Date published: 8 July, 2026
Date last updated: 8 July, 2026

NHS dentistry: care pathways guidance

Publication (/publication)

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1. Introduction

1.1 Care pathways to support patients with complex dental needs

On 23 June 2026, the dental quality and payment contract changes introduced care pathways for patients with complex dental needs.

These pathways support improved oral health outcomes for patients with either or both:

- significant caries
- unstable and more severe periodontitis

These care pathways recognise that eligible patients may have multiple underlying risk factors contributing to disease progression. Previously, the dental contract did not consistently support these more complex needs. As a result, these care pathways extend beyond reparative actions to include:

- risk factor management
- prevention
- support for self-care

This represents a more comprehensive approach than a purely surgical model (such as caries removal with drilling and restorative materials). These patients are distinct from those who require episodic reparative care without underlying progressive disease.

1.2 Purpose of this publication

This publication outlines evidence-based, best-practice approaches to assessing, planning and managing care using the care pathways. It includes worked examples of how care can be structured in practice.

These approaches are already widely used across the profession. This publication brings that practice together and sets out how it can be applied consistently within the contract.

The terms ‘risk’ and ‘susceptibility’ are used synonymously throughout.

1.3 What the care pathways involve

The care pathways offer 6 or 12-month care packages. They:

- build on and extend the current banded courses of treatment
- support longer-term, evidence-based clinical care
- optimise oral health outcomes
- introduce new funding arrangements to support this approach

In addition to the core payment for a care pathway, further units of dental activity (UDAs) and courses of treatment may be claimed in specific circumstances, including denture modifications and a Band 3 course of treatment, where clinically indicated.

1.4 Patient charges

For patients who normally pay dental charges, most will pay a single Band 2 charge for the care pathway, unless a Band 3 course of treatment is also needed, in which case the total patient charge payable is a Band 3.

This is designed to give patients with more complex disease additional certainty about the expected costs of their care.

1.5 Focus on prevention and self-care

The care pathways support care that dentists and clinical teams are already trained to deliver and reflect current clinical best practice:

- placing an equal importance on primary, secondary and tertiary prevention
- supporting patients to manage their own oral health
- working in partnership with the patient to deliver the best possible outcome

Setting and reviewing goals with the patient is an important part of this work. The care pathways are designed to support the kind of dentistry that clinicians have said they want to provide, underpinned by an ongoing partnership between the patient and their oral health team to deliver the best possible outcome.

1.6 Using the full dental team (skill mix)

The care pathways support the use of skill mix and provision of care by the full dental team.

There are no regulatory restrictions on who in the team can provide care, provided they are qualified and competent. Activities such as prevention, behaviour change and self-care support are well-suited to delegation across the team.

Further guidance is available in Building dental teams: supporting the use of skill mix in NHS general dental practice (https://www.england.nhs.uk/long-read/building-dental-teams-supporting-the-use-of-skill-mix-in-nhs-general-dental-practice-long-guidance/).

1.7 Related guidance

This publication should be read alongside the NHS Dentistry: Quality and Payment Reforms Contractual Guidance (https://www.england.nhs.uk/long-read/nhs-dentistry-quality-payment-reforms-contractual-guidance/), which sets out key elements from:

- the relevant regulations as enacted in June 2026
- The National Health Service (General Dental Services Contracts) Regulations 2005 (https://www.legislation.gov.uk/uksi/2005/3361/contents)
- The National Health Service (Personal Dental Services Agreements) Regulations 2005 (https://www.legislation.gov.uk/uksi/2005/3373/contents)
- The National Health Service (Dental Charges) Regulations 2005 (https://www.legislation.gov.uk/ukdsi/2005/0110736400/contents)

It also provides information on the pathway requirements, operational and payment arrangements.

2. Deciding between a care pathway and a banded course of treatment

Clinicians should decide, in partnership with the patient, whether care is best delivered through a care pathway or a pre-existing banded course of treatment.

All options (care pathways, Band 1, Band 2 and Band 3) are defined in the regulations as a course of treatment, which includes:

- an examination and assessment of a patient's oral health
- the planning of any treatment arising from that assessment
- the provision of each component of the planned treatment

2.1 When to consider a care pathway

The care pathways are designed to support patients who need longer-term care due to increased and/or unpredictable oral health needs.

Care pathways are likely to be most appropriate where:

- the extent of oral disease is significant and meets the clinical eligibility criteria for 1 of the care pathways
- the patient's care plan is uncertain at the outset and may need to change based on ongoing reassessment and changes in the patient's risk and disease profiles
- the patient has ongoing disease risks and needs active management over time
- the patient is willing and able to participate in a longer period of care

2.2 When to consider a banded course of treatment

Banded courses of treatment are more suited to a patient:

- with fewer or more predictable oral health needs
- where the treatment required can be delivered within a shorter, defined period

2.3 Stepped and phased care

The care pathways provide a clear legal basis for providing care to patients with more complex and progressive disease, including adapting the personalised care plan in line with the patient's response.

These pathways integrate the clinical concept of stepped or phased care and recognise the inherent uncertainty of determining care plans at the outset of treatment in patients with active disease and 5 or more carious teeth. As a result, “phased courses of treatment” (as defined in Avoidance of Doubt: provision of phased treatments (https://www.england.nhs.uk/publication/avoidance-of-doubt-provision-of-phased-treatments/)) should no longer be needed for this patient group.

Recording of phased courses of treatment for this cohort is expected to end by 31 December 2026.

2.4 Where a stepped approach may still be needed

A stepped approach to care delivery may still be appropriate for patients with active disease processes who do not meet the eligibility thresholds for care pathways. For example:

- those requiring supportive periodontal therapy on a 3-monthly basis
- those requiring the use of glass ionomer cements to encourage remineralisation and stabilise the active carious lesions

Further guidance on phased treatments will be reviewed and updated by the end of Autumn 2026.

3. Clinical eligibility for the pathways and diagnosis of disease

A patient would be eligible for a care pathway if they meet the clinical entry criteria as outlined in section 3.1.

Patients cannot be treated on more than 1 complex care pathway at the same time.

Eligible patients may present through either an unscheduled (urgent) care course of treatment or by seeking a routine appointment.

3.1 Clinical eligibility criteria

A patient is eligible for treatment under a care pathway if all of the following apply:

- they are 16 years or over
- they meet the clinical entry criteria
- they consent to the care pathway personalised care plan

To treat a patient under a care pathway, the dental practice must provide either or both:

- direct NHS care and treatment to at least 5 carious teeth (care pathways 1 and 2)
- the minimum number of periodontal treatment steps (care pathways 2 and 3)

3.2 Complex care pathway clinical entry criteria

Complex care pathway 1: dental caries in 5 or more teeth

- Eligible patients must be aged 16 years or over and have 5 or more teeth with caries into dentine.

Complex care pathway 2: dental caries in 5 or more teeth and unstable periodontal disease

- Eligible patients must be aged 16 years or over and have both:
- 5 or more teeth with caries into dentine
- unstable periodontal disease as defined by the BPS Flowchart Implementing the 2018 Classification (https://www.bsperio.org.uk/professionals/publications)

- Periodontal disease is to be evidenced by generalised unstable disease (not localised) affecting more than 30% of teeth on initial examination, and either of the following:
- a periodontal probing depth of 5mm or more
- a periodontal probing depth of 4mm or more and bleeding on probing, with a diagnosis of Stage II Grade B periodontitis and above; this means any of generalised unstable periodontal disease that is Stage II Grade B, Stage II Grade C, Stage I Grade C*, Stage III Grade B, Stage III Grade C, Stage IV Grade B, or Stage IV Grade C
- A patient with unstable Grade A periodontal disease may also be eligible for complex care pathway 2, where modifying risk factors are present that increase the complexity and grading of periodontitis under the BSP classification (https://www.bsperio.org.uk/professionals/publications).

Complex care pathway 3: first diagnosis of Stage III or unstable Grade C periodontal disease

- Patients must be aged 16 years or over and have either:
- a first diagnosis of Stage III periodontal disease (Grade A, B or C)
- unstable Grade C (including Stage I Grade C*, Stage II Grade C, Stage IV Grade A, B or C) periodontal disease as defined by the BPS Flowchart Implementing the 2018 Classification (https://www.bsperio.org.uk/professionals/publications)
- Periodontal disease is to be evidenced by generalised unstable disease (not localised) affecting more than 30% of teeth on initial examination and either of the following:
- a periodontal probing depth of 5mm or more
- a periodontal probing depth of 4mm or more and bleeding on probing

Exceptions

*A patient with Stage I Grade C unstable periodontal disease with a probing depth of less than 4mm would be eligible for:

- complex care pathway 2 if they also have 5 or more teeth with caries into dentine
- complex care pathway 3 if there are no caries into dentine, providing there is evidence of bleeding on probing, and the other clinical criteria are met

4. Delivery of care pathways

4.1 Examination and diagnosis of disease – staging and grading

Care begins with a comprehensive oral examination and assessment. This forms the basis for the patient's:

- disease profile
- risk profile
- personalised care plan

The examination and assessment will include:

- clinically indicated evaluation of presenting complaints
- medical and socio-behavioural history
- extra-oral and intra-oral structures (including soft and hard tissues)
- teeth, periodontal tissues, prosthetics, and occlusion as appropriate

Additional investigations may include radiographs, vitality tests and diagnostic aids.

Disease profile, risk profile and personalised care planning

The **disease profile** is a comprehensive description of a patient's current oral health status. This encompasses:

- type and severity of disease
- staging and grading
- disease activity (caries and/or periodontitis)
- relevant risk factors

It is used to guide clinical decision-making and is reviewed at each stage of care.

The **risk profile** is a structured summary of factors that influence the likelihood of developing or progressing oral disease. These may be both modifiable and non-modifiable (consider Appendix B). It is developed through assessment and informs preventive and therapeutic strategies within the personalised care plan.

The **personalised care** plan (also known as a 'treatment plan') is an individualised, stepwise plan collaboratively developed by the oral healthcare team and the patient to optimise oral health outcomes. It is tailored to the patient's unique needs, medical and oral health history, risk factors and preferences. It sets out:

- agreed objectives
- interventions
- review intervals

Staging, grading and assessment of disease activity

Established classification systems support accurate staging, grading and assessment of disease activity:

- periodontitis: BSP Flowchart Implementing the 2018 Classification (https://www.bsperio.org.uk/professionals/publications)
- caries: International Caries Detection and Assessment System (ICDAS) (https://www.iccms-web.com/content/icdas) or Minimum intervention oral care: staging and grading dental carious lesions in clinical practice (https://www.nature.com/articles/s41415-024-7843-4) could be used to support the diagnostic statements

The staging, grading and assessment of disease activity provide the diagnostic statements required when a patient enters a pathway. They also inform ongoing risk factor management* and the development of the personalised care plan. For further details, visit Appendix A.

*What we mean by 'risk factor management'

Risk factor management means the systematic identification, active surveillance and modification of risk factors (behavioural, biological, social and environmental) to reduce the likelihood of disease onset or progression.

Risk factor management is an integral and ongoing component of the personalised care plan.

4.2 Risk factor management and personalised care planning

The delivery of a care pathway is determined by ongoing assessment and management of the risk factors set out in section 4.1.

At intervals decided by the clinical team, the patient's progress is assessed to determine how effectively the personalised care plan has been implemented. When deciding on these intervals, the clinical team should consider the evidence on behaviour change. This ensures that reviews are both timely and relevant to the patient's needs.

Reviewing progress and adapting care

During each review, the clinical team should evaluate the goals established in the initial stages of care.

If these goals have not been reached, the initial risk factor management should be revisited. This may include behaviour management and appropriate clinical interventions, with consideration of the care to date and the information in Appendix C, which outlines risk factor management.

Another review should be scheduled at an interval appropriate to the patient's circumstances to assess progress towards these goals.

Where the patient's risk profile has improved:

- care should focus on continued support to maintain progress

If goals have not been met:

- goals should be reviewed
- further supportive care provided

Supportive examples

These delivery principles are illustrated in sections 6, 8 and 10 described through examples of personalised care plans for patients on each of the care pathways.

These are illustrative examples only and do not prescribe how care must be delivered in all cases.

A Word summary of all the care pathway examples will be available to download from the NHS England website (https://www.england.nhs.uk/primary-care/dentistry/dental-commissioning/dental-contract-reform/) in due course.

5. Care pathway 1 overview

Care pathway 1 is for patients aged 16 and over with 5 or more carious teeth into dentine as outlined in section 3. It is a 6-month pathway from the date of the initial oral examination and assessment.

The service requirements are designed to support the comprehensive clinical approach that dental teams would expect to adopt for patients in this high-need group, including:

- oral examination and assessment, including clinically appropriate radiographs
- recording of diagnosis and depth of active carious lesions
- identifying and recording modifiable risk factors (visit Appendix B)
- developing a personalised care plan based on findings from the oral examination and assessment and sharing this with the patient
- providing evidence-based preventative advice and support throughout the pathway

- providing clinically appropriate restorations and/or extractions of relevant teeth (minimum of 5 teeth), and endodontic therapy where required (consider Appendix D)
- re-evaluating care before completion of the pathway, including recording how the modifiable risk factors have been addressed
- setting a clinically appropriate recall interval based on risk factors on completion of the pathway

Care pathway 1 is designed for patients with severe caries. The example in section 6 sets out how care and treatment can be structured within this pathway, including how they may present in practice.

A Word summary of all the care pathway examples will be available to download from the NHS England website (https://www.england.nhs.uk/primary-care/dentistry/dental-commissioning/dental-contract-reform/) in due course.

6. Example of applying care pathway 1 in practice

6.1 Initial presentation during unscheduled care appointment, diagnosis and entering care pathway (month 0)

> A man aged 42 (Mr H) has not sought dental care for 8 years.
>
> He attends practice A with a spontaneous, severe throbbing pain on the lower right first molar tooth (LR6), not resolved by over-the-counter analgesia.

Mr H is diagnosed with an irreversible pulpitis of the LR6. He is treated for his presenting unscheduled care complaint through pulp extirpation and dressing of LR6 with a non-setting calcium hydroxide medicament in the root canal system, along with an appropriate restorative material to seal the access cavity.

He is advised that he has additional dental caries that require a follow-up appointment. A Band 1 urgent claim is submitted.

At the follow-up appointment, Mr H undergoes an oral examination and assessment, including periodontal assessment (BPE), soft tissue examination, updated dental and medical history and radiographic survey.

Findings are as follows:

- **caries**: generalised, 5 teeth with caries into dentine
- **periodontal**: mild generalised gingivitis; no pocketing greater than 4 mm; BPE recorded 122/221
- **soft tissues**: no mucosal abnormality detected
- **oral hygiene**: poor, brushing once daily; no interdental cleaning; plaque score 50%
- **risk factors**: high caries experience; infrequent attendance; high-frequency sugar intake, social and motivational barriers, poor plaque control

Based on this, Mr H is assessed as eligible for care pathway 1. He consents to this treatment.

A personalised care plan is developed and shared with Mr H, along with the SMART goals* for risk factor management (as in Appendix C). This will be delivered over the 6 months and involve the multidisciplinary team.

The initial declaration is completed and submitted. For more details about submitting a declaration, review section 4.4 of the NHS dentistry: quality and payment reforms contractual guidance (https://www.england.nhs.uk/long-read/nhs-dentistry-quality-payment-reforms-contractual-guidance/#4-

complex-care-pathways).

***What we mean by SMART goals**

SMART goals means objectives set within the personalised care plan that are:

- specific
- measurable
- achievable
- relevant
- time-bound

SMART goals allow both clinicians and patients to objectively monitor progress, adjust interventions, and ensure accountability.

6.2 Care and treatment under care pathway 1 (months 0 to 6)

Restorative treatment

The first stage addresses the caries through restorative treatment (secondary and tertiary prevention). This involves:

- caries removal (minimally invasive where indicated)
- placement of appropriate restorations across the 5 affected teeth, with material selection based on prognosis, site and clinical need

The number and length of appointments depend on factors such as:

- the location of the affected teeth
- the staging and grading
- patient tolerance for longer appointments

A risk factor management review is also undertaken.

Prevention and risk factor management

For the second stage of the personalised care plan, Mr H is seen by a dental hygienist (or a therapist or dental nurse with extended duties) to review risk factors and provide prevention advice and support (primary prevention). This stage may take place:

- alongside or immediately after stage 1
- around 4 to 6 weeks later, depending on factors such as wanting to review signs and symptoms related to the previous restorative care

At this appointment, the dental hygienist:

- undertakes a risk factor management review
- provides structured oral health education covering toothbrushing technique and interdental cleaning as outlined in Delivering better oral health: Chapter 8 (https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-8-oral-hygiene)

- provides dietary advice on fermentable carbohydrate frequency as outlined in Delivering better oral health: Chapter 10 (https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-10-healthier-eating)
- applies fluoride: 5% sodium fluoride (NaF) varnish (22,600 ppm fluoride) as outlined in Delivering better oral health: Chapter 9 (https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-9-fluoride)
- issues a prescription-strength fluoride toothpaste where clinically indicated, as outlined in Delivering better oral health: Chapter 9 (https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-9-fluoride)

Ongoing remote review (at 3 months)

At 3 months, Mr H has a remote consultation (by telephone or video) with the hygienist or therapist (primary prevention). During this consultation, the clinician:

- reviews risk factor management
- reinforces advice about oral health
- provides behaviour change support
- identifies and discusses emerging concerns

Given the positive response to self-care, Mr H is recalled at 3 months for ongoing care.

Unscheduled care during the pathway

During the pathway, Mr H contacts the practice with an unscheduled care dental need. He has fractured the mesio-buccal cusp on an upper first molar when biting on a fruit stone.

This is managed as an unscheduled care appointment, and he pays the band 1 urgent patient charge.

There is no evidence of caries associated with this fractured mesio-buccal cusp, and it is repaired with a composite resin restoration.

The dental practice claims for this intra-oral injury by submitting a Band 1 urgent FP17.

Final review and assessment (at 6 months)

At 6 months, Mr H attends for an oral examination and assessment, including bitewing radiographs.

This provides a further opportunity to review the patient's self-care regime and whether the caries process has stabilised over this extended period.

The bitewing radiographs at 6 months are consistent with Faculty of General Dentistry (FGDP) UK Selection Criteria for Dental Radiography (https://cgdent.uk/wp-content/uploads/securepdfs/FGDP-SCDR-ALL-Web.pdf) (section 4.3.1), which advise 6-monthly bitewings for high caries risk adults until the risk category reduces. This is justified in accordance with The Ionising Radiation (Medial Exposure) Regulations 2017 (https://www.legislation.gov.uk/uksi/2017/1322/contents).

Mr H's risk factors are reassessed as medium caries risk, reflecting improved oral hygiene and self-care. The radiographic interval is adjusted to 12-monthly in line with the FGDP(UK) Selection Criteria for Dental Radiography (https://cgdent.uk/wp-content/uploads/securepdfs/FGDP-SCDR-ALL-Web.pdf) (section 4.3.2).

Mr H would usually be advised to book his next appointment for 6 months, in line with National Institute for Health and Care Excellence (NICE) guidance for medium-risk patients. However, given the need to review endodontic healing, he is advised to have a 3-month recall.

This concludes the care pathway, and a final declaration is submitted.

6.3 Recall appointment following completion of the pathway

Mr H returns in 3 months, in line with the advised recall interval.

This is a separate course of treatment, for which a new patient charge would apply, and includes:

- re-assessment of caries risk and progression
- consideration of definitive endodontic treatment
- consideration of extra-coronal restoration – LR6

Depending upon the care provided, this could be claimed as a new Band 3 course of treatment.

If a Band 3 was provided within 3 months of completing the care pathway, the patient charge is capped at the difference between the Band 2 charge (for the care pathway) and the full Band 3 charge.

For any other course of treatment, the relevant patient charge would apply.

Review the contractual guidance (https://www.england.nhs.uk/long-read/nhs-dentistry-quality-payment-reforms-contractual-guidance/#4-complex-care-pathways) for full details.

6.4 Variation in approach for deep carious lesions

Where carious lesions are deep, care may be delivered differently.

In this case:

- the first stage would be to make these lesions cleansable and encourage the patient to keep the cavities clean and apply protective factors, including the use of prescription-strength fluoride toothpaste, as part of deep caries management
- at the second stage, a therapist or dentist could apply an appropriate restorative material to seal these cavities, having confirmed that the caries process has been altered in favour of remineralisation

7. Care pathway 2 overview

Care pathway 2 is for those aged 16 and over with 5 or more teeth with caries into dentine and generalised unstable periodontitis, as outlined in the clinical entry criteria in section 3.1. It is a 12-month pathway from the date of the initial oral examination and assessment.

The service requirements for care pathway 2 are the same as for care pathway 1, with the addition of provision of a minimum of 3 appropriate steps of periodontal treatment, in line with the patient's personalised care plan and clinically evidenced.

As care pathway 2 requires managing both caries and unstable periodontal disease, it is longer than the other pathways to allow for ongoing monitoring of the periodontal disease.

However, as with pathway 3, if the periodontitis is of a more rapidly progressive form (that is, grade C), an earlier referral to level 2 or 3 periodontal care, at around 6 months, may be considered, where available.

If a referral is made:

- continued maintenance is required to meet the requirements of the pathway
- it is beneficial to offer continuous support to the patient to attempt to stabilise or reduce the rate of disease progression

The example in section 8 sets out how care and treatment can be structured within this pathway. A Word summary of all the care pathway examples will be available to download from the NHS England website (https://www.england.nhs.uk/primary-care/dentistry/dental-commissioning/dental-contract-reform/) in due course.

8. Example of applying care pathway 2 in practice

8.1 Initial presentation, diagnosis and entering the care pathway (month 0)

> A woman, aged 45 (Ms J), presents with a history of irregular dental attendance and a long-standing history of multiple restorations and extractions, with complex restorative and periodontal needs.
>
> She reports increasing discomfort from a denture and books a routine appointment.

At the appointment, the dentist undertakes an oral examination and assessment, including periodontal assessment (BPE), soft tissue examination, updated dental and medical history and radiographic survey. The dentist also notes the complaint about the dentures.

The findings are as follows:

- **medical and social factors**: ex-smoker; alcohol less than 14 units per week; medications include citalopram, tramadol, morphine and hormone replacement therapy (HRT)
- **diagnosis of caries**: caries risk susceptibility assessment (CRSA) determined along with multiple active dentinal lesions in UR7, UR6, UL6 (middle third), UL5 and LR7 (inner third) as described by the staging of caries in Appendix A; UL5 with existing root canal treatment; LR7 tender to percussion (TTP)
- **endodontic**: irreversible pulpitis with no apical pathology at LR7
- **tooth wear**: moderate lower anterior wear
- **periodontal diagnosis**: generalised periodontitis, Stage 2 Grade B, currently unstable; BPE recorded 323/333; plaque score 47%; bleeding score 39%
- **extra-oral examination**: nothing abnormal detected (NAD)
- **soft tissues**: irritation of hard palate, remaining soft tissues NAD
- **oral hygiene**: brushes once daily with a manual toothbrush and fluoride toothpaste; flosses occasionally
- **risk factors**: high caries experience; irregular attendance; poor plaque control; likely medication-related xerostomia, behavioural and motivational barriers
- **tooth prognosis**: fair: UR7, UR6, UL6; guarded: LR7, UL5

Based on this, Ms J is assessed as eligible for care pathway 2. She consents to treatment on this pathway.

During this appointment, the dentist adjusts the denture to reduce the soft tissue irritation through relining the denture. This attracts a separate claim, in line with the contract reform contractual guidance.

A personalised care plan is developed and shared with Ms J, along with SMART goals for risk factors (consider Appendix C). This will be delivered over the 12 months and involve the multidisciplinary team.

The initial declaration is completed and submitted. For more details about submitting a declaration, visit section 4.4 of the NHS dentistry: quality and payment reforms contractual guidance (https://www.england.nhs.uk/long-read/nhs-dentistry-quality-payment-reforms-contractual-guidance/#4-

complex-care-pathways).

8.2 Care and treatment under care pathway 2 (month 0 to 12)

Initial treatment: caries care and first step of periodontal care

At the next appointment, scheduled as soon as feasible after the initial presentation, the dentist addresses the first stage of Ms J's personalised care plan. This involves:

- the first step of periodontal care in line with BSP UK clinical practice guidelines for the treatment of periodontal disease, step 1 periodontitis care (also referred to as 'BSP Step 1') (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) and the BSP UK Version of the S3 Treatment Guidelines for Periodontitis (also referred to as 'S3 guidance') (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis), including:
  - professional mechanical plaque removal (PMPR)
  - fluoride varnish application
  - use of disclosing to support effective plaque control
- selective caries removal and placement of clinically appropriate restorations, such as:
  - glass ionomer cement (GIC) for UR7, UR6, UL6, UL5 and LR7
  - pulpotomy of LR7 (refer to Appendix D and placement of a clinically appropriate restoration

At 4 weeks later, a risk factor management review (review of prevention measures provided at the first appointment) is undertaken, which may be delivered remotely where appropriate, reinforcing prevention in line with Delivering better oral health (https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention).

Ms J is provided with:

- ongoing dietary advice and oral hygiene reinforcement
- a prescription-strength fluoride toothpaste, which is to be continued where indicated
- review of pulp health at LR7

Additional information: restorative materials and endodontic considerations

Selection of restorative materials should be carefully considered.

Glass ionomer cements, including resin-modified and highly viscous varieties, are recommended when caries risk is high due to their fluoride-releasing capabilities.

These cements can 'recharge' by absorbing fluoride ions. This process is enhanced by fluoridated medicaments and the professional application of fluoride varnishes to their surfaces.

Glass ionomer cements can provide a longer-term solution and do not necessarily require further treatment within a specific timespan.

All carious lesions should be kept under active surveillance by the oral healthcare team at intervals appropriate to the patient's needs.

For endodontically managed teeth, especially those that have undergone vital pulp therapy, regular monitoring is necessary to assess pulp vitality. Should loss of vitality occur, pulpectomy should be performed to reduce the risk of future complications.

As a general principle, root canal obturation should only be completed once the oral healthcare team is confident that the disease risk profile has improved through effective risk factor management and the stabilisation or reversal of carious lesions.

Where Band 3 treatment is provided alongside or within 3 months of the pathway completing, then the dental contractor can claim the Band 3 UDAs in addition to the pathway payment.

Further detail is provided in:

- Appendix D on endodontics
- Appendix E on prosthodontics

Review after initial treatment (around 4 months)

At 4 months, Ms J is seen by an appropriate dental care professional for primary prevention and stabilisation.

At this appointment, the dental care professional:

- reviews risk factor management
- determines if clinical metrics for periodontitis have improved
- determines if there has been any improvement in clinical metrics for dental caries through review of previous restorations, modifying or replacing where indicated in line with the principles of 5 Rs (as detailed below)
- reviews pulp health at LR7
- agrees a review appointment for approximately 3 months to allow for gum healing and to assess ongoing response

The findings from this appointment inform the next step of periodontal care.

Depending on Ms J's response:

- if there is no improvement, repeats BSP step 1 (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) periodontitis care in line with S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis), including PMPR and any other clinical interventions from the initial treatment as required
- if there is improvement consistent with patient engagement, proceeds to BSP step 2 (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) periodontitis care in line with S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis), undertaking a detailed pocket chart (DPC) and providing subgingival instrumentation according to the DPC as part of the periodontitis management

Managing restorations: the 5 Rs approach

The principles of the 5 Rs should be considered where there is evidence of caries associated with restoration or sealant (CARS). This involves:

- **review** – regular monitoring of restorations to detect failures, such as marginal staining, wear or leakage, during routine check-ups
- **refurbish** – polishing and refinishing existing restorations to remove surface stains and improve margins, reducing the need for more invasive treatments
- **reseal** – sealing defective margins of a restoration to prevent recurrent decay, without necessarily replacing the entire restoration
- **repair** – correcting a specific area of a restoration that has failed (for example, a fractured part), preserving the existing, sound portion of the filling
- **replace** – fully removing and replacing a restoration only where necessary (for example, extensive caries and major failure), which is the last resort rather than the first choice

Reassessment of periodontal care (around 7 months)

At around 7 months, Ms J has a reassessment appointment with an appropriate dental care professional (for example a dentist, therapist or hygienist). At this point, both primary and secondary prevention steps are undertaken:

- primary prevention steps include:
  - reinforcing oral health advice
  - behaviour change support
  - assessing symptom resolution
  - reassessing plaque and bleeding control
  - identifying any emerging restorative or periodontal concerns
- secondary prevention steps include:
  - clinical examination and reassessment of periodontal health
  - plaque and bleeding scores
  - reviewing previous restorations with a view to modifying or replacing where indicated, referring to the principles of 5 R's and determination of the UL5 and LR7 prognosis, undertaking root canal treatment on LR7 as clinically indicated with appropriate coronal coverage
  - denture tolerance
  - tooth wear
  - further radiographs as clinically indicated and justified in accordance with The Ionising Radiation (Medial Exposure) Regulations 2017 (https://www.legislation.gov.uk/uksi/2017/1322/contents)

Depending on Ms J's response:

- if there is no improvement, repeat BSP step 1 (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) periodontitis care in line with S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis), including PMPR and any other clinical interventions from the initial treatment as required
- if periodontitis has stabilised, proceed to BSP step 4 (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) periodontitis care in line with S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis), undertaking a detailed pocket chart (DPC) and providing subgingival instrumentation according to the DPC as part of the periodontitis management
- if periodontitis has not stabilised, a patient may be referred to Level 2 or 3 services for pocket management or regenerative surgery.

- The remaining months of the care pathway should be completed repeating BSP step 1 or BSP step 2 (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf).
- If a referral is not possible, the clinical team should:
  - re-perform subgingival instrumentation on non-responding residual sites
  - provide supportive care as appropriate, that is BSP step 3 or BSP step 4 (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) of periodontal care respectively

Reassessment of periodontal care (around 10 months)

At about 10 months, Ms J attends for the reassessment and next appropriate step of periodontal care.

This follows the same approach outlined for the month 7 reassessment.

For the periodontitis, this involves:

- repeating the detailed pocket chart to assess response to sub-gingival instrumentation undertaken at the last appointment
- carrying out final sub-gingival instrumentation of non-responding sites (4mm or more or 4mm with bleeding on probing)

Care is then guided by these findings:

- **if there is an improvement** in oral health clinical metrics, evidenced by 4 sites or fewer with periodontal probing depth (PPD) of 5mm or more, Ms J can proceed with step 4 of periodontal care and review at completion of care pathway
- **if there are pockets of 6mm or more**, Ms J can be referred for Level 2 or 3 care where this is possible (if referral is not possible, re-perform subgingival instrumentation)
- **if there are pockets of PPD 4mm or more but no greater than 6mm with bleeding on probing**, repeat the clinical actions outlined at month 7 reassessment of periodontal care
- **if there are minimal or no improvements** in clinical metrics, repeat the clinical actions outlined at month 7 of periodontal care and deliver further prevention

For the dental caries, care involves:

- repeated caries risk susceptibility assessment
- reinforcing prevention messages
- replacing provisional restorations with a clinically appropriate restorative material where indicated
- review of pulp health at LR7

Completion of care pathway (at 12 months)

At about 12 months, Ms J attends her final appointment for a final review.

Ms J is advised to book her next appointment in 3 to 6 months, as she is assessed as remaining at high risk in line with NICE guidance.

Ongoing care will be maintained through the relevant banded course of treatment. At this point:

- the care pathway is complete
- the final declaration is completed

8.3 Recall appointment following completion of the pathway

Ms J returns in 4 months, in line with the advised recall interval and is provided with the relevant banded course of treatment.

This is a separate course of treatment and includes:

- reassessment for caries and periodontal risk and progression
- review of pulp health at LR7
- further treatment as clinically indicated

If further periodontal treatment is required, this may be claimed as a Band 2a. The relevant patient charge would apply to this separate course of treatment, if applicable.

Ms J remains at high risk unless a demonstrable improvement is observed in:

- oral hygiene
- disease control
- attendance

The recall remains at 3 to 6 months, with transition to lower risk status dependent on sustained engagement and stabilisation.

9. Care pathway 3 overview

Care pathway 3 is for those aged 16 and over with a first diagnosis of Stage III or unstable Grade C periodontal disease (or above), as outlined in section 3.1. It is a 6-month pathway from the date of the initial oral examination and assessment.

The service requirements for care pathway 3 are:

- oral examination and assessment, including clinically appropriate radiographs
- recording of the diagnostic statement for periodontitis
- identification and recording of modifiable risk factors (consider Appendix B)
- development of a personalised care plan in line with findings from the oral examination and assessment, shared with the patient
- provision of clinically evidenced preventative advice and support for the duration of the pathway, including recording how the modifiable risk factors have been addressed
- provision of a minimum of 2 appropriate steps of periodontal treatment in line with the patient's personalised care plan and the BSP S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis)
- assessment to determine the clinically appropriate interval for a risk-based recall on completion of this pathway

Where a patient eligible for care pathway 3 has 4 or fewer teeth with caries into dentine, the patient:

- should initially be treated under a single Band 2 course of treatment for their carious teeth
- should be moved into care pathway 3 as soon as possible afterwards

Care pathway 3 is designed for patients with a more aggressive, unstable form of periodontal disease. The example below sets out how care and treatment can be structured within this pathway. A Word summary of all the care pathway examples will be available to download from the NHS England website (https://www.england.nhs.uk/primary-care/dentistry/dental-commissioning/dental-contract-reform/) in due course.

10. Example of applying care pathway 3 in practice

10.1 Initial presentation, diagnosis and entering the care pathway (month 0)

> A man aged 58 (Mr S) presents with a history of irregular dental attendance, advanced periodontal disease.
>
> He wishes to retain his teeth and improve function and aesthetics.

Mr S attends for a routine appointment and informs the dentist that he has bleeding gums when brushing and mobile teeth.

The dentist undertakes an oral examination and assessment, including periodontal assessment (BPE), soft tissue examination, updated dental and medical history and radiographic survey.

Findings are as follows:

- **medical and social factors**: no current medications or allergies noted; smoker (10 per day); non-drinker
- **mobility**: UL1 and UL2 grade 2 mobile
- **tooth wear**: localised to lower anterior teeth, associated with attrition
- **extra-oral examination**: nothing abnormal detected (NAD)
- **intra-oral examination for soft and hard tissues**:
- soft tissues – generalised inflamed gingivae with gross calculus, especially lower anterior sextant, remaining soft tissues NAD
- hard tissues – heavily restored dentition and abfraction cavities present
- **detailed pocket chart:** if appropriate, or delayed until next appointment, particularly if calculus inhibits probing
- **radiographic investigations:** include full mouth periapical radiographs, taken to assess apical pathology and bone levels in relation to periodontitis extent
- **caries and restorative diagnosis**: mild generalised tooth wear with caries risk assessment determined to be low
- **periodontal diagnosis**: generalised periodontitis, Stage IV Grade C, currently unstable with risk factors of poor plaque control and smoking, irregular attendance, behavioural barriers to maintenance and plaque-retentive factors; plaque score 55%; bleeding score 41%; severe radiographic bone loss (up to 90% in the worst-affected areas) with subgingival calculus present
- **oral hygiene**: brushes twice daily with a manual toothbrush and fluoridated toothpaste; uses mouthwash; no interdental cleaning
- **tooth prognosis**: guarded prognosis for the UL1 and UL2 dentition depending on response to treatment
- **SMART goals**: plaque reduction, daily interdental cleaning, smoking reduction or cessation support, attendance adherence and periodontal stabilisation

Based on this, Mr S is assessed as eligible for care pathway 3. He consents to treatment on this pathway.

The personalised care plan is developed and shared with Mr S, together with the SMART goals for risk factor management (visit Appendix C). This will be delivered over 6 months and involve the multidisciplinary team.

The initial declaration is completed and submitted. For more details about submitting a declaration, review section 4.4 of the NHS dentistry: quality and payment reforms contractual guidance (https://www.england.nhs.uk/long-read/nhs-dentistry-quality-payment-reforms-contractual-guidance/#4-complex-care-pathways).

10.2 Care and treatment under care pathway 3 (month 0 to 6)

Initial treatment: first step of periodontal care and remote follow-up

The next appointment takes place around a month after the initial appointment. The dental hygienist or therapist (secondary prevention and stabilisation) undertakes a risk factor management review and recommendations provided in line with Delivering better oral health (https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention).

The hygienist provides:

- the first step of periodontal care as per BSP step 1 periodontitis care (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) in line with S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis)
- removal of plaque retentive factors, including professional mechanical plaque removal (PMPR)
- tailored oral hygiene coaching
- smoking cessation advice and signposting to services
- baseline detailed pocket chart if not undertaken at the first visit

A remote consultation is carried out by the hygienist 4 weeks later to assess progress in managing the risk factors.

In-person review (around 3 to 4 months)

At 3 to 4 months, in line with BSP guidance, Mr S attends another appointment with the dental hygienist (secondary prevention). At this appointment, the dental hygienist:

- undertakes a further risk factor management review
- records any clinical metric changes
- undertakes a detailed pocket chart (DPC)

The appropriate step of periodontal care is delivered in line with response:

- **if there is no improvement**, repeat BSP step 1 (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) periodontitis care in line with S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis), including PMPR and any other step 1 clinical interventions as required
- **if there is any improvement**, proceed to BSP step 2 (https://www.bsperio.org.uk/assets/downloads/SM4822_BSP_Treatment_Flow_Chart_-_Haleon_Version_3_PRESS_READY.pdf) periodontitis care in line with S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis), undertake a detailed pocket chart (DPC) and provide subgingival instrumentation based on findings

Adjunctive systemic antimicrobials may be considered for young, systemically healthy patients with Grade C disease as determined by a practitioner accredited for Level 2 and 3 care.

In-person review and completion of the pathway (at 6 months)

At 6 months, in line with BSP guidance, Mr S attends an appointment with the dentist. At this appointment, prevention steps are undertaken as follows:

- Secondary prevention steps include:
  - reinforcement of oral health advice
  - clinical metrics recorded
  - repeated periodontal review and detailed pocket charting to assess periodontal healing status
- Detailed pocket chart to determine next steps:
  - **if the periodontitis has not stabilised** as per parameters from S3 guidance (https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis), Mr S referred to Level 2 or 3 services for pocket management and/or regenerative surgery, where this is possible; if referral not possible, re-perform subgingival instrumentation
  - **for deep residual pocketing (6mm or more)**, consider referral to Level 2 or 3 care where possible
  - **re-perform subgingival instrumentation** on non-responding moderate (4 to 5mm) residual sites and at 6mm or more if referral is not possible
  - **supportive periodontal care strongly encouraged**, particularly for a successful outcome defined by 4 sites or fewer with PPD 5mm or more

Mr S has an elevated longer-term risk due to smoking history, and the recall is set at 3 months initially.

The care pathway is complete, and the final declaration is submitted.

10.3 Recall appointment following completion of the pathway

Mr S returns in 3 months in line with the advised recall interval.

This is a separate course of treatment and includes:

- reassessment for periodontal risk and progression
- further treatment as clinically indicated

If further surgical or non-surgical periodontal care is required, this may be claimed as a Band 2 course of treatment or as a Band 1 if care is limited to reinforcement of health advice. The relevant patient charge applies to this separate course of treatment if applicable.

Mr S remains at high risk unless a demonstrable improvement in:

- oral hygiene
- disease control
- attendance

Recall remains at 3-month intervals with transition to lower-risk status dependent on sustained engagement, risk factor reduction and stabilisation.

Appendix A: staging and grading of caries and periodontal disease

The clinical entry criteria for the care pathways and the specific approach to ongoing care are to be determined through diagnosis of the disease's staging, grading and activity profile. This guides the selection of the most suitable interventions for patients.

This appendix outlines information to support the diagnosis of caries and periodontal disease.

Dental caries

In accordance with Minimally Invasive Oral Care (MIOC) principles (https://www.nature.com/articles/s41415-024-7843-4), the thorough assessment of lesion extent and severity (staging) and activity (grading) is essential for ensuring that secondary and tertiary preventive interventions are appropriately selected.

This approach prioritises minimally invasive techniques whenever operative treatment is required.

Staging of caries

Clinicians may find it useful to use an evidence-based classification system for detecting, staging and assessing dental caries via clinical visual examination.

Alternatively, the International Caries Detection and Assessment System (ICDAS) (https://www.iccms-web.com/content/icdas) is another example of an evidence-based classification system.

The staging of caries is described as follows:

Code	Description
0	No evidence of caries
1 to 2	Initial caries (changes in enamel)
3 to 4	Moderate caries (enamel breakdown and shadowing; caries at the amelodentinal junction and/or progressed into the outer 3rd of dentine)
5 to 6	Extensive caries (distinct cavitation; caries in the middle or inner 3rd of dentine)

Further assessment methods, such as radiographs, may be used to complement clinical findings and provide a more precise assessment of the disease stage by combining both clinical and radiographic information.

Grading of caries

The grading and activity of caries are determined by evaluating both visual and tactile characteristics. Lesions are classified as likely active or likely inactive.

For likely active lesions, 1 or more of the following would apply:

- the enamel surface appears opaque with a loss of lustre and feels rough when gently probed with a ball-ended instrument
- the lesion is located in a biofilm stagnation area, such as pits or fissures near the gingival margin, or below the contact point

- the lesion is associated with significant biofilm build-up
- dentine feels soft or leathery when gently probed

For likely inactive lesions, 1 or more of the following would apply:

- the enamel surface is discoloured, shiny and smooth when gently probed
- the lesion is typically found at a distance from the gingival margin
- there is little to no biofilm build-up
- dentine feels shiny and hard when gently probed

Periodontal disease

The British Society of Periodontology has established a classification system for staging and grading periodontal disease (https://www.bsperio.org.uk/assets/downloads/BSP_Flowchart_Implementing_the_2018_Classification.pdf).

Modifying factors in treatment need assessment

The Royal College of Surgeons has outlined a series of modifying factors for the Index of Treatment Need (https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/complexityassessment.pdf). The presence of 1 or more of these factors raise the grading of periodontal disease to the next level. Modifying factors include:

- the requirement for coordinated medical (for example, renal or cardiac) and/or dental care
- the need for multidisciplinary care, such as oral surgery combined with orthodontic interventions
- a medical history that significantly affects clinical management, for example diabetes
- special needs that influence the acceptance or provision of dental treatment
- presence of mandibular dysfunction
- patients experiencing atypical facial pain
- cases of undiagnosed facial pain
- a tendency to retch during dental procedures
- limited operating access for the clinician
- concurrent mucogingival disease, such as erosive lichen planus

Appendix B: modifiable and non-modifiable risk factors

Oral disease risk factors are classified as either modifiable or non-modifiable. They can also be categorised according to patient-level, mouth-level, and tooth or site-level factors.

Modifiable risk factors can be altered or managed through patient behaviour or clinical treatment. These include:

- plaque
- poor diet
- smoking
- uncontrolled diabetes
- medications (notably those that cause xerostomia)
- stress
- alcohol
- obesity or overweight
- hyposalivation or low salivary flow rate
- overhanging or poorly contoured restorations
- open contacts
- prostheses
- motivation

- recent caries experience

Non-modifiable risk factors cannot be changed but must be considered when developing care and intervention strategies. These include:

- socioeconomic status
- genetics
- adolescence
- pregnancy
- medical conditions such as leukaemia

Appendix C: prevention and risk factor management

Prevention strategies are structured into primary, secondary and tertiary prevention. The application of the Delivering Better Oral Health (DBOH) toolkit (https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention) is required to support evidence-based preventive care.

Within each patient's personalised care plan, risk factor management is systematically addressed by identifying modifiable and non-modifiable risk factors, setting and reviewing SMART goals, and introducing protective factors, such as the use of fluoridated toothpaste.

Risk factors are sub-categorised at the patient, mouth, and tooth or site levels. The risk profile is used to inform interventions within the personalised care plan, with progress measured against clearly defined SMART goals.

Ongoing assessment and adaptation of the personalised care plan ensures continued optimisation of oral health outcomes.

Oral healthcare teams should consider the relevant evidence that sets out prevention in 3 principal aspects:

- primary prevention, which is advice and care aimed at preventing the onset of disease
- secondary prevention, which is advice and care aimed at detecting disease early and preventing its progression
- tertiary prevention, which is advice and care aimed at managing established disease, preventing its complications and rehabilitation

Risk factors can be mitigated by introducing protective measures, notably in caries. These include regular use of fluoridated toothpaste or topical fluoride applications.

Appendix D: provision of endodontics

In accordance with the guiding principles outlined above, endodontic therapy should adhere to contemporary evidence.

Special consideration is given to the use of vital pulp therapy (VPT), as recommended by the European Society of Endodontology.

In cases where VPT cannot be provided, as described below, then root canal treatment should be considered.

Vital pulp therapy

Vital pulp therapy (VPT) is a collection of biologically based procedures designed to maintain the vitality of the dental pulp following caries, trauma, or iatrogenic exposure.

It is a minimally invasive method intended to preserve pulpal vitality and ensure long-term tooth function when carried out with accurate diagnosis, proper asepsis, and contemporary bioactive materials.

The use of modern calcium-silicate biomaterials and minimally invasive techniques has led to improved outcomes, particularly when appropriate case selection and aseptic conditions are maintained.

VPT should be considered where the dentinal caries is in close proximity to the pulpal tissues.

This appendix aims to clarify the indications, underlying principles, procedural steps, materials, follow-up protocols, and success criteria for VPT.

The focus is on cases where the pulp is either healthy or displays reversible inflammation.

Case selection and diagnosis

- **Indications**

VPT is indicated when the pulp is vital, either normal or affected by reversible pulpitis, as confirmed through sensitivity tests.

- **Contraindications**

Cases exhibiting symptoms or signs consistent with irreversible pulpitis, or where the pulp is non-vital or necrotic, are contraindicated for VPT.

In such circumstances, consideration should be given to conventional root canal treatment.

- **Principles of vital pulp therapy**

The fundamental principles include accurate diagnosis, the use of calcium-silicate materials and achieving a secure coronal seal.

Types of vital pulp therapy

- **Indirect pulp treatment (IPT)**

Selective removal of infected dentine is carried out, preserving affected dentine near the pulp to prevent exposure.

Success is largely dependent on the integrity of the coronal seal.

- **Direct pulp capping**

A calcium-silicate material is placed directly over a pinpoint mechanical or carious exposure following haemostasis.

This technique is suitable for traumatic exposures and small carious exposures.

- **Partial (Cvek) pulpotomy**

This procedure involves excising 1 to 3 mm of inflamed coronal pulp tissue to reach healthy tissue.

It is especially effective for traumatic exposures and immature teeth, facilitating continued root development.

- **Full (coronal) pulpotomy**

The coronal pulp is removed while maintaining the vitality of the radicular pulp.

This approach is increasingly supported for carious exposures in mature permanent teeth when calcium-silicate biomaterials are used.

- **Materials**

Calcium-silicate cements, such as Mineral trioxide aggregate (MTA) and Biodentine, are used as primary materials.

General clinical protocol

The protocol begins with a thorough assessment and obtaining patient consent, including history, sensibility tests, and radiographs, as well as a discussion of risks, benefits, and alternatives.

A coronal seal must be achieved, and follow-up should include:

- a clinical review at 6 and 12 months
- radiographic review at 12 months and annually thereafter

Success criteria

Success is indicated clinically by the absence of spontaneous pain, normal responses to sensibility tests, and the lack of swelling, sinus formation or tenderness.

Management of failure

Should symptoms persist or pathology develop, root canal treatment should be considered.

Extraction may be necessary if the tooth cannot be restored or if the prognosis is poor.

Root canal treatment

In cases where VPT is not feasible, then root canal treatment (RCT) should be considered.

This involves the complete removal of the pulp tissues, combined with disinfection of the root canal system.

For patients who have entered the care pathways, it is also important to consider their current oral health.

In particular, this would involve the assessment of whether the disease profile has improved such as the tooth in question has a reasonable prognosis.

This would provide for 2 possible scenarios:

- the root canal system is dressed with a suitable material, such as non-setting calcium hydroxide, and there is ongoing assessment of the tooth and the wider oral health until such time that it is deemed reasonable to complete the root canal treatment (alternatively, other treatment options such as extraction may need to be considered)
- the prognosis of the tooth and the wider oral health is stable such that the root canal treatment can be completed

In either scenario, this care may be provided during the care pathway or afterwards, depending on each individual circumstance.

It would also be expected that consideration is given to the restoration of the coronal tissue that may involve:

- placing a direct restoration such as a glass ionomer cement
- placing an indirect cuspal-coverage restoration, such as a provisional or definitive inlay, onlay or crown

Appendix E: provision of prosthodontics

Overview of prosthodontic types

Prosthodontics are typically classified into 2 main categories, each offering distinct methods for the replacement of missing teeth and restoration of oral function:

- Removable prostheses are provided through partial or full dentures:
  - These may be constructed using acrylic resin or may use a cobalt-chrome framework, depending on clinical requirements and patient needs
- Fixed prostheses are delivered in the form of inlays, onlays, crowns and bridges:
  - These can be designed in various configurations to suit the specific restorative goals identified in the patient's personalised care plan

Decision-making and individualised care

Decisions regarding prosthodontic provision are guided by the patient's personalised care plan, risk profile and disease profile.

Each of these elements ensures that treatment is tailored to the individual's current oral health status and anticipated future needs.

Retrievability and adaptability of prostheses

The retrievability of a prosthesis is of particular importance in cases where the ability to remove the prosthesis should difficulties arise is desirable, such as increased disease risk due to plaque retention or patient discomfort.

In such cases, the patient can be restored to their original condition.

Planning for future changes, such as the potential loss of additional teeth, is also important. This is especially relevant in the case of acrylic resin dentures, which permit additions if further tooth loss occurs.

As a result, removable prostheses are often favoured, particularly for patients on care pathways.

Careful discussion of these options with the patient is essential to ensure informed decision-making.

Timing and considerations for fixed prosthodontics

During active management of oral disease, the retrievability and adaptability of prostheses are prioritised.

Consequently, fixed prosthodontic treatments are generally postponed until risk factors and disease profiles have been successfully managed.

However, if endodontic therapy is undertaken, it may become necessary to consider fixed prosthodontic solutions, such as cuspal-coverage restorations, to protect the tooth structure.

Publication reference: PRN02513_i

Date published: 8 July, 2026

Date last updated: 8 July, 2026