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NHS

Avoidance of doubt: Provision of phased treatments

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Equalities and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England and NHS Improvement's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Background

The purpose of this document is to support dental professionals, and to clarify where it might be appropriate to provide phased treatment spanning over several courses of treatment (CoT). In turn, this should improve access to high quality NHS dentistry to meet the needs of patients who will not usually have accessed and completed routine dental care in the previous 24 months. This cohort of patients would generally be those with high dental needs and as such are more likely to be adults from a vulnerable background with additional health or social needs.

Description of phases

Phased treatment may consist of up to three courses of treatment; all these CoTs will usually be completed within a 12-month period. It is acknowledged that often the first CoT (CoT 1) is an initial assessment with pain relief, stabilisation of active disease and initiation of initial preventive measures where it is not possible to produce a robust plan for further treatment at the examination stage.

It is only after this first course has been completed and the patient reassessed to see how they have responded that a further treatment can be devised (CoT 2). In some cases, a further reassessment and plan will be required (CoT 3).

At the very outset the patient should be made aware that they will be required to return for further courses of treatment, and that this may incur further NHS dental charges. It is not always possible to predict the exact nature and, therefore, cost of the next phase until the reassessment course of treatment.

What needs to be documented in terms of phased treatment?

In CoT 1 the proposed treatment should be detailed with notes about the reasons for phasing into different CoTs. The patient should be made aware that the future CoT will be dependent on the reassessment at CoT 2 and so at this stage a detailed plan cannot be provided for the future CoTs. An appropriately completed FP17DC must be provided to the patient at each CoT. The impact on the patient charges must be explained to the patient and their understanding confirmed. The explanation for phasing treatment must be recorded in the notes. Clinical and patient factors should be considered carefully before advance care is provided.

Table 1: Example of documentation for phased treatment Course of Treatment (CoT 1)

CoT 1 Urgent treatment unless the patient wishes to have a full examination and treatment plan and enter the phased treatment pathway.	• Examination (Band 1) • Risk assessment (Band 1) • Preventative advice (Band 1) • Periodontal assessment (Band 1) • Other appropriate treatment, such as: – dressing of carious lesions (Band 1, Urgent, or 2) – treating periodontitis – Step-1 of care (Band 2) – pulp extirpation (Band 1, Urgent, or 2) – extraction of teeth/tooth fragments (Band 1, Urgent, or Band 2)

Table 2: Example of documentation for phased treatment Course of Treatment (CoT 2)

CoT 2 Reassessment	• Examination (Band 1) • Risk assessment (Band 1) • Assess whether active caries has been halted (Band 1) • Reinforcement of preventative advice (Band 1) • Periodontal reassessment (Band 1) • Other appropriate treatment, such as: – definitive restorations (Band 2) – treating periodontitis – Step-2 care in an 'engaging patient' (Band 2) – endodontic therapy (Band 2) – extractions (Band 2) • Decisions regarding further courses and timescale

Table 3: Example of documentation for phased treatment Course of Treatment (CoT 3)

CoT 3 Definitive	• Examination (Band 1) • Risk reassessment (Band 1) • Reinforcement of preventative advice (Band 1) • Treating periodontitis – Step-3 of care in an 'engaging patient' (Band 2) • Other appropriate treatment, such as: – crowns, bridges (Band 3) – dentures (Band 3) – periodontal therapy (Band 2) • Setting of recall interval

What can be claimed?

Each CoT can be claimed separately. Phased treatment could potentially produce various clinical scenarios, each resulting in differing generation of both bands of treatment and patient charges.

Table 4: Example of potential bands and patient charges generated from phased treatment

Phases	Bands	Patient charges 2021/22
CoT 1 Urgent treatment unless the patient wishes to have a full examination and treatment plan and enter the phased treatment pathway	Urgent, 1 or 2	Up to £65.20
CoT 2 Reassessment phase	1 or 2	Up to £65.20
CoT 3 Definitive phase	Up to 3	Up to £282.80

There will be cases where an immediate prosthesis may be provided in the initial CoTs. This will be Band 3 treatment.

For the most up to date patient charges please refer to the NHS website here.

FAQs

If I provide a phased treatment will it put me at risk of being highlighted by the Business Services Authority (BSA)?

Claims for multiple CoTs will be acceptable where the clinical notes clearly state that rationale for the phased treatment for patients with high and complex dental, medical or social needs with supporting clinical evidence. The BSA data will continue to track Units of Dental Activity (UDAs) claimed per patient and number of FP17s per patient.

Would it be appropriate to treat patients who already attend my practice with the phased treatment approach?

Normally patients who regularly attend your practice should not require phased treatment spanning several CoTs. However, there may be a very small number of patients where there has been a significant and unexpected decline in dental health where this approach may be appropriate.

How many patients can I use the phased treatment approach for?

As many patients that the phased approach is appropriate for. However, it is considered unlikely that this will be significant in relation to the practice's patient base. The BSA will be

monitoring activity and in the case of outliers, may request clinical records to be reviewed for possible phased treatment to ensure appropriate claims have been made.

What should I record in the patient's clinical record?

Patient clinical records should clearly state that rationale for the phased treatment for patients with high and complex dental, medical or social needs. They should fall in line with current clinical record keeping guidelines. Each new course of treatment should contain a full examination and record of discussion with the patient of their treatment needs.

What if my patient fails to attend (FTA) part way through a course of treatment?

If a patient fails to return and you have made a reasonable attempt to get the patient to return, then close the treatment off as incomplete. However, multiple new CoTs with the patient failing to attend, with incomplete claims, would be considered inappropriate.

What if a patient requires an urgent appointment?

If you have an open CoT, then the urgent care is part of that CoT. If you do not have an open CoT, then it would be reasonable to treat the acute problem under an urgent CoT (generating 1.2 UDAs). This would be in addition to the routine CoTs which would make up the rest of the phased treatment. However multiple urgent CoTs for the patient in a short time period would not be appropriate.

When should I claim for an urgent appointment, and what should I claim if the patient FTA after the first appointment when I have relieved pain?

If you have carried out treatment / relieved pain appropriate to an urgent appointment, then an urgent claim should be made. It would not be appropriate to claim a Band 2 CoT for a single item of treatment, such as extraction of a tooth.

What information should I record for phased courses of treatment related to periodontal disease management?

Please see below

Clarification of how the Avoidance of Doubt Note on phased treatments applies to periodontitis

Overview

Periodontal disease management is significantly linked and important to management of long-term conditions.[1, 2] This document is a clarification following questions on how phased treatments apply to patients diagnosed with periodontitis. It **must be read** in conjunction with

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[1] https://onlinelibrary.wiley.com/doi/epdf/10.1111/jcpe.12808
[2] https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/jcpe.13189

the BSP guidance on Delivering phased-care for periodontitis patients under UDA banding: Road map to prevention and stabilisation.

First course of treatment – Step 1 of care

Aim: Risk factor control, supragingival professional mechanical plaque removal (PMPR)

The first course of treatment is aimed at disease diagnosis and guiding and supporting behaviour change by motivating patients to take ownership of their oral health and undertake successful supragingival plaque and risk factor control. This will involve a band 2 course of treatment and should record and include the following:

- Appropriate radiographs
- Baseline plaque & bleeding score – (full mouth or abbreviated using 'Ramfjord's teeth' -UR6, UL1, UL4, LL6, LR1 and LR4, using mesial, distal, buccal, lingual surfaces (24 scores and calculate as % score)
- Risk factor assessment, identification
- Provisional diagnosis and classification
- Behaviour change, oral hygiene and plaque control advice (Delivering Better Oral Health)
- Professional mechanical plaque removal/control (PMPR) including supra gingival scaling/debridement.
- Other treatment should be delivered in conjunction and as determined clinically by examination and appropriate radiographs eg caries stabilisation, extractions, etc
- It is expected that step 1 of care will entail more than one visit.

Second course of treatment after three months

Aim: Determine patient engagement with prevention in order to allow progression of treatment to Step 2 of care (Sub-gingival instrumentation of affected sites)

After three months from the end of the first course of treatment the patient should be re-assessed. This includes assessing patient engagement relative to baseline measures defined in step 1.

A repeat plaque and bleeding score (presence or absence after disclosing either full mouth or on six abbreviated teeth (score 1 or 0 at four surfaces of each of the six teeth – total score /24) should be carried out to determine this. The thresholds for patient engagement have been outlined here.

Step 2 of care will be unsuccessful unless it is supported by patient engagement with adequate oral hygiene and risk factor control. Therefore, before commencement of Step 2,

acceptable levels of plaque control need to be achieved in order to facilitate optimal treatment outcomes and appropriate allocation of resources and funding. The patient should be supported by the dental team through delivery of thorough Step 1 of care in order to achieve this. This should include review of risk factors identified and documented at the initial assessment.

Non-engaging patient

At the three-month reassessment, if the patient has not achieved adequate plaque control, Step 1 of care should be repeated.

Recall three months after the end of this course of treatment. A repeat plaque and bleeding score (full mouth or abbreviated) should be carried out to determine this (disclose for plaque and note presence or absence). The thresholds for patient engagement have been outlined here.

If the patient remains non-engaging, then after discussion with the patient, they can enter into a palliative periodontal care pathway as define in NHS England and NHS Improvement's Commissioning Standard for Restorative Dentistry (page 31) and recalled according to clinical risk in line with NICE guidelines.

Step 2 of care – for engaging patients

Aim: Subgingival dental biofilm and calculus removal (root surface debridement)

An engaging patient will progress to Step 2 of care. This will involve a further band 2 course of treatment and should include the following:

- A detailed periodontal chart (DPC) in line with BSP guidelines
- A repeat plaque score with disclosing (full mouth or abbreviated using 'Ramfjord's teeth' -UR6, UL1, UL4, LL6, LR1 and LR4, using mesial, distal, buccal, lingual surfaces (24 scores and calculate as % score)
- Subgingival instrumentation (root surface debridement/subgingival PMPR) with the aim to remove subgingival plaque, calculus and endotoxin from root surfaces
- Reinforce behaviour change, oral hygiene and plaque control advice (Delivering Better Oral Health)
- Whole mouth treatment is ideally completed within a 2-4-week period under this course of treatment.

Third course of treatment – Step 3 of care – for engaging patients

Aim: Detailed periodontal pocket/bleeding chart and repeat plaque score. Treat areas and sites not responding adequately to 2nd step of therapy (presence of pockets ≥4mm with bleeding on probing or presence of deep pockets (≥ 6mm)

The patient will need to be recalled three months after the second course of treatment and Step 2 of care. This will involve a further Band 2 course of treatment and should include the following:

- A DPC in line with BSP guidelines
- A repeat plaque score with disclosing (full mouth or abbreviated using 'Ramfjord's teeth' -UR6, UL1, UL4, LL6, LR1 and LR4, using mesial, distal, buccal, lingual surfaces (24 scores and calculate as % score)
- Repeated supra- and subgingival instrumentation of non-responding sites (PPD ≥4mm with bleeding on probing) or presence of deep pockets [≥ 6mm])
- Reinforce behaviour change, oral hygiene and plaque control advice with focused advice for non-responding areas
- Referral for level 2 or 3 care provision if ≥4 remaining unstable sites with PPD >4mm with bleeding to probe, or ≥6mm on one or more teeth. Referral is in line with complexity levels defines on page 11 or 32 of the NHS England and NHS Improvement Commissioning Standard for Restorative Dentistry (Page 11 or 32).
- If the patient is stable (PPD ≤4mm with no BOP at 4mm sites) or has reached an acceptable endpoint for treatment and disease control (overall ≤ 4 sites with PPD ≥5mm) at this re-examination, treatment would move to supportive periodontal care (SPC) (Step 4)

Fourth course of treatment – Step 4 – for engaging patients

Aim: Maintain periodontal stability in treated periodontitis patients by combining preventive and therapeutic interventions as outlined in Step-1 and Step-2 of care.

Maintenance via SPC, which will be personalised to patient need and / or risk as 3-montly or longer intervals.

- A DPC in line with BSP guidelines – record probing pocket depths ≥4mm and BOP as a minimum
- A repeat plaque score with disclosing (full mouth or abbreviated using 'Ramfjord's teeth' -UR6, UL1, UL4, LL6, LR1 and LR4, using mesial, distal, buccal, lingual surfaces (24 scores and calculate as % score)
- Reinforcing behaviour change, patient motivation, oral hygiene and plaque control
- Risk factor control

- Detailed pocket charting – probing pocket depths ≥4mm and BOP as a minimum
- Professional mechanical plaque removal (PMPR)
- Localised subgingival instrumentation of residual pockets
- Longer appointment time is required.

References

- https://www.nhsbsa.nhs.uk/sites/default/files/2017-05/Dental%20handbook%20v1.0.pdf
- https://www.legislation.gov.uk/ukdsi/2005/0110736400/contents
- https://www.england.nhs.uk/wp-content/uploads/2014/05/dental-assurance-frmwrk-may.pdf
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