



**The Big Decision
The nGDS contract
NHS or Private?
Which way should I go?**

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January 2006

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Executive Summary

- April 2006 represents the biggest change in dentistry since the inception of the NHS
- Whether you decide to accept or decline the new contract it will impact upon your practice
- Dentists will now be under contract with PCT's. The PCT will therefore have the power to decide at a local level its NHS dental needs
- The first three years maybe attractive financially but beyond this period expect a more robust assessment by each PCT of its dental needs and budgets
- Post the initial 3 year "protected period", we expect PCT's to be much clearer of their dental needs, and expect PCT's to drive down contract values where there are perhaps too many NHS practices
- It is our belief that the dental practices of the future will cut into two distinct forms.
 - There will be utility, low cost, low investment, necessity-driven dentistry under the residual auspices of the NHS, and;
 - There will be private practice that derives its fees from paying patients, which will need to deliver on many fronts, including financial, consumer and clinical fronts
- We believe "mixed practice" dentistry will be difficult to sustain. It is very difficult to work in two different ways or to two different standards and the idea of being able to perform high volume NHS dentistry one minute and commence high quality, time intensive private treatment the next is counter intuitive
- Under the new system, dentists will find new possibilities opening up to work the *system* to their benefit and detriment
- The UDA (Unit of Dental Activity) will become the central unit of currency post 2009 and therefore believe this three year contract must be regarded as the transition cost to a far more controlled future

So what should you do?

- We believe *now* is the perfect time to review your position on whether to accept the contract or not, and make a decision based on your business NOT just on the terms offered by the PCT
- To make a successful informed decision you need an understanding of the basic principles of financial analysis including an understanding of your fixed and variable costs, your break even point and your profit margin
- Do you know how efficient or profitable your practice is currently? Efficiency and profitability of the practice can be calculated using a range of formulae. These figures will be affected by adopting a new way of working.
- The seven steps we have detailed will help you with making your decision for your practice – to stay or to go from the NHS?
- You must consider what you, your team and your patients think, as this will affect your working environment.

- There are many places you can get help and advice but you need to consider who is best positioned to respond to your needs and consider non-financial aspects as well as financial ones.

What will your big decision be?

The Big Decision aims to help you quickly get to grips with the basics of financial analysis so that you can apply them to your own practice. Before you can sensibly decide what to do next, you need to have a clear understanding of where you are now.

We will provide you with the tools and a systematic approach to help you analyse your business as it now stands. Having set this as your benchmark, this will allow you to compare a range of future scenarios both with each other and with the here-and-now. We will also encourage you to think about the wider impacts of your decision upon all the stakeholders, and what your practising environment is likely to look like in the future depending on which route you take. When you have done all of this then your decision and your negotiations with PCTs and LHBs will be better informed.

The Big Decision will allow you to take control - rather than letting the changes control you!

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1.0 The ever changing dental world

At long last it looks like the “new contract” is finally (and actually) going to land upon us and force us to make some very important choices about our future direction and the way that we do business with the NHS.

The changes that are about to happen in April 2006 are the biggest thing to hit dentistry in the last fifty eight years (since the inception of the National Health Service). Whilst Sir Kenneth Bloomfield told us that “no change is not an option” back in the early nineties, for many practices not much change has really been evident. For some, there has been a change in the mix of dental activity. For some PDS contracts have been adopted in substitution of the old GDS. However, for most the cataclysm that is about to unfold will represent a change in the way of working that is unprecedented.

The nature of change of any sort is that it usually hurts and it usually generates great fear and anxiety. That isn't to say that change is not a good thing. Few would argue against the fact that the old system was creaking. It was cumbersome, difficult to manage and very bureaucratic. For patients it generated great uncertainty about the amount they were going to be asked to pay. For practice teams it meant a lot of form filling and a level of record keeping that consumed vast amounts of time. But the one thing about the old system was the fact that we were all familiar with it. We had been warned that change was coming, but few were anticipating the scale of the change that is actually proposed. The fact that the announcement of the change was made on 7th July – the day of the London bombings – may or may not be significant in the considering the government's perception of the likely impact of the news. Either way, it's safe to say that this is BIG!

So what are you going to do about it? How is your practice going to react? This paper seeks to look at the steps that you should take in making what is probably the biggest decision that your practice is likely to make in the foreseeable future. And make no mistake – deciding to stay with the NHS is just as much of a decision as choosing to leave it. Therefore, before you make a move, ensure you have thought about it and that you have educated yourself with a rational analysis of the options available. This paper will help you do just that.

2.0 The New Contract

April 2006 will see the arrival of two new sets of regulations that will at once replace the old style GDS and the PDS. The National Health Service (General Dental Service Contracts) Regulations 2006 and the National Health Service (Personal Dental Service Agreements) Regulations 2006 will come into force and will directly change the way dentists work within the NHS. The two sets of regulations look and read remarkably similarly to each other. The reason that two sets of regulations were necessary is that the GDSC regulations introduce nGDS and the PDSA regulations ratify the extant PDS schemes into something that looks more or less the same. The similarity of

the two sets of regulations means that for the purposes of this paper we will treat them as identical.

The biggest difference with the introduction of these new regulations is perhaps the intended recipients. In the old world, the regulations bore largely upon dentists themselves with the PCTs and the DPB acting only as enforcers of the Terms of Service for Dentists and the Statement of Dental Remuneration. The new regulations control the responsibilities and powers of the local bodies and dictates what they must provide by way of services and what contractual terms they can cannot and must include when contracting with dentists and dental practices.

Perhaps the most significant change resulting from the revocation of the old and the implementation of the new is that dentists will now formally be under contract with an individual Primary Care Trust (PCT) in England or a Local Health Board (LHB) in Wales. Under the old arrangements the power of the local health bodies was very limited and dictated by statutory regulation. In the new scheme of things the regulations dictate the content of the contracts, but the terms themselves are directly between the dentist (or practice owner) and the local commissioning body. This means that the local bodies will be able to dictate far more prescriptively the activities of local practitioners.

The most recent edition of the proposed draft contract runs to no less than 158 pages of detailed civil service style wording. In addition to setting contract values and activity levels the contract requires practice owners to submit to a plethora of forms of scrutiny ranging from financial audit, patient forum visitations, external clinical appraisal, and employee and training reviews to mention but a few.

Digesting the full significance of a document of this size and complexity is no mean feat and would take a non-lawyer quite some time and would still be likely to leave significant areas of uncertainty. On the other hand, asking your contract lawyer to give you a review of it would be likely to cost a significant amount of money and yet still leave substantial areas of uncertainty. Getting to the bottom of issues like whether it's better to contract as an "NHS Body" or not is a combination of complicated further reading and ultimately personal preference and choice. Within the text there are many other areas that leave the practitioner bound and vulnerable, but with no corresponding benefits on his or her side. It is certainly the case that a commercial contract would never be as long or as demanding and it would be open for both parties to negotiate points to mutual advantage. This is very much a "take-it-or-leave-it" contract. Under the regulations the PCTs and LHBs are simply prohibited from softening any of the requirements as described. Consequently, all a prospective contractor can hope to do is understand what obligations are placed upon them and whether they are satisfied to be so bound. At that point they can attempt to see whether the demands in terms of activity seem reasonable and whether they are likely to be able to make the numbers work. If all that stacks up, the contractor may decide to sign and accept at least the first three years of service.

Beyond the first three years the contractor should be prepared for a far more robust contracting process. By then the “protected period” will be over. The PCTs and LHBs will be better versed in the art of negotiation and will have a clearer view of what they want and where they want it. They are likely to be far more prescriptive and in parallel with the commissioning of pharmacy services are likely to pick and choose which practices they want to deal with and which they don't. They may also find themselves with areas of surfeit and areas of need. This will put them in a far better position to drive down contract values in areas where there are too many practices bidding for a smaller number of contracts. Correspondingly they will be able to divert “incentive” money to encourage new practices to open in areas of scarcity. From the public perspective this may be seen as an excellent way of making sure practices are positioned where they are needed. From a small business perspective, a three year contract horizon may be a limiting factor in deciding whether to commit substantial funds in setting up in such a highly geared business. Practitioners being offered partnership or other equity in an NHS practice my think twice before committing such funds against an uncertain future.

Given the scale of this change and the complexity of both the draft contract itself and the arcane activity calculations, it is a great concern that many practices will launch themselves into it without having a full understanding of what they are letting themselves in for. Government representatives have repeatedly exhorted the profession to “trust us”, and we're sure that these pleas are made honourably from a personal perspective. However, this is a huge request – In business terms, thousands of small businesses are being asked to commit to new ways of working that are very controlled, directed by untested local managers and with financial and activity requirements that are hugely difficult to translate in advance. This is against the backdrop of the vague threat that if you do not accept the new terms before the end of March you may not be able to contract with the NHS at all. To us this seems like a very pressurised environment; a huge decision, incomplete information, changing terms, complex calculations and a dead line!

Because it's not possible to look into the future, it's impossible to tell how this will all pan out. Will the practices that go private wish that they'd taken an nGDS contract. Will the nGDS practices watch enviously as their private neighbours grow from strength to strength. In the end, it is our view that the thing that will matter is whether the individuals concerned will feel that they have taken positive control rather than merely being buffeted by the waves.

Now is the time to begin to take control of your future and consider how you want it to be. You can only do this by formally reviewing your current situation and making a proactive decision about what you are going to do. As the one position becomes more uncertain and unpredictable, perhaps it is time to build a structure that is more within your own specification.

It is our belief that dental practice of the future will cut into two distinct forms. There will be utility, low cost, low investment, necessity-driven dentistry under the residual auspices of the NHS. This type of dentistry will be tightly controlled by the increasingly empowered local commissioning bodies. It will

be highly cost conscious and recurring contract rounds will be price-driven. Practices in this market will have to bid against each other and in line with other public sector commissioning, the local commissioners will buy solely on price. As a result the investment potential and expenditure on materials and staff will be driven ever and ever downwards. This will be welfare type dentistry that will focus on need and basic treatments only.

At the other end of the spectrum there will be private practice that derives its fees from paying patients, either on a fee per item basis or as part of private capitation plans. These practices will need to deliver on many fronts. They will need to demonstrate investment in the infrastructure, both clinical and the public areas. They will need to invest in their skill bases both from a perspective of customer service and from a perspective of clinical standards. Having made that investment they will also have to bite the bullet and put into place realistic pricing structures that reflect it. If these businesses are to survive they will need to spend time understanding their financial needs and acting in a correspondingly business-like way. This will be private dentistry where the options to spend time and explore modern techniques are standard expectations

We believe that increasingly, “mixed practice” will become a difficult thing to sustain. Whilst there may be opportunities under the NHS contract for “private upgrades” this will not really be in the same category as private treatment *per se*. This will still be utility dentistry and will need to be modestly priced reflecting both the expectations of the consumer base and the available levels of investment in skill, equipment and materials within the practice. It is very difficult to work in two different ways or to two different standards and the idea of being able to complete low grade NHS dentistry one minute and commence high quality, time intensive private treatment the next is counter intuitive.

3.0 The Big Decision – Weighted Courses of Treatment / UDAs

Notwithstanding all the other impacts of the new contract, the world seems, understandably, to be pre-occupied with Units of Dental Activity. The figures have now been received from the DPB and historic activity has been calculated both by way of financial performance and activity. The translation of the old fee per item type activity into UDAs must have involved a very complicated algorithm given that treatments were spread over a significant period of time and many visits.

Knowing the integrity of the DPB it can be confidently assumed that this analysis has been done conscientiously and accurately. What is difficult is for the practice to replicate the task from the retrospective data in order to see what it means in an operational context. The fact that each of the banded treatments may be carried out over multiple visits means that it will be difficult initially to see whether targets are likely to be met. When do you count the UDA contribution? At the beginning, the middle or the end? Are we likely to

hit our target? Will we need to devise a cunning system of assessing UDAs in progress?

As with every other change that has confronted the dental profession it is certain that we will become adept at operating the system. The difference in this instance is the scale of the change and its potential impact. Adopting the new system will have major financial consequences and will be policed by people that we have no experience of working with. The plea to “trust us” is a bold one given the size of the impact.

As with other payment systems dentists will eventually learn the vagaries of the UDA. Historically, whilst dentists have operated conscientiously they have also learned to work within the system. What are the likely implications of the UDA to treatment patterns? Will dentists just go ahead with their treatment not influenced by the new bandings or will there be “*band threshold stickiness*”? that is to say the phenomenon whereby treatments vary little from the minimum requirement in a particular band – for example will most Band 1 treatments involve just an examination and simple scale and polish? Band 2s just one filling and no more? And Band 3s no more than one crown?. Will root canal treatment become a thing of the past on the NHS on the basis that extraction of a tooth represents a perfectly acceptable option to restore oral health. Will dentists show ingenuity and introduce a middle priced set of private upgrade options?

The government have risen to the challenge of trying to modernise the dental payments system. They tell us that they are trying to free dentists from the treadmill and reflect more current treatment needs. Against a backdrop of reduced manpower availability they are also seeking to encourage less-interventive approaches and save public money. The UDA satisfies all of these requirements as the pressures within the system change from those of volume to those of throughput.

The historic and local basing of both cash and time value of the UDA mean that in the current context at least it is anything but a comparable unit. A dentist in one surgery is unlikely to have the same value as even her colleague next door. This may seem unfair but it merely brings to the fore a fact that has been present for a long time. Simply that practitioner treatment modalities are different and that practitioners work at different speeds.

We say within the current context advisedly, because this of course is a transitional period only. This three year contract must be regarded as the transition cost to a far more controlled future. At the end of that time, local finance officers within the commissioning bodies will have collated data with regard to relative outputs and efficiencies (and therefore dentists would be well advised to do the same). When the next contract round begins you can anticipate that the PCTs and LHBs will be knocking first on the doors of those whose UDAs worked out cheapest or correspondingly who produced the most of them.

Thus whilst the UDA may seem innocuous and only partially relevant for the time being, make no mistake, it will be the central unit of currency in the world

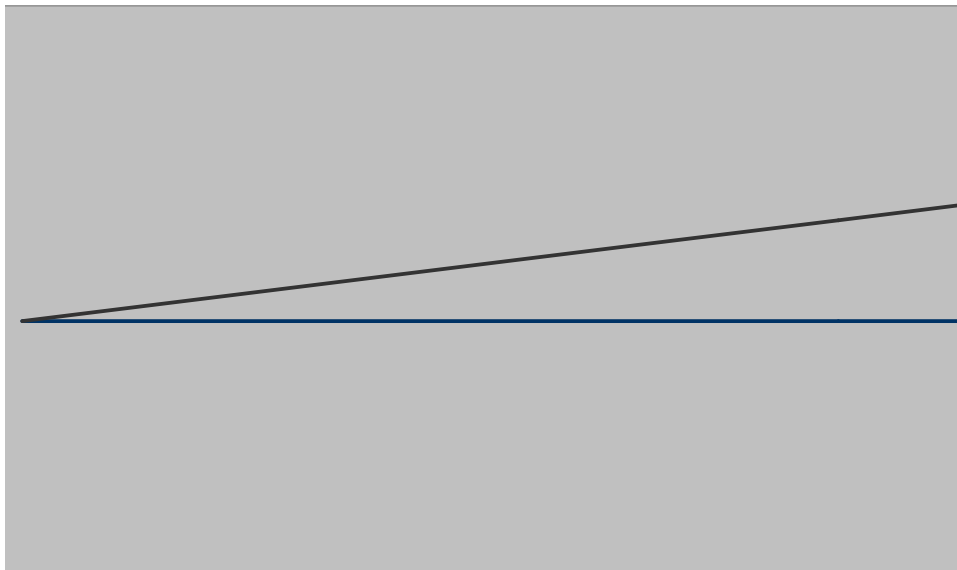
beyond 2009. It is likely that in that world a far more precise contract specification will be available. The number of UDAs required will be published as will the price per UDA and hence the total contract price. The “take-it-or-leave-it” nature of the contract already described will be further refined to place where the contract goes to the lowest bidder.

So what should you do?

4.0 Begin at the Beginning – Some of the basics of business analysis

One of the most fundamental things is to make sure that your practice can at least break even with the new contract. Whilst this sounds like an obvious thing to say, do you really know what it means? In order to understand this basic concept let’s look at the overhead structure of your business.

FIXED AND VARIABLE COSTS



In the diagram above the horizontal line represents the fixed costs of the practice. These are things like property rent and, in the steady state, staff wages. These are the things that you have to pay for whether or not the practice is actually producing anything. As you arrive at the practice every morning this element of your costs begins to run before you even open the front door.

The inclined line on top of the fixed cost line represents the variable costs for the practice. These are the costs that you begin to incur only when you begin to consume things. So as you turn the electricity on, as you use filling

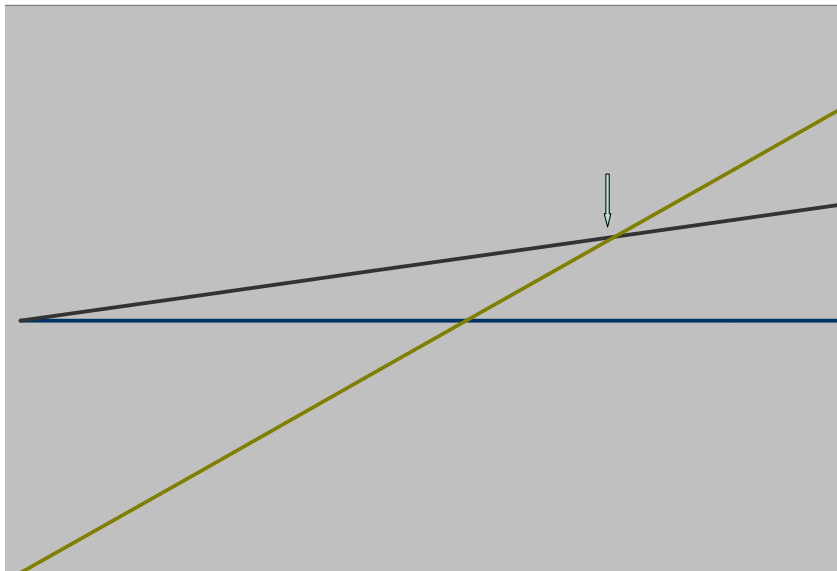
materials and as you stick stamps on recall cards an additional element of cost is added to the fixed costs.

The two lines together represent the total running costs of your business.

Of course the story doesn't end there. Once you start to work you should also begin to start generating income for the practice. It will take some time before the fees that you generate meet and outstrip the total running costs of the business. Up until that point, the practice will be running in deficit. It is the point where the incremental income passes through the total cost line that the practice begins to break even.

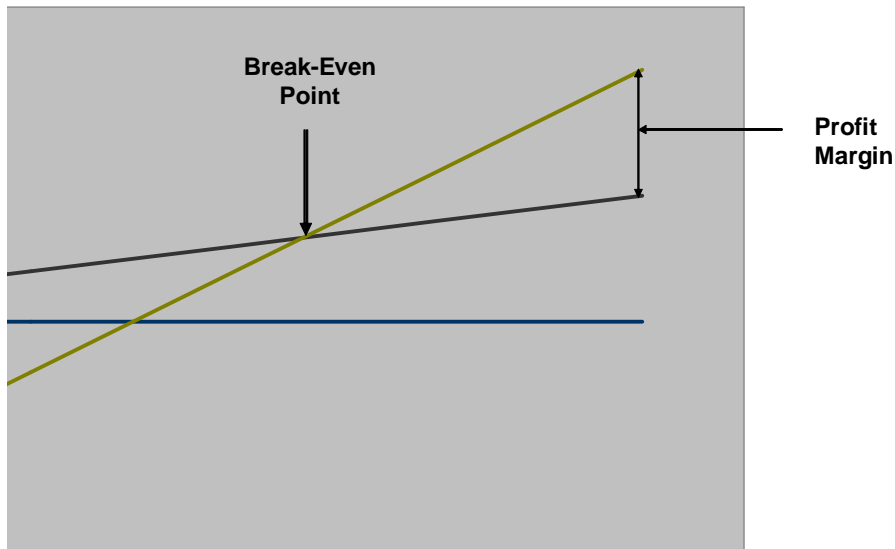
The diagram below shows the practice income growing to exceed the total running costs.

BREAK EVEN POINT



Going beyond the break even point, the total difference between the total running costs and the practice income is identified as the profit margin.

PROFIT MARGIN



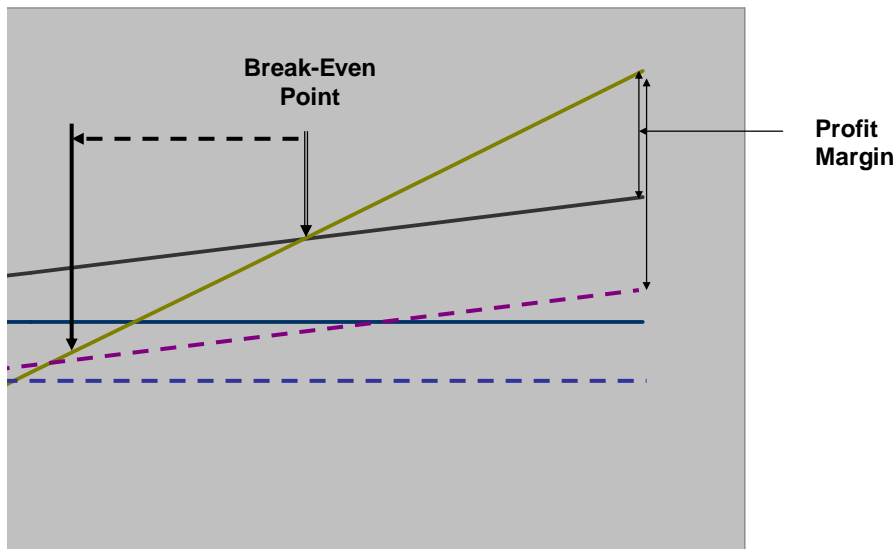
This is really the basis of everything else you need to know. Once you have identified the components of your practice running costs and your current practice revenues you will have an idea of what the current profitability of the business is. This should be the starting point from which to decide which way to go next.

5.0 Comparing different types of business model and enhancing profitability for your practice

When deciding whether to go private or whether to stay within the NHS it is important to understand what you can do to influence the profitability of your business when moving forward.

Within the NHS, the contract price will be fixed at the beginning of the contract term and therefore you will be in a position to know precisely what your earning stream will look like from the outset. This obviously offers a comforting level of predictability when considering your future. However, it also results in the fact that you have limited means by which you can influence the profitability of the practice;

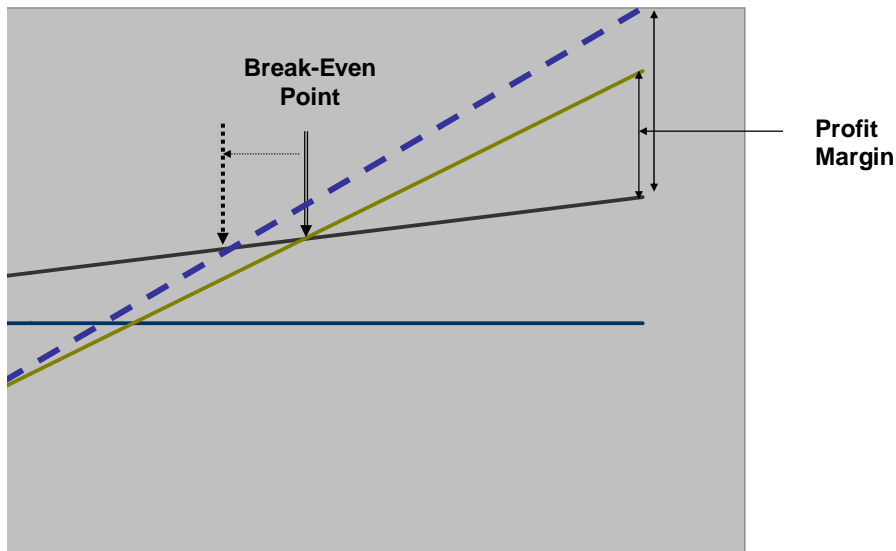
REDUCING THE FIXED AND VARIABLE COSTS



Here it can be seen that whilst the income line remains the same, the total costs of the practice have been reduced. This has the impact of allowing the practice to break even at a lower level and to increase its profitability. This is a practice where overheads are strictly controlled. There is little room for major investment in new equipment and other infra-structure. It is a practice where materials used need to be keenly scrutinised to avoid waste either in terms of excess or high-priced branded goods.

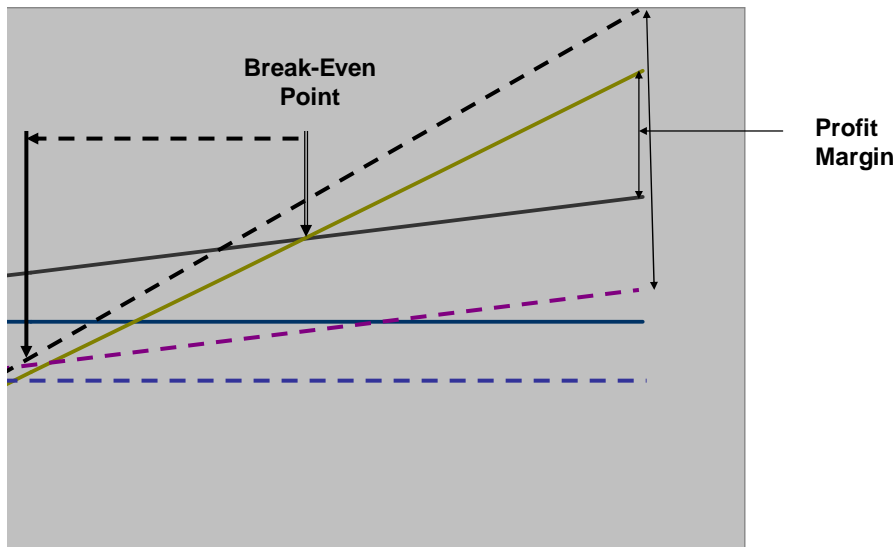
By moving into a private environment, a practice gives itself the opportunity to influence its profitability in another way. By looking at pricing and levels of activity, the practice can drive up the total income of the practice against its existing overhead base as demonstrated in the following diagram:

INCREASING THE CHARGE OUT RATE



Of course this practice also has the opportunity to look at its overheads as well and so can have a further impact on profitability;

INCREASING THE CHARGE OUT RATE AND REDUCING THE COSTS



Here the practice has managed to drive up income and drive down costs at the same time. This might not be easy in an environment where you are trying to demonstrate an improvement in the quality of service, but it does demonstrate that the opportunities to influence profit are greater in a de-restricted environment.

So what does all this mean in real life?

- You have choices.

What do you need to know to make an informed decision?

6.0 Analysis of your Practice

The analysis of your practice can be carried out both at an individual level and at an aggregate practice level. It is actually preferable to do both as this will allow you to compare performance within the practice and so identify the more profitable areas (but beware because it will also identify the less profitable areas!)

This exercise alone will be very useful as it should allow you immediately to identify best practice and eliminate waste. Beyond this it will allow you to compare what you have now with what both possible future scenarios offer.

We strongly recommend you assess your practice using the following steps.

Step One – Calculate current levels of profitability and activity

By accessing your most recent profit and loss account you will be able to see last year's figure both in terms of turnover and in terms of overheads. From this you will be able to get an understanding of how profitable the business is.

Overheads and costs (O)

You may want to ask yourself some questions about whether the overheads are roughly right and whether they are properly apportioned between the operators within the practice.

- Are there any areas where you might immediately make savings?
- Conversely, are there areas where you think you might need to spend more next year?
- Using the figures in hand try to get a feel for what, if nothing changes, the overheads and costs are likely to be next year.

Income (I)

Next look at the level of income. Try to get an understanding of how it was derived relative to the mix of activity.

- How much was derived from the NHS?
- How much was derived from private work?
- What about the total income? How did that compare with previous years? Has it gone up? ...gone down? ...stayed the same?
- Are there any ready explanations for any changes?

Profitability (P)

Profit is simply income minus overheads and costs.

- So how profitable were you?

- And how satisfied with that profit were you? Did the profit provide the level of income you desire for your lifestyle?
- How do you want to do this year? Was it about right? Do you need more? Could you cope with less?
- Using the actual figure for last year try to set yourself a goal for the coming year.

Activity level (A)

There are various ways that you might be able to calculate or estimate activity levels. Probably the most accurate is the use of the management information system in your practice management software. This should be able to tell you how many working hours each of the operators worked within the year.

If you don't have this facility, you may be able to obtain the same information manually by looking at holiday rotas, training schedules and normal working patterns. Whichever method you use, you should aim to get an idea of what level of activity, in terms of %, each operator is currently contributing

Step two – Carry out some ratio analysis

Having derived the raw data you can now begin to get a better understanding of how the practice is doing;

Efficiency (P/T)

By dividing the Profit figure by the turnover figure you can obtain an indication of how much effort you have to put in to deliver your actual income.

This should be very revealing. The opposite ends of the spectrum might be described as “busy fools” (where a lot of activity generates a small profit) to “idle rich” (where relatively little input generates large profits).

Hourly Running Costs (O/A)

By dividing the overheads and costs by the number of available earning hours you can get a better understanding of what it costs you in each hour to run the practice.

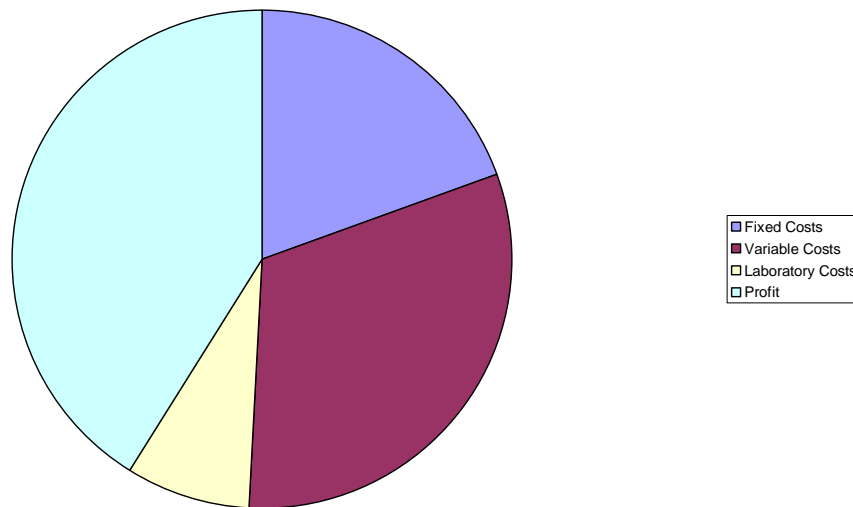
This will show you what you must earn as a bare minimum just to break even.

Hourly Profit and Loss ((O+P)/A)

If you depict this as a pie chart this may help your understanding of hourly performance.

You may be able to translate this visually as a clock and see what stage in each hour you start to make money.

Hourly Profit and Loss



In the example shown it can be seen that until just after twenty five to the next hour all the activity is consumed paying overheads, cost and the laboratory. Only after that time is profit generated. Alternatively if the chart represents the eight hours of a working day you can see that the practice only begins to make profit after the first five hours.

Other Ratios

These are only a few of the possible ratios that you might use. You can experiment with others to provide yourself with information that is meaningful to you.

Step Three – Establish a standard data set

Once you have looked at a variety of different measures and ratios you should decide upon a small number of key performance indicators that define the effectiveness and efficiency of your business as it currently stands.

Having decided on the key indicators for the business you can use historic data to compare previous performance.

- Are there any trends evident? Is the business improving? Deteriorating? Staying the same?
- How do the different parts of the practice compare with each other? How does current performance compare with your needs? Is it likely to satisfy future needs?

Step Four – Analyse the indicative numbers from the DPB

You will have received the standard documentation from the DPB that will include the contract value for the year and the contract activity requirement. There will also be an indication of what your level of time commitment will

need to be. Now being a master of ratio analysis you will readily be able to understand how to analyse this raw data and to derive the income per UDA (Unit of Dental Activity) and the time requirement per UDA. By using your own data you will also be able to determine your required costs per UDA and therefore your profitability.

By working out the income for each unit of dental activity you will begin to get a flavour for how your time in the practice will need to be spent. This should also begin to give you an idea of how much non-contracted time you might have spare.

From our understanding, different PCT's have given different contract values to dentists, so comparing contract values amongst dentists on a national level could prove difficult at this stage.

Step Five – Compare the old with the new

Having now derived both your historic performance data and the proposed future contract values, you will now be in a position to compare the future arrangements with your recent expectations. Only at this point will you begin to be able to make a sensible comparison between what has been offered with what you have been used to. You will also have a view about what levels of investment the practice needs and what your future personal expectations are. From a purely financial perspective you can now begin to decide whether what is being offered is attractive to you.

Step six – Think about alternatives

Much discussion takes place in abstract terms about “going private”, but what exactly does that mean? Having got to this stage you are in possession of sufficient data to see how your future would map out as compared to your historic experience. Against this backdrop you can now begin to properly consider what a private transition might look like.

You can look at the financial implications in terms of likely income in each scenario and likely workload. You should also think about the indirect impact of each position:

- If you are going private you will need to demonstrate to your patients that you are maintaining and improving the practice. You will need to invest in the whole team so that they understand the high levels of customer service that your patients (who will be paying more) will come to expect.
- On the other hand everything in the NHS contract environment will be driven by managing overheads. You won't be able to afford extravagant investment. You will need to generate a cost consciousness amongst the team. You may need to invest in a substantial management information system to allow you to manage the costs.

You also need to think about the views of yourself and your team. How do you feel about each of the scenarios? What are your ideological drivers? What are your personal financial needs? The whole team needs to think this one through. Unless you are committed to whichever course you take you are unlikely to succeed.

And what about your patient base? Does the socio-economic/demographic profile realistically support the possibility of a private conversion? You should be careful about making subjective assessments on this point. Both hapless optimism and unnecessary pessimism can steer you down the wrong path. You should try to make an informed decision with a scientific assessment of the position. Other significant factors might include the length of standing of the practice, the age profile of the practitioners and their proximity to pensionable age.

Step seven – Think about getting help!

As you can see the process for making your decision is a complex one. It involves a number of management disciplines and a considerable amount of time.

To some this will be a refreshing and rewarding challenge. To others it may appear to be a daunting and depressing burden.

Whatever your feelings about the process, the one truth is that if you are going to make a rational decision about the next step you will need to put some effort in. As a full time practising dentist you may feel that your skills are better directed in the clinical context and you may lack confidence in your own ability to come to the right conclusions.

The fortunate thing is that there has been an expansion in the number and range of practice support agencies that can offer you support. In addition many of the private capitation plan providers offer consultancy service in practice appraisal and private conversion. Do beware of advisers with a particular agenda however. If they are in the business of selling private practice then there may be a bias in favour of that route even if it doesn't necessarily match your practice needs. Many accountancy firms are in a position to offer advice in wider areas than just tax returns and financial statements.

Make sure anyone you turn to for advice has the capacity to provide advice that takes other issues into consideration and doesn't focus solely on just the money! Yours is a people business, and whilst an understanding of the finances is imperative, it is far from the end of the story.

The financial analysis informs the art of the possible – the rest of the exercise helps you decide upon the business you actually want to be in!

If this paper has struck a chord with you, and you want to find out more about how you can help your self about this critical decision in your practice book yourself on one of two evening seminars we are holding over the next few weeks! See below for details:

Evening Seminars
The Big Decision
The New Contract – In or Out?
Central London
Tuesday 17th January
Tuesday 7th February

In April 2006 the New Contract comes into being and it will be time to decide – are you in or out?

Samera Ltd have commissioned Dr Peter Ward BDS MBA LLB(Hons), with 25 years dental experience and the former head of a dental corporate, to compile a comprehensive report on the new contract and the implications for the UK dental industry.

In an evening seminar, Peter and Arun Mehra, Managing Director of Samera Ltd, will present the findings of the report in a manner designed to help you make sense of the contract and make it easier to make the decisions which will affect the way you practice dentistry.

The evening will cover the following topics:

- An overview of the current status
- Caution – beware of making ill informed decisions
- The tools you will need to make your decision
 - The questions you need to answer
 - The implications for your practice
 - What you need to do next

Event details – Spaces strictly limited

Location: Central London

Time: 6.30pm for 7pm

Cost: £50

Contact: Sarah Trott, Marketing Executive
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