, in both cases reasonably determined by the Board. The Remuneration Committee reviews compensation packages for all senior executives and any employees who earn a salary greater than £110,000 per year, and all other employee compensation packages are reviewed annually by the Board.

Share ownership

Certain members of the board of directors and senior management of the group directly, or indirectly, own shares of Equityco. See "Principal shareholders".

Principal shareholders

As at the date of this Annual report, the issued share capital of the Issuer consisted of 50,000 ordinary shares with a total par value of £1.00. All the issued share capital of the Issuer is held by the Parent Guarantor, a private limited company incorporated under the laws of England and Wales and a wholly owned subsidiary of MidCo, a private limited company incorporated under the laws of England and Wales. Other than the preference shares, the issued share capital of MidCo is held by EquityCo, a private limited company incorporated under the laws of England and Wales.

Ownership in EquityCo

EquityCo has five classes of ordinary equity capital. The ordinary shares of EquityCo are designated as A1, A2, B, E1 and E2 shares. The A1 ordinary shares have a nominal value of £0.01, the A2 shares and B shares each have a nominal value of £0.04, the E1 shares have a nominal value of £0.10 and the E2 shares have a nominal value of £0.001. The following table sets out certain beneficial ownership information regarding the holders of over 5% of the ordinary shares in EquityCo, and the number and percentage owned by each shareholder as at 31 March 2020:

	Carlyle[1]		**Palamon[2]**		**Management[3]**		**Total**	
	(‘000)	%	(‘000)	%	(‘000)	%	(‘000)	%
A1 Ordinary Shares	1,282	57.5	400	17.9	–	–	1,682	75.4
A2 Ordinary Shares	–	–	–	–	18	0.8	18	0.8
B Ordinary Shares	–	–	–	–	300	13.5	300	13.5
E1 Ordinary Shares.....	–	–	–	–	82	3.7	82	3.7
E2 Ordinary Shares.....	–	–	–	–	147	6.6	147	6.6
**Total..... **	**1,282**	**57.5**	**400**	**17.9**	**547**	**24.6**	**2,229**	**100.0**

(1) The Carlyle Group is the beneficial owner of shares in EquityCo held by CEP III Participations S.à.r.l. SICAR, an investment vehicle for Carlyle.

(2) Palamon Capital Partners is the beneficial owner of shares in EquityCo held by its fund Palamon European Equity II, L.P. In addition, ADP Primary Care Acquisitions Limited, an entity controlled by Palamon, holds preference shares in MidCo with a par value of £20 million.

(3) Current and former members of our senior management hold interests in the A2 and B ordinary shares of EquityCo indirectly through their interests in Turnstone Management Investments Limited. The E1 and E2 ordinary shares were issued on 12 June 2017 and are held directly by certain members of our senior management team and by an employee benefit trust on behalf of other members of our senior management. No member of management individually or together with such member of management’s immediate family members or personal trust beneficially holds more than 5% of the ordinary shares of EquityCo.

Information about our principal shareholders

Carlyle

Funds formed and managed by The Carlyle Group hold 57.5% of our equity interests. The Carlyle Group is a global investment firm with $217 billion of assets under management as of 31 March 2020. Carlyle’s purpose is to invest wisely and create value on behalf of its investors, portfolio companies and the communities in which we live and invest. The Carlyle Group employs more than 1,775 people in 32 offices across six continents. Carlyle’s investment in IDH is made through its €5.4 billion third European Buyout fund.

Palamon

Funds formed and managed by Palamon Capital Partners hold 17.9% of our equity interests. Palamon Capital Partners is a private equity partnership that invests throughout Europe in service-oriented businesses with high growth potential. Palamon manages funds with capital commitments of €1.5 billion and other investments by the firm in the healthcare sector include SARquavitae, Prospitalia, and OberScharrer Group.

Subscription and Shareholders Agreement

On 28 January 2011, EquityCo, MidCo and BidCo, inter alios, entered into a subscription and shareholders' agreement (the "Subscription and Shareholders' Agreement"), amended on 11 May 2011, relating to the shares held in EquityCo by each of Carlyle and Palamon (together, the "Lead Investors") and certain members of our senior management, and governing the management and affairs of EquityCo and its subsidiaries.

The Subscription and Shareholders' Agreement contains provisions, amongst other things, regulating (i) the proceedings and general meetings of the Board, the BidCo board of directors and the board of directors of Turnstone Management Investments Limited, (ii) matters which are reserved for the prior written consent of the Lead Investors, (iii) restrictions and rights on transfers of debt and equity instruments in EquityCo or Turnstone Management Investments Limited (including rights of first offer and tag-along and drag-along rights), (iv) pre-emption rights, (v) acquisition and rescue issues, (vi) the manner and process of exit, (vii) rights and obligations of holders of debt and equity instruments in EquityCo or Turnstone Management Investments Limited (including distributions and ranking), (viii) the rights and obligations of Management, (ix) rights and obligations of EquityCo, MidCo, the Parent Guarantor, BidCo and Turnstone Management Investments Limited and (x) matters relating to indemnification of the parties under the Subscription and Shareholders' Agreement.

Certain relationships and related party transactions

In the ordinary course of business we may enter into transactions with related parties. Described below are the most significant transactions with related parties.

Letter of credit to clinical directors

Certain of our clinical directors act as partners in the dental practices we acquire through partnership structures. In order to indemnify such clinical directors against the risks inherent in these arrangements, Lloyds Bank has issued a letter of credit in favour of such clinical directors in the amount of £1.8 million. The letter of credit is issued under our Revolving Credit Facility.

Description of material debt instruments

For a description of our material debt instruments, please see "Description of other indebtedness" and "Description of the Notes" in the offering memorandum dated 22 July 2016 in respect of the £275.0 million 6¼% Senior Secured Fixed Rate Notes due 2022 and our £150.0 million Senior Secured Floating Rate Notes due 2022 issued by IDH Finance plc, which has been posted to our website at www.mydentist.co.uk under "—Investors—Archive".

Certain definitions

In this Annual report:

"**BDA**"	means the British Dental Association;
"**BF Mulholland**"	means BF Mulholland Limited, a supplier of dental consumables, materials and equipment to the Northern Irish and Irish markets, that we acquired on 8 September 2017;
"**BidCo**"	means Turnstone Bidco 1 Limited;
"**Board**" or "**Directors**"	means the Board of Directors of the Issuer;
"**Carlyle**"	means The Carlyle Group;
"**CMA**"	means the United Kingdom's Competition and Markets Authority;
"**Collateral**"	has the meaning ascribed to it in "Description of the Notes—Security";
"**CQC**"	means the United Kingdom's Care Quality Commission;
"**dbg**"	means the Dental Buying Group, a UK supplier of medical and dental equipment and supplies, that we acquired on 16 April 2013;
"**DD**"	means the supplier of dental products, including orthodontics, oral hygiene, surgical accessories and equipment, that we acquired on 17 April 2014, together with a number of other smaller businesses including dbg, Dolby Medical, Med-FX, and BF Mulholland which were, together, previously known as the "Dental Directory" division.
"**Department of Health**"	means the United Kingdom's Department of Health;
"**Dolby Medical**"	means Dolby Medical Limited, a dental equipment and services supplier that we acquired on 31 March 2016;
"**EquityCo**"	means Turnstone Equityco 1 Limited;
"**EU**"	means the European Union;
"**Euro**" or "**€**"	means the lawful currency of the Member States of the European Union participating in the European Monetary Union;
"**FSMA**"	means the Financial Services and Markets Act 2000;
"**GDC**"	means the United Kingdom General Dental Council;
"**GDS Contract**"	means a general dental services contract with NHS England;
"**GP**"	means a general practitioner of medicine;
"**Guarantees**"	means the guarantees of the Notes on a senior secured basis by the Guarantors;
"**Guarantors**"	means, collectively, the Parent Guarantor and the Subsidiary Guarantors;
"**HMRC**"	means HM Revenue & Customs;
"**IDH**"	means Integrated Dental Holdings;
"**IFRS**"	means the International Financial Reporting Standards as adopted by the European Union;

"**Indenture**".....	means the indenture governing the Notes dated as at the Issue Date by and amongst, *inter alios*, the Issuer and the Trustee, as described in "Description of the Notes";
"**Issue Date**"	means 5 August 2016;
"**Issuer**"	means IDH Finance plc, a public limited company incorporated under the laws of England and Wales on 7 May 2013, with registered number 08516986. and a registered office located at Europa House, Europa Trading Estate, Stoneclough Road, Kearsley, Manchester, M26 1GG, United Kingdom;
"**Med-FX**"	means Med-FX Limited, the facial aesthetics business that we acquired on 31 August 2015;
"**MidCo**".....	means Turnstone Midco 1 Limited, a wholly owned subsidiary of EquityCo and the indirect parent company of the Issuer;
"{**my}dentist**"	means our dentistry business, formarly known as "patient services";
"**NHS**".....	means the United Kingdom's National Health Service;
"**NHS England**"	means England's independent national health services commissioning board, an executive non-departmental public body under the Department of Health in England, formerly known as the NHS Commissioning Board;
"**NHS Improvement**"	means the NHS organisation responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care;
"**NHS Regions**"	means one of the four NHS regions or their respective sub-regions that act on behalf of NHS England, with responsibilities for primary care contract management in England;
"**Notes**"	means, collectively, the Senior Secured Fixed Rate Notes and the Senior Secured Floating Rate Notes;
"**Palamon**".....	means Palamon Capital Partners;
"**Parent Guarantor**".....	means Turnstone Midco 2 Limited, the direct parent company of the Issuer;
"**PDS Contract**".....	means a personal dental services contract with NHS England;
"**PDS Dental Laboratory**"	means PDS Dental Laboratory Leeds Limited, a laboratory providing crown and bridge work, dentures and implant assistance to dentists across the United Kingdom that we acquired on 18 March 2016 and sold on 4 October 2018;
"**Pound**," "**pounds sterling**," "**U.K. pound**" or "**£**".....	mean the lawful currency of the United Kingdom;
"**Previous Fixed Rate Notes**".....	means the £200.0 million in aggregate principal amount of the Issuer's 6% senior secured fixed rate notes due 2018 issued on 30 May 2013 and redeemed on 5 August 2016 as part of the Previous Notes Redemption;
"**Previous Floating Rate Notes**"	means the £225.0 million in aggregate principal amount of the Issuer's senior secured floating rate notes due 2018 issued on 30 May 2013 and 9 May 2014 and redeemed on 5 August 2016 as part of the Previous Notes Redemption;
"**Previous Notes**"	means, collectively, the Existing Fixed Rate Notes, the Previous Floating Rate Notes and the Previous Second Lien Notes;

"**Previous Notes Redemption**".....	means the satisfaction and discharge of the Issuer's obligations under the indentures governing the Previous Notes on 5 August 2016 in connection with the Refinancing;
"**Previous Revolving Credit Facility**".....	means the revolving credit facility governed by the Previous Revolving Credit Facility Agreement;
"**Previous Revolving Credit Facility Agreement**".....	means the £100.0 million super senior revolving credit facility agreement dated as at 20 May 2013, amongst, *inter alios*, Turnstone Midco 2 Limited, Turnstone Bidco 1 Limited and Credit Suisse AG, London Branch and J.P. Morgan Limited as arrangers, which was replaced by the Revolving Credit Facility Agreement from 25 July 2016;
"**Previous Second Lien Notes**".....	means the £75.0 million in aggregate principal amount of the Issuer's 8½% second lien notes due 2019 issued on 30 May 2013 and redeemed on 5 August 2016 as part of the Previous Notes Redemption;
"**Private Placement**".....	has the meaning ascribed to it in "Summary—The Refinancing—Private Placement of Second Lien Notes";
"**PTPL**".....	means Petrie Tucker & Partners Limited;
"**Refinancing**"	means the transactions described under "Summary—The Refinancing";
"**Registrar**".....	means Elavon Financial Services DAC;
"**Revolving Credit Facility**".....	means the revolving credit facility governed by the Revolving Credit Facility Agreement;
"**Revolving Credit Facility Agreement**".....	means the £100.0 million super senior revolving credit facility agreement dated 25 July 2016, amongst, *inter alios*, the Parent Guarantor, BidCo, Credit Suisse AG, London Branch, ING BANK N.V., London Branch, Lloyds TSB Bank PLC, Mizuho Corporate Bank Ltd, Societe Generale, London Branch, and The Royal Bank of Scotland plc as arrangers and the Security Agent;
"**Second Lien Notes**"	means the £130.0 million in aggregate principal amount of the Issuer's senior secured fixed rate notes due 2023 placed by the Issuer with certain private investors pursuant to the Private Placement on 5 August 2016.
"**Security Agent**"	means U.S. Bank Trustees Limited;
"**Security Documents**".....	means the agreements to be entered into between, amongst others, the Security Agent, the Issuer and the Guarantors pursuant to which security interests in the Collateral are granted to secure the Notes, which as at the Issue Date consist of (i) an English law governed debenture, (ii) a Scots law governed bond and floating charge and (iii) a Scots law governed share pledge;
"**Senior Secured Fixed Rate Notes**".....	means the £275.0 million in aggregate principal amount of the Issuer's 6.25% senior secured fixed rate notes due 2022 issued on 5 August 2016;
"**Senior Secured Floating Rate Notes**" ...	means the £150 million in aggregate principal amount of the Issuer's senior secured floating rate notes due 2022 issued on 5 August 2016;
"**Sponsors**"	means, together, Carlyle and Palamon;
"**Subsidiary Guarantors**".....	means those companies set out under "Listing and general information—Subsidiary Guarantors";

"**Trustee**".....	means US Bank Trustees Limited in its capacity as trustee of the Senior Secured Fixed Rate Notes and the Senior Secured Floating Rate Notes, as the context requires.
"**UDA**"	means unit of dental activity;
"**UK Government**"	means the government of the United Kingdom;
"**United Kingdom**" or "**UK**".....	means the United Kingdom of Great Britain, Northern Ireland, Guernsey, Jersey and the Isle of Man;
"**United States**," "**US**" or "**U.S.**".....	means the United States of America, its territories and possessions, any State of the United States of America, and the District of Columbia;
"**US dollars**" or "**US$**"	means the lawful currency of the United States;
"**we**" or "**us**"	means the Parent Guarantor and its subsidiaries, unless where expressly stated otherwise or where the context requires otherwise; and
"**Whitecross**".....	means Whitecross Dental Care Limited.

Impact of the adoption of IFRS 16

The tables on the following pages set out the impact of the adoption of IFRS 16 on the Consolidated income statement for the quarter ended 31 March 2020, the Consolidated income statement for the year ended 31 March 2020, the Consolidated balance sheet as at the transition date of 1 April 2019 and as at 31 March 2020 and the Consolidated cash flow for the quarter ended 31 March 2020 and for the year ended 31 March 2020.

As IFRS 16 has been adopted from 1 April 2019, there is no impact on the results previously reported for the year-ended 31 March 2019.

Consolidated income statement
For the quarter ended March 2020

	Q4 FY20		*Q4 FY20*
	Previous IFRS	*IFRS 16*	*As reported*
	£'000	£'000	£'000
Revenue	154,198		154,198
Cost of sales	(87,362)		(87,362)
Gross profit	66,836	-	66,836
Distribution costs	(4,940)		(4,940)
Administrative expenses	(146,962)	942	(146,020)
Other operating income	199		199
Other losses	490		490
Operating loss	(84,377)	942	(83,435)
EBITDA before non-underlying items	18,900	3,468	22,368
Amortisation of intangible assets	(7,624)		(7,624)
Depreciation	(5,492)	(2,526)	(8,018)
Amortisation of government grant income	13		13
Impairment of intangible assets/ROU asset	(77,821)	(483)	(78,304)
Impairment of non-current assets reclassified as held for sale and profit/(loss) on closure or disposal of dental practices	(10,729)	789	(9,940)
Value of employee services arising from shares granted	(270)		(270)
Other non-underlying items	(2,150)		(2,150)
Foreign exchange losses	490		490
Operating loss	(84,683)	1,248	(83,435)
Finance costs	(11,033)	(1,647)	(12,680)
Finance income	16		16
Net finance costs	(11,017)	(1,647)	(12,664)
Loss before income tax	(95,700)	(399)	(96,099)
Income tax charge	(13,434)		(13,434)
Loss for the period	(109,134)	(399)	(109,533)
Attributable to:			
Owners of the parent	(109,134)	(399)	(109,533)
Non-controlling interests	-		-
	(109,134)	(399)	(109,533)

Impact of the adoption of IFRS 16

Consolidated income statement
For the year ended March 2020

	YTD 2020		*YTD 2020*
	Previous IFRS	*IFRS 16*	*As reported*
	£'000	£'000	£'000
Revenue	600,471		600,471
Cost of sales	(342,843)		(342,843)
Gross profit	257,628	-	257,628
Distribution costs	(19,868)		(19,868)
Administrative expenses	(325,121)	2,511	(322,610)
Other operating income	1,548		1,548
Other losses	(140)		(140)
Operating loss	(85,953)	2,511	(83,442)
EBITDA before non-underlying items	62,121	14,118	76,239
Amortisation of intangible assets	(30,525)		(30,525)
Depreciation	(21,745)	(11,913)	(33,658)
Amortisation of government grant income	52		52
Impairment of intangible assets/ROU asset	(79,053)	(483)	(79,536)
Impairment of non-current assets reclassified as held for sale and profit/(loss) on closure or disposal of dental practices	(10,760)	789	(9,971)
Value of employee services arising from shares granted	(1,077)		(1,077)
Other non-underlying items	(4,826)		(4,826)
Foreign exchange losses	(140)		(140)
Operating loss	(85,953)	2,511	(83,442)
Finance costs	(44,057)	(4,367)	(48,424)
Finance income	56		56
Net finance costs	(44,001)	(4,367)	(48,368)
Loss before income tax	(129,954)	(1,856)	(131,810)
Income tax charge	(8,657)		(8,657)
Loss for the period	(138,611)	(1,856)	(140,467)
Attributable to:			
Owners of the parent	(138,611)	(1,856)	(140,467)
Non-controlling interests	-		-
	(138,611)	(1,856)	(140,467)

Impact of the adoption of IFRS 16

Consolidated balance sheet

As at 31 March 2020

		Q4 FY20		*As at 31 March 2019*	*Opening adjustment*	*As at 1 April 2019*
	Previous IFRS	*IFRS 16*	*As reported*	*As previously reported*	*IFRS 16*	*As reported*
	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets						
Goodwill	142,063		142,063	224,285		224,285
Other intangible assets	295,569		295,569	330,966		330,966
Property, plant and equipment	99,802	88,036	187,838	95,175	96,391	191,566
	537,434	88,036	625,470	650,426	96,391	746,817
Current assets						
Inventories	25,053		25,053	28,400		28,400
Trade and other receivables	53,345	(2,169)	51,176	39,732	(1,948)	37,784
Current income tax	40		40	40		40
Derivative financial instruments	289		289	-		-
Cash and cash equivalents	76,063		76,063	8,861		8,861
	154,790	(2,169)	152,621	77,033	(1,948)	75,085
Total assets	692,224	85,867	778,091	727,459	94,443	821,902
Equity attributable to the owners of the parent						
Share capital	410,961		410,961	410,961		410,961
Accumulated losses	(543,140)	(1,856)	(544,996)	(405,535)		(405,535)
	(132,179)	(1,856)	(134,035)	5,426	-	5,426
Non-controlling interest	-		-	-		-
Total equity	(132,179)	(1,856)	(134,035)	5,426	-	5,426
Non-current liabilities						
Borrowings	645,977		645,977	570,177		570,177
Other payables	163		163	229		229
Deferred income tax liabilities	19,527		19,527	10,633		10,633
Post employment benefits	401		401	593		593
Provisions	7,730	(3,465)	4,265	7,757	(3,443)	4,314
Other liabilities - leases	-	79,392	79,392	-	85,843	85,843
Total non-current liabilities	673,798	75,927	749,725	589,389	82,400	671,789
Current liabilities						
Trade and other payables	149,024	(1,563)	147,461	130,371	(1,473)	128,898
Provisions	1,581	(974)	607	1,794	(921)	873
Other liabilities - leases	-	14,333	14,333	-	14,437	14,437
Derivative financial instruments	-		-	479		479
Total current liabilities	150,605	11,796	162,401	132,644	12,043	144,687
Total liabilities	824,403	87,723	912,126	722,033	94,443	816,476
Total equity and liabilities	692,224	85,867	778,091	727,459	94,443	821,902

Impact of the adoption of IFRS 16

Consolidated cash flow statement

For the quarter ended 31 March 2020

	Q4 FY20		
	Previous IFRS	*IFRS 16*	*As reported*
	£'000		
Cash flows from operating activities			
Loss before taxation	(95,700)	(399)	(96,099)
Depreciation of property, plant and equipment	5,492	2,526	8,018
Amortisation of government grants	(13)		(13)
Amortisation of intangible assets	7,624		7,624
Finance costs	11,033	1,647	12,680
Finance income	(16)		(16)
Loss on business and asset disposals	10,728	(789)	9,939
Impairment of intangible assets	77,821	483	78,304
Differences between contingent consideration paid and initial estimates	(33)		(33)
Defined benefit pension scheme service cost	22		22
Net unrealised foreign exchange losses	(858)		(858)
Value of employee services arising from shares granted to directors and employees	269		269
Pension contributions	(15)		(15)
Cash generated from operations before movements in working capital	16,354	3,468	19,822
Changes in working capital			
Movement in inventories	3,296		3,296
Movement in trade and other receivables	(6,177)	221	(5,956)
Movement in trade and other payables	(1,124)	(90)	(1,214)
Movement in provisions	(159)	759	600
Cash generated from operations	12,190	4,358	16,548
Cash flows from investing activities			
Acquisitions (net of cash acquired)	(77)		(77)
Proceeds from sale of practices	(105)		(105)
Purchase of property, plant and equipment	(5,112)		(5,112)
Proceeds from business and asset disposals	(6)		(6)
Interest received	16		16
Net cash outflow from investing activities	(5,284)	-	(5,284)
Cash flows from financing activities			
Drawdown of bank loans	73,200		73,200
Bank and bond interest paid	(14,818)		(14,818)
Lease cash payments	-	(4,358)	(4,358)
Net cash inflow from financing activities	58,382	(4,358)	54,024
Net increase in cash and cash equivalents	65,288	-	65,288
Cash and cash equivalents at the beginning of the period	10,775		10,775
Cash and cash equivalents at the end of the period	76,063	-	76,063

Impact of the adoption of IFRS 16

Consolidated cash flow statement

For the year ended 31 March 2020

	YTD FY20		
	Previous IFRS	*IFRS 16*	*As reported*
	£'000		
Cash flows from operating activities			
Loss before taxation	(129,954)	(1,856)	(131,810)
Depreciation of property, plant and equipment	21,745	11,913	33,658
Amortisation of government grants	(52)		(52)
Amortisation of intangible assets	30,525		30,525
Finance costs	44,057	4,367	48,424
Finance income	(56)		(56)
Loss on business and asset disposals	10,791	(789)	10,002
Impairment of intangible assets	79,053	483	79,536
Differences between contingent consideration paid and initial estimates	(98)		(98)
Defined benefit pension scheme service cost	22		22
Net unrealised foreign exchange losses	(768)		(768)
Value of employee services arising from shares granted to directors and employees	1,077		1,077
Pension contributions	(62)		(62)
Cash generated from operations before movements in working capital	56,280	14,118	70,398
Changes in working capital			
Movement in inventories	3,264		3,264
Movement in trade and other receivables	(13,721)	221	(13,500)
Movement in trade and other payables	18,925	(90)	18,835
Movement in provisions	(1,495)	759	(736)
Cash generated from operations	63,253	15,008	78,261
Cash flows from investing activities			
Acquisitions (net of cash acquired)	(443)		(443)
Proceeds from sale of practices	(149)		(149)
Purchase of property, plant and equipment	(27,305)		(27,305)
Proceeds from business and asset disposals	20		20
Interest received	56		56
Net cash outflow from investing activities	(27,821)	-	(27,821)
Cash flows from financing activities			
Drawdown of bank loans	78,200		78,200
Repayment of bank loans	(5,000)		(5,000)
Bank and bond interest paid	(41,430)		(41,430)
Lease cash payments	-	(15,008)	(15,008)
Net cash inflow from financing activities	31,770	(15,008)	16,762
Net increase in cash and cash equivalents	67,202	-	67,202
Cash and cash equivalents at the beginning of the period	8,861		8,861
Cash and cash equivalents at the end of the period	76,063	-	76,063