NHS Dental Contract Complex Care Pathways (CCP)

Comprehensive Operational, Clinical & Claiming Implementation Guidance for Dental Teams

Authoritative Guidance: NHS England Reform 2026 **Effective Date:** 23 June 2026 **Target Audience:** Dentists, Therapists, Hygienists, PMs

1. Executive Summary & Regulatory Background

On 23 June 2026, NHS England formally introduced **Complex Care Pathways (CCPs)** as part of the NHS Dental Quality and Payment Contract Reforms. These care pathways establish a modernised, evidence-based legal and financial framework designed specifically for adult patients (aged 16 and over) presenting with high-volume, progressive dental disease—specifically **significant dental caries** and/or **unstable, severe periodontitis**.

Historically, NHS dental remuneration struggled to adequately support the extended time, biological stabilisation, multi-disciplinary prevention, and patient self-care coaching necessary to manage high-risk, disease-active patients. Historically, clinical teams were pushed toward purely episodic, reparative surgical intervention (drilling and filling). The 2026 Complex Care Pathways resolve this structural misalignment by introducing 6-month and 12-month care packages supported by tariff-based UDA crediting and structured monthly declarations.

> **CRITICAL CONTRACTUAL CHANGE: Transition from Phased Care**
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> Complex Care Pathways provide a clear legal basis for managing progressive disease over extended timeframes and adapting treatment plans based on patient healing and behavior change. Consequently, **"Phased Courses of Treatment" (under pre-existing Avoidance of Doubt guidance) are phased out**. Recording phased courses of treatment for this patient cohort must entirely end by **31 December 2026**.

2. The Three Complex Care Pathways: Clinical Eligibility Matrix

Entry onto a Complex Care Pathway requires meeting strict clinical thresholds, obtaining full informed consent to a Personalised Care Plan, and providing care within an NHS General Dental Services (GDS) contract or Personal Dental Services (PDS) agreement delivering mandatory services. Patients cannot be enrolled on more than one pathway simultaneously.

Care Pathway	Duration	Clinical Entry Criteria	Mandatory Care Requirements
CCP 1: Dental Caries	6 Months	• Age 16 years or over. • **5 or more teeth** with active caries into dentine.	• Restorations and/or extractions of **at least 5 carious teeth**. • Evidence-based primary & secondary prevention. • Risk factor re-evaluation & recall set.
CCP 2: Caries & Unstable Periodontitis	12 Months	• Age 16 years or over. • **5 or more teeth** with caries into dentine **AND** • **Generalised unstable periodontitis** (>30% teeth affected on examination) with PPD ≥ 5mm, OR PPD ≥ 4mm with BOP. • Diagnosis: Stage II Grade B+ up to Stage IV Grade C (or Grade A with modifying risk factors).	• Restorations/extractions of ≥ 5 carious teeth. • **Minimum of 3 steps/cycles of periodontal treatment** adhering to BSP S3 Guidelines. • Mid-point (M6) clinical data reporting. • Risk factor re-evaluation at 12 months.
CCP 3: Complex Periodontitis	6 Months	• Age 16 years or over. • **First diagnosis** of Stage III periodontitis (Grade A, B, or C), OR • Unstable Grade C periodontitis (Stage I Grade C*, Stage II Grade C, Stage IV Grade A/B/C) affecting >30% of teeth with PPD ≥ 5mm or PPD ≥ 4mm+BOP.	• **Minimum of 2 steps/cycles of periodontal care** adhering to BSP S3 Guidelines. • Multidisciplinary risk factor control. • Reassessment & Level 2/3 referral triage. • *Note: CCP 3 is single-entry only!*

Special Clinical Provision: Patients with < 5 Carious Teeth Needing CCP 3

If a patient has fewer than 5 carious teeth into dentine but meets the periodontal eligibility for **CCP 3**, the clinician may deliver restorative treatment under a standard Band 2 course of treatment *prior* to initiating CCP 3. If CCP 3 commences within 3 months of completing that Band 2, a **single Band 2 patient charge** covers both courses of care.

3. Step-by-Step Clinical Delivery Framework

CCP 1 Delivery Timeline (6 Months)

Month 0: Baseline Assessment
Comprehensive oral exam, justified radiographs, caries staging/grading, identify modifiable risk factors, agree SMART goals, share Personalised Care Plan, submit Initial Declaration.

Months 1–3: Operative & Prevention Stage 1
Restoration/extraction of minimum 5 carious teeth. Initial OHE, dietary advice, fluoride varnish application (5% NaF), high-fluoride toothpaste prescription (2800/5000ppm).

Months 4–5: Prevention Review & Healing
Review caries activity, check restoration integrity via 5 Rs, reinforce behavior change & self-care.

Month 6: Re-evaluation & Final Declaration
Assess risk factor mitigation, verify disease arrest, establish risk-based recall interval (NICE), submit Final Declaration.

CCP 3 Delivery Timeline (6 Months)

Month 0: Baseline Assessment
Full exam, periapicals, BSP 2018 classification, plaque/bleeding scores, record risk factors (smoking/diabetes), submit Initial Declaration.

Month 1: BSP Step 1 Periodontal Care
Professional mechanical plaque removal (PMPR), removal of plaque-retentive factors, oral hygiene coaching, smoking cessation signposting. Remote review at W4.

Months 3–4: BSP Step 2 & Detailed Pocket Chart
Record baseline DPC. Subgingival instrumentation under local anaesthesia for sites ≥ 4mm. Re-evaluate plaque/bleeding control.

Month 6: Reassessment & Triage
Repeat DPC. If pockets ≥ 6mm persist, refer to Level 2/3 care if available, or repeat subgingival instrumentation. Set recall (typically 3 months). Submit Final Declaration.

Care Pathway 2 Operational Framework (12 Months Timeline)

Month 0 (Initial Exam & Assessment): Diagnose 5+ carious teeth & generalised unstable periodontitis. Formulate combined care plan, record baseline risk factors, issue SMART goals, submit Initial Declaration.

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Months 1–3 (Stage 1 Stabilisation & BSP Step 1): Perform urgent restorative care (selective caries removal, GIC temporisation/stabilisation), pulpotomies if indicated. Deliver BSP Step 1 (PMPR, fluoride varnish, plaque control, OHE). Remote follow-up at 4 weeks.

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Month 4 (Intermediate Review & BSP Step 2): Review caries status using 5 Rs. If plaque control is acceptable, undertake Detailed Pocket Chart (DPC) and perform BSP Step 2 subgingival instrumentation.

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Month 6 (Mid-Point Reassessment & Mandatory Clinical Data Submission): Re-evaluate tissue response and caries arrest. Submit **Mandatory 6-Month Clinical Data Declaration**. Proceed to second cycle of periodontal therapy (Step 2 or Step 4 maintenance).

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Months 7–10 (Stage 2 Definitive Care & BSP Step 3/4): Finalise definitive restorations (composite/amalgam/coronal coverage). Repeat DPC at Month 10. Conduct third cycle of periodontal care (subgingival instrumentation on residual deep sites ≥ 4mm).

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Month 12 (Pathway Completion & Re-evaluation): Final clinical review, record outcome risk factors, complete definitive endodontics/prosthetics if stable, set NICE recall (3–6 months), submit Final Declaration.

4. Evidence-Based Clinical Modalities & Guidelines

A. Caries Management & The 5 Rs Framework

In alignment with Minimally Invasive Oral Care (MIOC) principles, existing and newly restored surfaces must be managed using the structured **5 Rs Approach** to avoid unnecessary invasive replacement:

- **Review:** Regular clinical and radiographic monitoring of marginal integrity, stain, and wear during recall visits.
- **Refurbish:** Polishing, re-contouring, or refinishing overhanging or rough restoration margins to remove biofilm traps without removing the filling.
- **Reseal:** Applying high-penetration resin or glass ionomer surface sealants over defective or stained margins to arrest microleakage.
- **Repair:** Excavating and restoring localized marginal failure or partial fracture while preserving sound structural filling material.
- **Replace:** Total removal and re-placement of the restoration—strictly reserved as a last resort for total structural failure or extensive recurrent caries.

B. Vital Pulp Therapy (VPT) & Endodontic Strategy

To preserve pulpal health in deep carious lesions, clinicians should prioritize biologically based Vital Pulp Therapy (VPT) using modern calcium-silicate biomaterials (e.g., MTA, Biodentine):

- **Indirect Pulp Treatment (IPT):** Selective excavation leaving affected dentine over the pulp, sealed with high-grade GIC/RMGIC to promote remineralisation.
- **Direct Pulp Capping / Partial (Cvek) Pulpotomy:** Application of calcium-silicate directly over small traumatic/carious exposures followed by immediate fluid-tight coronal seal.
- **Full Coronal Pulpotomy:** Removal of exposed coronal pulp tissue to the canal orifices in mature teeth with reversible pulpitis.

> **Endodontic Obturation Protocol**
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> As a core contractual principle, **definitive root canal obturation should be deferred** until the oral health team is satisfied that overall disease risk has been controlled and caries activity stabilized. Vitality must be actively monitored.

C. Periodontal Management (BSP S3 Guidelines)

Periodontal care must follow the European/BSP S3 Clinical Practice Guidelines structured into 4 sequential steps:

- **Step 1:** Managing risk factors (smoking cessation, diabetes control, dietary counseling), hygiene coaching, and professional mechanical plaque removal (PMPR).
- **Step 2:** Subgingival instrumentation (scaling & root planing) of sites with probing depths ≥ 4mm under local anaesthesia, performed after achieving satisfactory self-performed plaque control.
- **Step 3:** Re-evaluating non-responding residual deep pockets (≥ 6mm). Involves repeated subgingival instrumentation or referral for Level 2/3 periodontal care (surgical/regenerative therapy).
- **Step 4:** Supportive Periodontal Care (SPC) / maintenance, combining recall PMPR, risk monitoring, and selective re-instrumentation.

5. Contractual Claiming, Declarations & Financial Rules

Because Complex Care Pathways span 6 to 12 months, activity is credited incrementally via **monthly electronic declarations** submitted through Compass / Dental Services Portal. This prevents financial cash-flow bottlenecks and eliminates complex year-end clawback scenarios.

Overview of Declaration Types & Submission Timelines

Declaration Type	Submission Window	Clinical & Operational Requirements
Initial Declaration	Within **2 months** of start date	• Confirms clinical entry criteria met. • Patient details, date of commencement, signed Personalised Care Plan. • Baseline modifiable risk factors recorded (tobacco, alcohol, sugar, hygiene, xerostomia, stress, diabetes). • Triggers first UDA Declaration Credit.
Interim Declarations	Monthly (after 1st of each month)	• Submitted sequentially in numerical order. • Confirms patient remains under active care. • Interim cut-off window: **9 months** (CCP 1 & 3), **15 months** (CCP 2). • **Month 6 Interim for CCP 2:** Requires mandatory clinical progress data submission.
Suspension Declaration	Max **1 per pathway** (valid max 3 months)	• Used if patient is hospitalized, away, or unable to attend for > 1 month. • Pauses UDA credits for up to 3 months. • Must be submitted within 2 months of last declaration. • Cut-off submission deadlines: Month 4 (CCP 1 & 3), Month 10 (CCP 2). • Pathway resumes via subsequent Interim Declaration. If no interim is submitted within 3 months, system auto-incompletes.
Incomplete Declaration	Within **2 months** of care stopping	• Used when patient disengages, moves away, or fails to attend despite follow-up. • Formally terminates the pathway and applies final partial UDA credit.
Final Declaration	Within **2 months** of completion date	• Confirms all minimum service requirements met. • Final recording of addressed risk factors & clinical outcome metrics. • Confirms periodontal referral status (Referred Level 2/3, Not Needed, or Service Unavailable). • Triggers final UDA Declaration Credit.

Patient Charge Framework & Concurrent Claiming Rules

> **Patient Fee Guarantee**
> For charge-paying adults, a **single Band 2 charge** covers the entire Complex Care Pathway (CCP 1, CCP 2, or CCP 3), regardless of how many visits, restorations, hygiene sessions, or radiographs are delivered over the 6 or 12 months.

- **Band 3 Co-Provision:** If prosthodontics (e.g., dentures, crowns) become clinically necessary during or within 3 months of completing a CCP, a Band 3 course of treatment can be claimed. The patient charge is **capped at the difference between Band 2 and Band 3**.
- **Denture Modifications & Urgent Care:** Concurrent claims for denture repairs, denture modifications (relines/rebases/additions), or Band 1 Urgent Care can be submitted alongside an active CCP where clinically required.
- **Post-Pathway Care:** Upon pathway completion, the patient transitions to routine risk-based recall (NICE). Any subsequent treatment required at recall constitutes a separate course of treatment (e.g., Band 2a for ongoing supportive periodontal therapy) with standard patient charges.

6. Skill Mix & Team Integration

Delivering Complex Care Pathways efficiently relies on maximizing the full scope of practice of the entire dental team. There are no regulatory restrictions on delegation, provided team members are qualified, competent, and indemnity-covered.

Team Role	Key Responsibilities in Care Pathways
Dentist	Comprehensive examination, diagnosis, path selection, Personalised Care Plan creation, complex restorative care, endodontics, surgical extractions, overall clinical governance, prescribing prescription-strength fluoride.
Dental Therapist	Direct restorative care (fillings in carious teeth), periodontal subgingival instrumentation (BSP Steps 1–3), detailed pocket charting, OHE, interim reviews.
Dental Hygienist	Periodontal risk assessments, detailed pocket charting (DPC), BSP Steps 1–4 periodontal therapy (PMPR & subgingival instrumentation), preventative advice, fluoride varnish application.
Extended Duty Dental Nurse (EDDN)	Application of fluoride varnish (under dentist prescription), structured oral health education, dietary advice, smoking cessation coaching, remote follow-up calls, clinical data entry.

7. Clinical Summary & Best Practice Checklist

Practice Operational Checklist for CCP Success

1. **Triage & Identify:** Ensure reception and clinical staff spot patients presenting with ≥ 5 carious teeth or severe gum disease.
2. **Pathway Selection:** Dentist confirms eligibility, obtains written patient agreement to the multi-month plan, and submits Initial Declaration within 2 months.
3. **Delegate Prevention:** Schedule hygiene/therapy appointments for BSP Step 1, OHE, and fluoride application immediately following or alongside initial restorative care.
4. **Monthly Compass Workflow:** Assign a practice administrator or clinician to submit monthly Interim Declarations immediately after the 1st of each calendar month.
5. **Biological Stabilisation First:** Use GIC/RMGIC for initial caries sealing and delay root canal obturation until disease activity subsides.
6. **Re-evaluate at Completion:** Perform thorough outcome review at M6/M12, submit Final Declaration within 2 months, and set appropriate recall interval.