Summary tables for care pathway examples

The summary tables provide a concise, high-level reference of the care pathway examples set out in full in the NHS dentistry: care pathways guidance.

They present illustrative examples of how each of the 3 care pathways may be delivered in practice, summarising the key stages of care, expected clinical actions and associated record-keeping requirements across the example patient journeys.

They do not prescribe how care must be delivered in all cases; clinical judgement should always be exercised based on the individual patient's needs and circumstances.

Example of care pathway 1 – caries management

Timeline	Expected actions	Expected record keeping requirements
Initial presentation during unscheduled care appointment	• Diagnose irreversible pulpitis of LR6. • Provide unscheduled care: pulp extirpation, non-setting calcium hydroxide medicament, and temporary restoration. • Advise patient of additional carious lesions requiring further care and need for a follow-up appointment.	• Diagnosis recorded • Details of unscheduled care provided • Band 1 urgent claimed

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Timeline	Expected actions	Expected record keeping requirements
Comprehensive assessment and start of care pathway (First month)	• Undertake an oral examination and assessment, including periodontal assessment (BPE), soft tissue examination, radiographs as indicated, and updated medical and dental history. • Stage and grade carious lesions (minimum 5 teeth affected, with caries into dentine) following a Caries Risk Susceptibility Assessment (CRSA). • Identify modifiable risk factors. • Explain diagnosis, risk factors and agree a personalised care plan with the patient, including specific, measurable, achievable, relevant, and time-bound (SMART) goals. • Review endodontic healing LR6.	• Patient meets the entry criterion • Diagnosis and depth of active carious lesions • Identification and recording of modifiable risk factors • Patient has agreed to the treatment plan • An initial declaration when a patient starts on a care pathway
Restorative treatment and risk factor review (Months 1 to 2)	• A risk factor management review including behaviour change support, plaque control, management of plaque-retentive, dietary and other risk factors. • Caries removal (minimally invasive where indicated). • Placement of clinically appropriate restorations, with material selection based on prognosis, site and clinical need. • Review endodontic healing LR6.	• Risk factor review findings • Preventive interventions provided • Oral health education delivered. • Fluoride application and prescriptions recorded.

Timeline	Expected actions	Expected record keeping requirements
Prevention and risk factor management appointment (alongside or 4 to 6 weeks after restorative care)	• Undertake a risk factor management review. • Provide structured oral health education covering toothbrushing technique and interdental cleaning as outlined in Delivering better oral health: Chapter 8. • Provide dietary advice on fermentable carbohydrate frequency as outlined in Delivering better oral health: Chapter 10. • Apply fluoride: 5% sodium fluoride (NaF) varnish (22,600 ppm fluoride) as outlined in Delivering better oral health: Chapter 9. • Issue a prescription-strength fluoride toothpaste where clinically indicated, as outlined in Delivering better oral health: Chapter 9.	• Risk factor review findings • Preventive interventions provided
Ongoing remote review via telephone or video (3 months dependent on when prevention and risk management appointment occurred)	• Review progress against SMART goals. • Reinforce oral health and dietary advice, provide as appropriate advice on interdental cleaning and adjunctive toothpaste or mouthwash. • Provide behaviour change support. • Identify and discuss emerging concerns.	• Risk factor review findings • Advice and support provided
Unscheduled care during pathway (example at 5 months)	• Assess fractured mesio-buccal cusp of upper first molar and provide composite resin restoration.	• Diagnoses and treatment provided • Band 1 urgent claimed for intra-oral injury

Timeline	Expected actions	Expected record keeping requirements
Final review, assessment and completion of the pathway (Month 6)	• Oral examination and assessment including clinically indicated bitewing radiographs. Adjust future radiographic interval as appropriate. • Review response to personalised care plan and SMART goals, reinforce as needed oral hygiene, dietary advice and behaviour change. • Reassess caries activity and oral hygiene. Review and management of existing restorations, modify or replace if indicated, applying the 5 Rs principle. • Review endodontic healing LR6 (and if clinically appropriate consider definitive endodontic treatment and placement of an extra-coronal restoration on LR6. Depending on the treatment provided, this may be claimed as a concurrent Band 3 course of treatment). • Advise 3-month recall due to need to review endodontic healing.	• Examination findings • Updated patient history, including oral health behaviours • Changes in risk factors • Clinically appropriate restorative interventions provided • Potential concurrent Band 3 course of treatment • Personalised risk-based recall interval in line with NICE guidance • Complete final declaration

Example of care pathway 2 – caries and periodontitis management

Timeline	Expected actions	Expected record keeping requirements
Initial presentation, diagnosis and start of the care pathway (First month)	• Oral examination and assessment including BPE, clinically appropriate radiographs, medical and social history, soft tissue examination. • Stage and grade carious lesions (minimum 5 teeth affected, with caries into dentine) following a CRSA. • Diagnose generalised unstable Stage 2, Grade B periodontal disease in line with The British Society of Periodontology (BSP) guidance. • Diagnose irreversible pulpitis with no apical pathology at LR7. • Diagnose irritation of the hard palate from a denture and provide denture reline/adjustment to address soft tissue irritation (separate claim). • Identify modifiable risk factors. • Explain diagnosis, risk factors and agree a personalised care plan with the patient, including SMART goals.	• Patient meets the entry criterion • Diagnosis and depth of active carious lesions into dentine • Diagnosis statement for periodontitis • Identification and recording of modifiable risk factors • Patient has agreed to the treatment plan • An initial declaration when a patient starts on a care pathway • Concurrent denture modification claim

Timeline	Expected actions	Expected record keeping requirements
Initial treatment: caries care and first step of periodontal care (Months 1 to 2)	• Use of disclosing to support effective plaque control. • Give tailored oral hygiene coaching and dietary advice in line with Delivering Better Oral Health guidance, including behaviour change support as well as support for other risk factors. Any emerging concerns raised by the patient should also be identified and addressed. • Apply high fluoride varnish, gel or other remineralising agents in line with Delivering Better Oral Health guidance. • Provide step 1 of care as per BSP practice guidelines: Professional Mechanical Plaque Removal (PMPR) where indicated, including supra- and subgingival scaling of the clinical crown. • Selective caries removal and placement of appropriate restorations (for example GIC restorations). • Manage pain as needed, including pulp therapy, pulpotomy and restoration of LR7	• Clinical interventions undertaken recorded • Teeth treated and restorative materials used recorded • Updated assessment of disease activity and risk factors • Record of oral health advice and prevention delivered
Remote review of prevention measures provided (Around 4 weeks later)	• Review prevention measures and patient engagement. • Reinforce oral health and dietary advice, provide as appropriate, advice on interdental cleaning and adjunctive. toothpaste or mouthwash. • Review pulp health of LR7.	• Declaration patient is receiving care on the care pathway • Risk factor progress documented against SMART goals • Advice provided recorded • Pulp health review documented

Timeline	Expected actions	Expected record keeping requirements
Reassessment (Around month 4)	• Management of caries and periodontal disease through hard and soft tissue examinations. • Review of risk factor management and reinforce as needed oral hygiene, dietary advice and behaviour change. • Assess improvement in periodontal clinical metrics, including a detailed pocket chart for periodontal tissues. • If disease risk remains high, perform step 1 of care as per BSP practice guidelines and continue supporting patient to achieve their goals. • If improvement is demonstrated, perform step 2 of care as per BSP practice guidelines. • Assessment and management of caries and existing restorations, modify or replace if indicated, applying the 5 Rs principle. • Review pulp health of LR7.	• Updated plaque, bleeding and periodontal outcomes recorded • Assessment of caries status and restorations recorded • Pulp health review documented • Periodontal treatment step delivered

Timeline	Expected actions	Expected record keeping requirements
Reassessment of periodontal care (Around month 7)	• Detection and management of caries and periodontal disease through hard and soft tissue examinations including clinically indicated and justified radiographs in accordance with The Ionising Radiation (Medical Exposure) Regulations 2017. • Reinforce oral hygiene coaching, dietary advice and behaviour change in line with Delivering Better Oral Health guidance. Includes plaque control and risk factor management. Address any emerging concerns from the patient. • Review denture tolerance and tooth wear. • Record clinical metrics to assess response to advice given (plaque and bleeding scores). • If SMART goals have not been met, repeat step 1 of care as per BSP practice guidelines and continue supporting patient to achieve their goals. • If the periodontitis has stabilised perform step 4 of care as per BSP practice guidelines. • If the periodontitis has not stabilised, perform step 3 of care, if SMART goals have been met, as per BSP practice guidelines. Re-perform subgingival instrumentation on non-responding moderate (4 to 5mm) residual sites. For deep residual pocketing (6mm or more), consider alternative causes and assess the need for referral to Level 2 or Level 3 periodontal services for pocket management or regenerative surgery. If this referral occurs, complete the remaining months of the care pathway by repeating BSP step 1 or BSP step 2. Where referral is not possible, re-perform subgingival instrumentation as appropriate. • Review and management of existing restorations, modify or replace if indicated, applying the 5 Rs principle.	• Preventive support provided • Changes in risk factors • Periodontal treatment step delivered • Referral decision and rationale documented

Timeline	Expected actions	Expected record keeping requirements
Reassessment of periodontal care (Around month 10)	• Follow same approach as for month 7 reassessment (see row above). **For dental caries, this involves:** • repeat the CRSA, reinforce prevention advice and support, replace provisional restorations with a clinically appropriate restorative material where indicated, and review pulp health at LR7 **For the periodontitis, this involves:** • repeat the detailed pocket chart to assess response to subgingival instrumentation undertaken at the previous appointment • carry out final subgingival 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, proceed with step 4 of periodontal care and review at completion of care pathway • if there are pockets of 6mm or more, refer 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.	• Preventive support provided • Changes in risk factors • Restorative or endodontic care delivered • Periodontal treatment step delivered

Timeline	Expected actions	Expected record keeping requirements
Final review assessment and completion of the pathway (Around month 12)	• Final review and assessment. • Personalised risk-based recall interval set at 3 to 6 months due to ongoing high risk, in line with NICE guidance: Dental checks: intervals between oral health reviews.	• Recording of any relevant clinical information • Personalised risk-based recall interval in line with NICE guidance • Complete final declaration

Example of care pathway 3 – periodontitis management

Timeline	Expected actions	Expected record keeping requirements
Initial presentation, diagnosis and start of the care pathway (First month)	• An oral examination and assessment, including periodontal assessment (BPE), soft tissue examination, updated dental and medical history and radiographic survey • A detailed pocket chart: if appropriate, or delayed until next appointment, particularly if calculus inhibits probing. • Identify modifiable risk factors. • A first diagnosis of 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. • Explain diagnosis, risk factors and agree a personalised care plan with the patient, including SMART goals.	• Patient meets the entry criterion • Diagnosis statement for periodontitis • Identification and recording of modifiable risk factors • Patient has agreed to the treatment plan • An initial declaration when a patient starts on a care pathway

Timeline	Expected actions	Expected record keeping requirements
Initial treatment (Months 1 to 2)	• Risk factor management review. • Give tailored oral hygiene coaching and dietary advice in line with Delivering Better Oral Health guidance, including behaviour change support, plaque and dietary control, management of plaque-retentive and other risk factors. • Address any emerging concerns from the patient. • Smoking cessation advice and signposting. • Baseline detailed pocket chart (if not undertaken at the first visit). • Provide step 1 of care as per BSP practice guidelines, removal of plaque retentive factors, including professional mechanical plaque removal (PMPR).	• Preventive advice provided • PMPR and other periodontal treatment provided • Updates to personalised care plan and SMART goals documented • Smoking cessation advice recorded
Remote review with hygienist or therapist (Around 4 weeks after initial treatment)	• Review progress against agreed risk factor goals. • Reinforce self-care advice and smoking cessation support.	• Progress against SMART goals documented • Any changes to risk profile recorded • Advice and actions agreed documented

Timeline	Expected actions	Expected record keeping requirements

In-person review
 	
(Months 3 to 4)
	• Risk factor management review.
	• Record clinical metrics to assess response to advice given during Initial treatment, including a detailed pocket chart for periodontal tissues. The appropriate step of periodontal care is delivered in line with response:
	  ○ if SMART goals have not been met, repeat step 1 of care as per BSP practice guidelines and continue supporting patient to achieve their goals
	  ○ if SMART goals have been met, proceed to step 2 of care as per BSP practice guidelines, undertake a detailed pocket chart (DPC) and provide subgingival instrumentation based on findings
		• Clinical metrics and treatment response recorded
		• Decision and rationale for Step 1 or Step 2 care documented
		• Periodontal treatment step delivered
		• Any antimicrobial prescribing and clinical justification recorded

Timeline	Expected actions	Expected record keeping requirements
Final review assessment and completion of the pathway (Month 6)	• Further periodontal review in line with BSP guidance. • Record clinical measures to assess response to advice given, including a detailed pocket chart to assess periodontal healing status. • Give tailored oral hygiene coaching and dietary advice in line with Delivering Better Oral Health guidance, including behaviour change support, plaque and dietary control, management of plaque-retentive and other risk factors. Address any emerging concerns from the patient. • If SMART goals have not been met, repeat step 1 of care as per BSP practice guidelines. • If the periodontitis has not stabilised, assess the need for referral to Level 2 or Level 3 periodontal services, particularly for the management of deep residual pocketing (6mm or more), pocket management, or regenerative surgery. Where referral is not possible, re-perform subgingival instrumentation. • Re-perform subgingival instrumentation on non-responding moderate (4 to 5mm) residual sites (and at 6mm or more if referral is not possible). • Strongly encourage supportive periodontal care, particularly where a successful outcome is defined by 4 sites or fewer with PPD of 5mm or more. • Personalised risk-based recall interval set at 3-6 months due to ongoing high risk, in line with NICE guidance Dental checks: intervals between oral health reviews.	• Updated clinical findings • Preventive support provided • Changes in risk factors • Referral decision and rationale (if applicable • Periodontal treatment step delivered • Outcome against SMART goals documented • Personalised risk-based recall interval in line with NICE guidance • Complete final declaration