An investigation into the variability of primary care oral surgery contracts and tariffs in England and Wales (2014/2015)

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In brief

Discusses primary care oral surgery tariffs in England and Wales.

Discusses contract types in primary care oral surgery in England and Wales.

Includes evidence-based recommendations for standardisation of primary care oral surgery contracts and tariffs.

Primary care oral surgery services vary markedly throughout the country but until now there has been a paucity of data on these services. The British Association of Oral Surgeons (BAOS) primary care group (the authors) were tasked to gather data around primary care oral surgery contracts and tariffs and provide evidence-based recommendations on the commissioning of these services. Following a freedom of information (FOI) request, data were obtained for 27 English local area teams and seven Welsh local health boards. The data demonstrated both regional and national variability with respect to primary care oral surgery contracts, concerning both contract type and level of remuneration. These differences are discussed and the authors make recommendations for standardising oral surgery contracts and tariffs.

Introduction

The Medical Education England *Review of oral surgery services and training* published in 2010 recommended the expansion and development of commissioning of primary care oral surgery (PCOS) services to better serve local need. It concluded 'there is considerable support for the expansion and extension of OS services in the primary care setting to support local delivery of services.'[1] While some areas had already successfully commissioned services,[2,3] the increase and development of PCOS followed this review.

The aspirations of this document have been expanded upon in the *Guide for commissioning oral surgery and oral medicine*[4] which was published in 2015. This guide describes the direction required to commission oral surgery services in primary care using a consistent and coherent approach. Further work on the implementation of this guide is ongoing.

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Refereed Paper. Accepted 21 February 2017
DOI: 10.1038/sj.bdj.2017.500

The BAOS became aware that there was considerable variation nationally in both the type of contracts being awarded and in the level of remuneration made available. Disappointingly, high quality national data on these contracts was not easily accessible. BAOS was invited by the Chief Dental Officer, Sara Hurley, to provide evidence-based recommendations around the commissioning of oral surgery services to assist with implementation of the visions set out in the commissioning guide.

Materials and methods

The BAOS primary care group (the authors) formulated a request for disclosure of data relating to primary care oral surgery contracts in accordance with the Freedom of Information Act.[5] This was submitted to every area team (the local dental commissioning arms of NHS England) and to their Welsh equivalents (health boards).

This very detailed request was refused by NHS England under Section 12 of the Act[5] as they estimated that the cost of compliance would exceed the prescribed limit of eighteen hours of administration time. Following further discussions with the freedom of information team the request was modified (see Box 1) and resubmitted. Data were ultimately received for 27 English local area teams (LATs) and seven Welsh local health boards (LHBs).

In addition to this data, the accounts of an urban practice holding a regional oral surgery

Box 1 The FOI request

Please provide the following information relating to all area teams under the Freedom of Information Act. For the purposes of this request primary care oral surgery can be defined as oral surgery taking place outside a hospital environment.

For the financial year 2014/15;

1) The total commissioned activity for primary care oral surgery (£)
2) – minimum, maximum and mean fee payable for a consultation
   – minimum, maximum and mean fee payable for a surgical extraction with local anaesthesia alone
   – minimum, maximum and mean fee payable for a surgical extraction with inhalational (nitrous oxide) sedation
   – minimum, maximum and mean fee payable for a surgical extraction with intravenous sedation

(For contracts paid through UDAs, please provide the minimum, maximum and mean UDA value).

contract was analysed to provide data on the cost of establishing and running a stand-alone primary care oral surgery service.

Results

The figures for the total commissioned activity for primary care oral surgery (PCOS) for 27 English LATs and seven Welsh LHBs are shown in Table 1. Some of the English data were grouped into regions (shown in the first column). The second column details the LATs in each region. Columns three and four show the total spend on oral surgery commissioned and the population per region.[6,7] The last column shows the regional oral surgery spend per head of population which varies from £0.12 in Lancashire and Greater Manchester to £1.75 in Hertfordshire and South Midlands.

Four out of the seven Welsh LHBs who replied commission oral surgery services (Cwm Taf, Powys and Betsi Cadwallader do not). The figure for Cardiff and Vale is improbably high and is most likely to include secondary care services. Attempts to clarify the correct figure have been unsuccessful.

If Cardiff and Vale is excluded, the total PCOS spend of the 27 LATs and three LHBs (19 regions) ranges from just under £200,000 (Shropshire and Staffordshire) to just over £4.5 million (Hertfordshire & South Midlands). The total commissioned activity is just under £49 million with a mean spend of £2.7 million.

The data showed that there are two main contracts offered – primary dental service (PDS) contracts based around units of dental activity (UDA) and service level agreements (SLAs).

Eight regions (five English and three Welsh) run PDS contracts with a mean UDA value across all respondents of £60. The value was highly variable, ranging from £20 in Cardiff and Vale to £99 in Yorkshire and Humber (Fig. 1). Additionally, four out of eight regions demonstrated considerable intra-regional variation. Information on the number of UDAs per course of treatment was not available (although the norm is three, this cannot be assumed). Aneurin Bevin and ABMU boards only commission PDS contracts (Cardiff and Vale also commission PDS contracts and may commission SLA contracts but this is unclear from their data) while the five others provide services under a mixture of PDS and SLAs.

Table 1 Total commissioned activity and cost per head of population for primary care oral surgery (PCOS) 2014/15 by region, local area teams and health boards

Region	Local area teams and Welsh health boards	Total commissioned activity PCOS	Population[6,7]	£1.12
Cumbria and North East	Cumbria, Northumberland, Tyne & Wear; Durham, Darlington & Tees	£2,142,905.00	1,910,000	£0.67
Yorkshire and Humber	North Yorkshire and Humber; South Yorkshire and Bassetlaw; West Yorkshire	£3,576,857.82	5,352,000	£0.48
Cheshire and Merseyside	Cheshire, Warrington and Wirral; Merseyside	£1,124,295.00	2,365,000	£0.13
Shropshire and Staffordshire	Shropshire and Staffordshire	£191,909.00	1,496,000	£0.44
Derbyshire and Nottinghamshire	Derbyshire and Nottinghamshire	£854,000.00	1,933,000	£1.21
Leicestershire and Lincolnshire	Leicestershire and Lincolnshire	£2,032,683.00	1,674,000	£1.75
Hertfordshire and South Midlands	Hertfordshire and South Midlands	£4,600,838.00	2,628,000	£0.19
West Midlands	Birmingham and the Black Country; Arden, Herefordshire and Worcestershire	£730,211.00	3,925,000	£0.73
Midlands and East	East Anglia; Essex	£2,912,464.00	3,993,000	£0.36
South Central	Bath, Gloucestershire, Swindon and Wiltshire; Thames Valley	£1,213,904.00	3,396,000	£0.19
Wessex	Wessex	£484,591.00	2,550,000	£0.16
South West	Bristol, North Somerset, Somerset and South Gloucestershire; Devon, Cornwall and Isles of Scilly	£493,612.00	3,065,000	£0.40
South East	Surrey and Sussex; Kent and Medway	£1,708,515.00	4,302,000	£0.39
London	North East London; North West London; South London	£3,058,854.00	7,758,000	£0.12
Lancashire and Greater Manchester	Lancashire; Greater Manchester	£487,597.00	4,060,000	£0.86
Aneurin Bevan	Aneurin Bevan	£499,902.00	580,400	£1.30
Hywel Dda	Hywel Dda	£500,000.00	384,000	£0.51
ABMU	ABMU	£268,053.60	523,000	£50.69
Cardiff and Vale	Cardiff and Vale	£24,432,000*	482,000	-
Cwm Taf	Cwm Taf	-	296,000	-
Powys	Powys	-	132,700	-
Betsi Cadwallader	Betsi Cadwallader	-	694,000	-

*The figure for Cardiff and Vale LHB is improbably high and probably includes secondary care services. Attempts to clarify the correct figure have been unsuccessful.

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Fig. 1 PDS contracts: UDA values

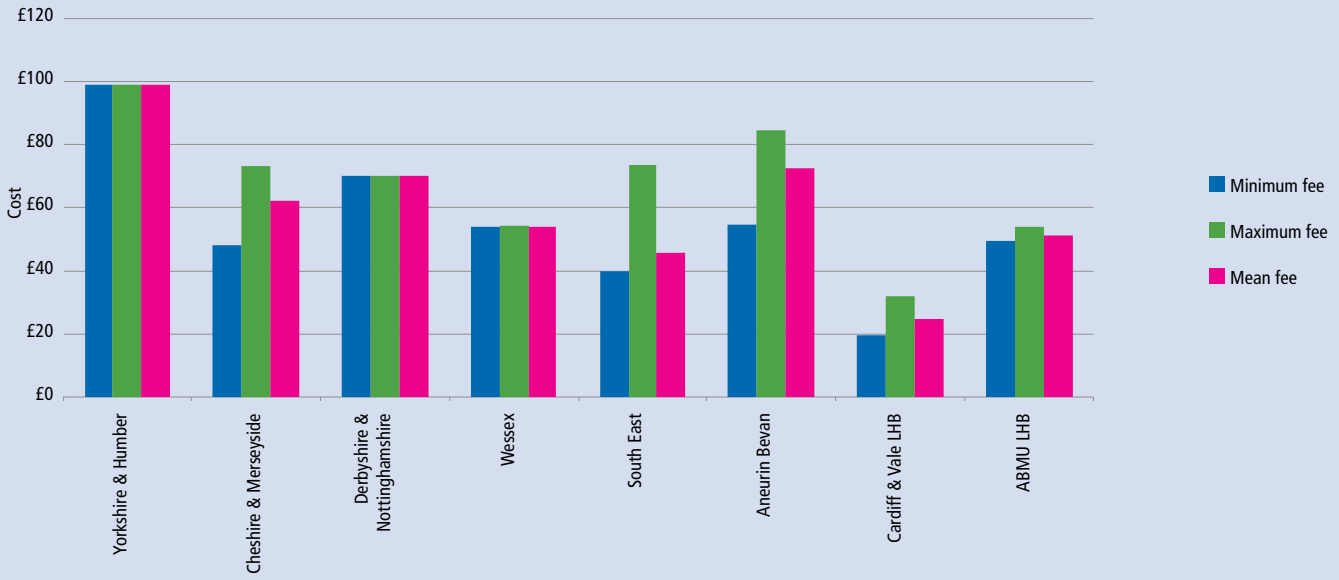

Fig. 2 SLA contracts: fees per case for assessments

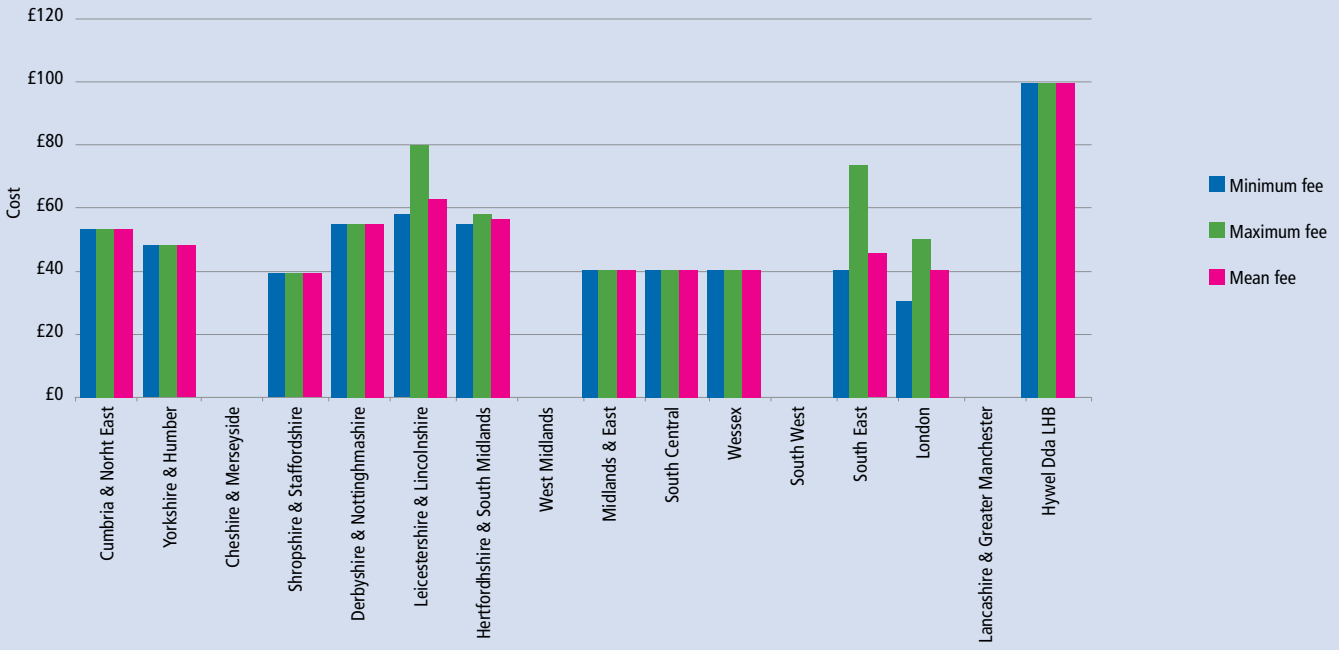

Figure 2 shows the 17 regions that commission SLA contracts and the assessment fees paid. These range from £30 (London) to £100 (Hywel Dda). Three regions appear to pay nothing for an assessment visit.

SLA fees for treatment with local anaesthesia alone, from the same 17 regions, are shown in Figure 3. The mean fee across all respondents was £199. These are again very variable (from £100 in South Central to £546 in Lancashire and Greater Manchester). Some of these fees may include assessment within the fee.

Figure 4 shows SLA fees for the 14 out of 17 regions that commission treatment with local anaesthetic and sedation. The mean fee across all respondents was £277. Once again, the tariffs are highly variable (from £112 in London to £621 in Yorkshire and Humber).

One region (Yorkshire and Humber) responded to the request with a very detailed 'fee per item' tariff, which is reproduced in Table 2. This is given to ten out of 21 PCOS providers in the region. The remaining 11 providers command tariffs varying from £120–£225 per procedure, including sedation.

Table 3 shows the 2013/2014 profit/loss for an urban stand-alone single surgery OS practice in the North East of England. The bottom-line profit is 7.6%.

Discussion

The data received from the freedom of information request provides a valuable national picture of how variable the PCOS commissioning landscape is. The complexity of different

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Fig. 3 SLA contracts: fees per case for local anaesthetic.

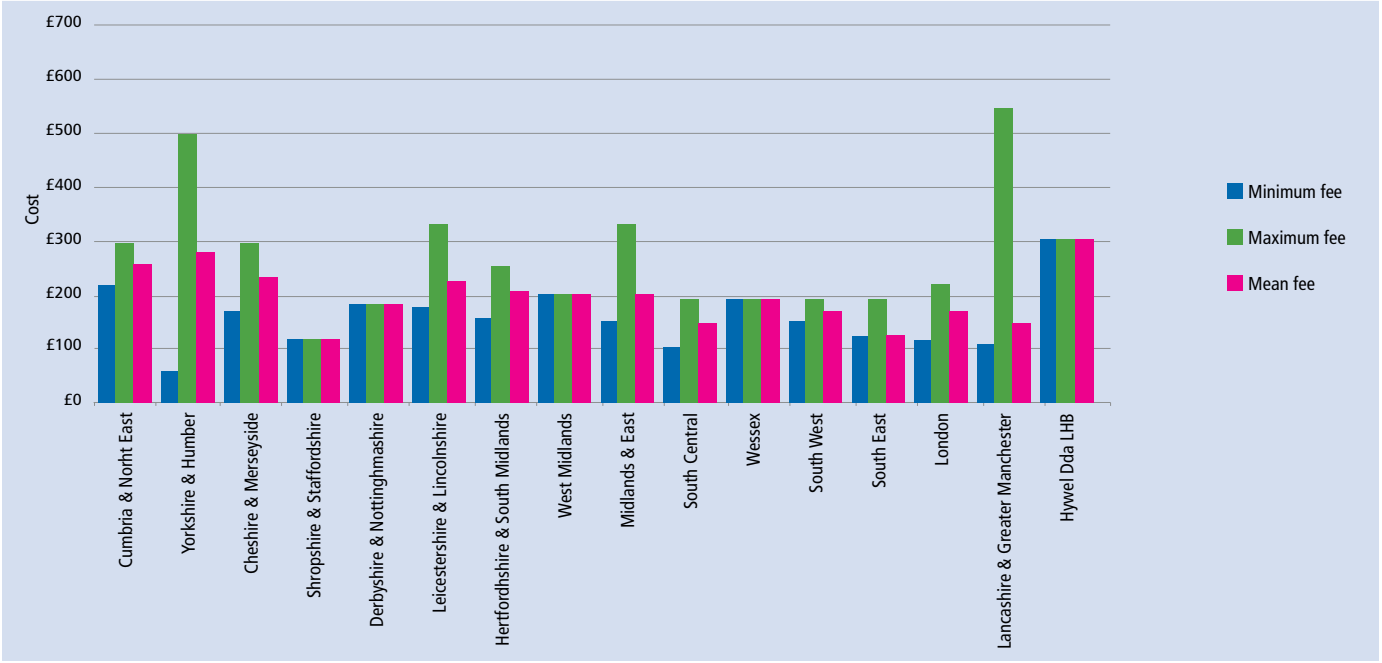
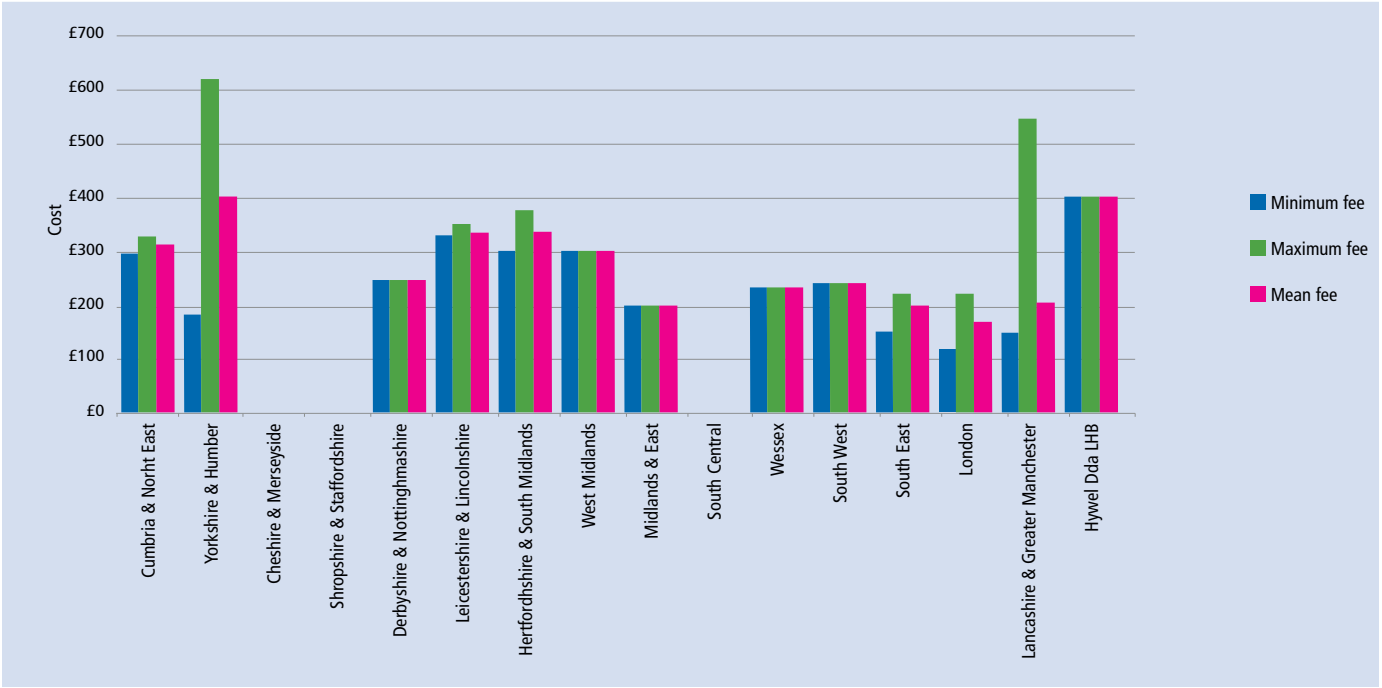


Fig. 4 SLA contracts: fees per case for local anaesthetic with sedation



contract types and the challenge of even defining the boundaries of primary and secondary care mean some figures should be interpreted with caution. This was illustrated by the Cardiff and Vale response, which appears to be an outlier and is very likely to include secondary care spend. Despite this, the huge differences in remuneration for providers were clearly evident and cannot be accounted for by the geographically variable cost of providing the service, especially in light of substantial variation within the LAT or LHB regions. The best example of intra-regional variability was Yorkshire and Humber where ten out of 21 providers in the region receive a fairly complex 'fee per item' tariff (Table 2) while the remainder are on considerably variable PDS and SLA tariffs. This seems illogical and unnecessarily complicated.

Despite some difficulty with interpretation (confounded by the regional grouping of the English data), these data provide a reasonable starting point for understanding how PCOS is currently commissioned across England and Wales. Three regions were using PDS contracts alone, five a mix of PDS and SLA, and twelve SLA alone. Table 4 summarises the numerous differences between the two contract types. The discrepancies in the levying of patient charges and payment of superannuation are the most controversial of these and this variation seems inequitable to both providers and patients alike.

As PCOS expands, there is likely to be greater demand from patients for a consistent

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and logical approach to the collection of patient charges, especially given the widespread expectation that specialist services (previously delivered in hospital settings) should be free at the point of delivery. This is the case with SLA contracts but not PDS, with some patients being charged for a procedure while others are not.

The data on sedation showed that inhalational sedation (IHS) with nitrous oxide was very rarely commissioned and the vast majority of sedation carried out is intravenous (IV) in nature. This is perhaps an oversight as IHS can often be used when IV sedation is contraindicated. Furthermore, IHS has been shown to be effective in reducing anxiety in adults attending for oral surgery procedures[8] making it a good alternative for those unsuitable for IV sedation on medical or social grounds.

Some commissioning bodies pay an additional fee for sedation and some do not. As there is clearly a cost to the provider in meeting the mandatory and best practice standards in sedation[9,10] it would seem reasonable for this to be remunerated. It is possible that in some areas the additional cost has either been 'built in' to a generic fee or that the fee has been omitted to discourage over-prescription of sedation. Two out of three regions, which do not appear to pay an assessment fee, also commission sedation services. This is at odds with best sedation[9] and medico-legal[11] practice. Those regions that do not commission sedation in primary care may be paying more for their patients to be treated in secondary care where tariffs are often higher.[2]

Table 2 Fee per item tariffs for Yorkshire and Humber

Visit type	Tariff
Adult – Consultation	£47.69
Adult – Surgical referral	£47.69
Adult – Post-op emergency	£36.28
Adult – Post-op review	£36.28
Adult – Sutures	£36.28
Adult – Dressings	£36.28
Paediatric – Dental out-patient appointment (45 minutes)	£157.02
Paediatric – Dental treatment appointment (30 minutes)	£104.68
Procedures – Oral surgery	**2014/15 Tariff**
Additional extractions same session	£ -
All 4 third molars impacted same session	£496.44
Apicectomy	£217.67
Apicectomy (additional roots)	£87.83
Extracted wisdom tooth upper same session	£108.84
Extraction clearance/plasty/curettage	£326.51
Extraction lower same session	£149.89
Extraction wisdom tooth impacted lower	£217.67
Extraction wisdom tooth upper impacted	£149.89
Hemisection/root resection	£217.67
Panoral X-ray	£32.46
Peri-apical X-ray	£10.51
Prescription fee	£11.46
Simple extraction per tooth	£57.28
Surgical exposure/impaction orthodontic	£217.67
Surgical extraction (minor intervention)	£71.61
Treatment of infected socket	£54.43
IV Sedation per hour (minimum fee)	£124.11

Commissioners also need to consider any additional services that primary care oral surgeons may be able to provide, for example, soft tissue biopsies. This will mean organising for the specimen to be processed histopathologically as well as perhaps seeing the patient for a follow up appointment to check healing and to discuss the results. Similarly, specialist oral surgeons may be competent to see patients with temporomandibular joint pain or intra-oral white patches such as lichen planus. These conditions can require longer appointments to consult with and diagnose the patient with the potential need for multiple follow up appointments. Conditions such as these are not easily grouped into a basic oral surgery tariff and we would recommend an in-depth discussion with the provider to ensure a suitable tariff is agreed upon.

The broad nature of the request to include all PCOS means that the activity will reflect a wide skill mix ranging from dentists without formal training, but with an interest in oral surgery, to consultant-delivered care.[12] As commissioning becomes more structured around the three tiers of care central to the commissioning model for dentistry,[4] it is anticipated that managed clinical networks (MCNs) will take on a greater quality assurance role in matching treatment complexity to provider competence. What is of vital importance is that the provider should either be on the specialist list for oral surgery or be able to objectively demonstrate their competence. Any GDPs providing tier 2 oral surgery should be appropriately quality assured and all providers monitored to ensure they are delivering an optimal service.

The extent of the variation in tariff is surprising and the cost of providing a service illustrated in Table 3 makes it difficult to see how some of the minimum tariffs could be profitable while maintaining quality. The proposed introduction of patient reported outcome and experience measures[4] (PROMS/PREMS) in England may go some way to providing real-time data on service quality.

Recommendations

In order to encourage the expansion of PCOS there should be an expectation that tariffs and contracts do not favour incumbent providers. New services require substantial investment in infrastructure and human resources to deliver complex treatment in a primary care environment. Contracts should reflect this, both in their duration and in the level of their remuneration. Robust management of

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contracts by commissioners is essential and can be facilitated through means such as MCN oversight of skill mix, PROMS/PREMS data and mandatory SAAD inspections[9] for services offering sedation.

Any tariff has to be viable to allow potential providers to run their business. This may depend on the size of the practice as well as additional contracts in operation. Setting up a stand-alone practice is costly and any business plan will need to be approved for a business loan. In order for this to happen, the contract duration must be sufficient for the viability of a loan and for this reason the authors would recommend a minimum duration of five years for a contract. It may not be possible to offer a service for some of the lower tariffs unless other income streams in the practice provide sufficient long-term stability to make investment viable. This would be impossible for a stand-alone oral surgery provider. In addition, an annual uplift needs to be built in to the tariff to allow for inflation and the inevitable increasing costs of running a service over time.

A reasonable profit enables a practice to re-invest in equipment and infrastructure as well as to provide the appropriate staff training to ensure a gold standard oral surgery and sedation service. A narrow profit margin could result in corner cutting where patients will ultimately suffer if services fail or are of poor quality.

Table 5 shows the authors' recommended SLA tariff, which is based on a current SLA contract in Wales and is competitively priced based on the figures we obtained from our FOI request. The SLA fees should reflect the fact that there is no superannuation included (as with a PDS contract) and therefore should be higher to compensate for this.

We realise that the inclusion of a fee for patients who fail to attend is controversial but would advocate this providing the practice has taken all possible steps to ensure attendance. By this, we mean that it is not acceptable to merely send the patient an appointment letter in the post hoping that they will attend. We would suggest that once a patient is at the top of the waiting list they are sent a letter inviting them to contact the practice to make a mutually convenient appointment. Once the patient has telephoned and confirmed an acceptable time and date to attend, a confirmation letter with those details together with other relevant information is sent out via post or email. In addition to this, the patient should be sent a text message two days before the appointment. If after all of these measures, a patient still fails to attend their

Table 3 Profit/loss accounts for an urban stand-alone practice in North-East England

Sales			**Minor oral surgery**
NHS income	155 assessments only @ £53.03	1532 assessment & treatments @ £295	£460,159.65
	(On average 20 minutes assessment and 45 mins – 1hr of treatment time)		
Total income			**£460,159.65**
Direct costs			
Pathology fees			£1,578.00
Stock and materials			£25,457.58
Specialist oral surgeon		1.3 × WTE	£140,280.00
Additional superannuation expense employers contributions 16.9%			£0
Total direct costs			£167,315.58
Gross profit			£292,844.07
Gross profit%			63.60%
Indirect costs			
Gross wages			£100,478.58
Employers NI and auto enrolment @ 1%			£28,457.58
Rent and rates			£32,000.00
Insurance			£1,346.89
Heat, light and power			£3,940.21
Printing, postage and stationary			£7,674.53
Telephone			£2,954.69
Computer expenses			£5,094.18
Communication that is, website, documentation for patients, referrers			£6,636.37
Accounting fees			£1,191.40
Repairs and maintenance			£9,624.77
Cleaning			£5,000.00
Clinical waste			£3,899.07
General waste			£5,405.30
Bank charges and capital loan interest			£4,124.56
Annual capital expenditure repayment based on five year contract			£40,000.00
Total expenditure			**£257,828.13**
Net profit			**£35,015.94**
Net profit%			**7.60%**

Notes
These figures are based on the following assumptions:
1) A commitment to a 5-year Contract to allow for £200,000 capital investment repaid at £40,000 annum.
2) The Profit and Loss account reflects the revenue and expenditure of 1 year of this Minor Oral Surgery Service in Primary Care
3) These costs relate to the set up of running a 1 surgery facility with Reception & Waiting area, Decontamination facilities, X-ray Equipment, Staff Rooms and Toilets
4) Gross Wages & National Insurance is based on 2 x Receptionists 2 X Nurses 1 X Decontamination Nurse 1 x Practice Manager
5) For this service oral surgeons are not part of the NHS Superannuation scheme as this is a service level agreement contract. This seems unfair as these are NHS specialist clinicians delivering NHS services and an additional 16.9% employers contribution would be required. If the provider is to pay this superannuation, additional income would be required on top of fee levels
6) The Net Profit% is not sustainable for 5 years due to inflation of costs such as compliance, regulation, staffing and depreciation. The current tariff would not be sustainable for a 5 year period.
7) Treatment Fees include IV or Inhalational Sedation when required and on average this is for around 70% of patients.

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Table 4 Differences between PDS and SLA contracts

PDS contract	SLA contract
Based around UDAs – generally 3 UDAs are payable for assessment + treatment	Usually based around flat fees, although this can be a customised 'fee per item' scale
Limited flexibility	Greater flexibility
A Band 2 charge is normally collected by the referrer from non-exempt patients (currently £53.90[14])	No charge is normally made to patients
Superannuation is paid	No superannuation is paid
Sedation may or may not attract an additional fee for the provider and/or Band 2 patient charge	Sedation sometimes attracts an additional fee for the provider with no patient charge

Table 5 Recommended tariff for SLA PCOS contracts

Treatments	Tariff
Consultation and treatment under LA	
Consultation visit	£85
Treatment visit	£165
Additional treatment visit	£150
Consultation and treatment under sedation	
Consultation visit	£100
Treatment visit	£300
Additional treatment visit	£250
Failure to attend (FTA)	
FTA consultation appointment	£35
FTA LA treatment appointment	£85
FTA Sedation treatment appointment	£125
Temporomandibular dysfunction consultation	**£250**

appointment we would argue that the practice has taken all possible steps to ensure the patient attends and as such the practice should not be financially disadvantaged if they do not. The 'fail to attend fee' does not provide any profit for the practice but, at least, goes some way towards covering the administration and surgery costs that have been incurred.

We would also recommend a higher consultation fee for patients with temporomandibular dysfunction. These patients have traditionally been seen in secondary care and can be more time consuming to see and treat. Some primary care specialists have the skills to manage a proportion of this group of patients[12] and commissioners may want to take this into account, particularly if there are high waiting times for oral surgery out-patient appointments in secondary care in their region.

With regard to a PDS contract, the authors would recommend setting a minimum UDA value of £65. As there are units of orthodontic activity (UOAs)[13] perhaps unit of surgical activity or 'USA' could be used rather than UDA. As per the PDS contract terms, one UDA (USA) would be awarded for a consultation alone, with three UDAs (USAs) being awarded per consultation and treatment episode. If IV sedation is provided, a fee equivalent to an additional three UDAs (USAs) should be paid (an additional service fee). In a deviation from the standard PDS contract, we would recommend more flexibility in treating patients with a higher clinical need. Our suggestion would be that for specific cases a second course of treatment could be claimed, allowing the oral surgeon the means to provide more than one treatment visit. We would anticipate that cases which may need a second treatment visit would be those where patients require extraction of more than six teeth, where patients need multiple extractions in three or four quadrants or where medically compromised patients need treatment to be staged. These proposals will involve ensuring consistent data gathering and robust data monitoring by commissioners and providers alike.

While there is a need for national consistency in commissioning, some local flexibility must be maintained. Although both contract types have advantages and disadvantages, their simultaneous use creates inequities to both providers and patients, therefore it would be preferable to move forward with a single contract model. Recommendations have been made by the BAOS for both PDS and SLA models. However, in terms of ease of use and of flexibility for the speciality of oral surgery, we feel that the use of an SLA system is more appropriate. The PDS system is restrictive in terms of structure of the contract as well as requiring a great deal more input in terms of administrative time. The SLA contract is more in line with secondary care contracts and, crucially, patients are not disadvantaged by being charged a fee for specialist oral surgery in primary care. If this type of contact could be tied in with superannuation it would be far more equitable for the providers and keep them in line with the rest of the NHS workforce.

Conclusion

Contracts in primary care oral surgery are extremely variable, in both their nature and remuneration. There is unquestionably scope for standardisation of tariffs and contracts both regionally and nationally. High priority should be given to procuring gold standard services provided by appropriately trained individuals, be they specialists or other quality assured and experienced oral surgeons outwith the specialist list. NHS England could and should address this promptly to ensure optimal patient care.

Acknowledgements

The authors would like to thank Dr Paul Averley for his help and advice during the preparation of this paper.

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