

Dental recall

Recall interval between routine dental
examinations

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NICE clinical guideline 19

guidance.nice.org.uk/cg19

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Introduction

Six-monthly dental check-ups have been customary in the General Dental Service (GDS) in the United Kingdom since the inception of the NHS. In recent years there has been significant debate over the timing of recall intervals for dental check-ups, and this has coincided with a move towards making NHS dental services in England and Wales more oriented to prevention and more clinically effective in meeting patients' needs.

The Department of Health's strategy document *NHS Dentistry: Options for Change* (2002) and subsequent legislation are bringing about changes in the organisation of dental services and the way in which oral health is assessed. Under the new arrangements, a comprehensive oral health assessment (OHA) will be conducted when a patient first visits a dental practice and will involve taking full histories, carrying out thorough dental and head and neck examinations and providing initial preventive advice. The dentist and patient will discuss the findings and agree a personalised care plan and a 'destination' for this journey of care. The dental team and patient will then work through this first personal care plan (see Appendix D).

After an agreed interval, the patient will return for an oral health review (OHR), during which the histories and examination will be updated and any changes in risk factors noted. The dental team will also assess the effectiveness of the treatment and preventive advice provided previously, and will give more advice as necessary. The patient and dentist will discuss the findings of the review and agree the next, refined, personalised care plan and a specific 'destination' for this new journey of care (see Appendix D).

The purpose of this guideline is to help clinicians assign recall intervals between oral health reviews that are appropriate to the needs of individual patients. The recommendations apply to patients of all ages (both dentate and edentulous) receiving primary care from NHS dental staff in England and Wales. The guideline takes into account the potential of the patient and the dental team to improve or maintain the patient's quality of life and to reduce morbidity associated with oral and dental disease.

The recommendations take account of the impact of dental checks on: patients' well-being, general health and preventive habits; caries incidence and avoiding restorations; periodontal health and avoiding tooth loss; and avoiding pain and anxiety.

This guideline does not cover:

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- recall intervals for scale and polish treatments
 - the prescription and timing of dental radiographs
 - intervals between examinations that are not routine dental recalls; that is, intervals between examinations relating to ongoing courses of treatment
 - emergency dental interventions or intervals between episodes of specialist care.

The following guidance is based on the best available evidence. There is evidence relating to risk factors for oral disease and on the effectiveness of dental health education and oral health promotion, and this was used to inform the guideline recommendations. However, the research evidence on many aspects of dental recall intervals was limited, and recommendations were based on the clinical experience of the Guideline Development Group and advice received during the consultation process.

1 Guidance

Section 1.1 of this guidance contains the clinical recommendations. Tools to support clinicians in implementing these recommendations can be found in Appendix E.

1.1 *Clinical recommendations*

- 1.1.1 The recommended interval between oral health reviews should be determined specifically for each patient and tailored to meet his or her needs, on the basis of an assessment of disease levels and risk of or from dental disease.
- 1.1.2 This assessment should integrate the evidence presented in this guideline with the clinical judgement and expertise of the dental team, and should be discussed with the patient.
- 1.1.3 During an oral health review, the dental team (led by the dentist) should ensure that comprehensive histories are taken, examinations are conducted and initial preventive advice is given. This will allow the dental team and the patient (and/or his or her parent, guardian or carer) to discuss, where appropriate:
- the effects of oral hygiene, diet, fluoride use, tobacco and alcohol on oral health
 - the risk factors (see the checklist in Appendix E) that may influence the patient's oral health, and their implications for deciding the appropriate recall interval
 - the outcome of previous care episodes and the suitability of previously recommended intervals
 - the patient's ability or desire to visit the dentist at the recommended interval
 - the financial costs to the patient of having the oral health review and any subsequent treatments.
- 1.1.4 The interval before the next oral health review should be chosen, either at the end of an oral health review if no further treatment is indicated, or on completion of a specific treatment journey.

1.1.5 The recommended shortest and longest intervals between oral health reviews are as follows.

- The shortest interval between oral health reviews for all patients should be 3 months.

A recall interval of less than 3 months is not normally needed for a routine dental recall. A patient may need to be seen more frequently for specific reasons such as disease management, ongoing courses of treatment, emergency dental interventions, or episodes of specialist care, which are outside the scope of an oral health review.

- The longest interval between oral health reviews for patients younger than 18 years should be 12 months.

There is evidence that the rate of progression of dental caries can be more rapid in children and adolescents than in older people, and it seems to be faster in primary teeth than in permanent teeth (see full guideline). Periodic developmental assessment of the dentition is also required in children.

Recall intervals of no longer than 12 months give the opportunity for delivering and reinforcing preventive advice and for raising awareness of the importance of good oral health. This is particularly important in young children, to lay the foundations for life-long dental health.

- The longest interval between oral health reviews for patients aged 18 years and older should be 24 months.

*Recall intervals for patients **who have repeatedly demonstrated that they can maintain oral health and who are not considered to be at risk of or from oral disease** may be extended over time up to an interval of 24 months. Intervals of longer than 24 months are undesirable because they could diminish the professional relationship between dentist and patient, and people's lifestyles may change.*

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- 1.1.6 For practical reasons, the patient should be assigned a recall interval of 3, 6, 9 or 12 months if he or she is younger than 18 years old, or 3, 6, 9, 12, 15, 18, 21 or 24 months if he or she is aged 18 years or older.
 - 1.1.7 The dentist should discuss the recommended recall interval with the patient and record this interval, and the patient's agreement or disagreement with it, in the current record-keeping system.
 - 1.1.8 The recall interval should be reviewed again at the next oral health review, to learn from the patient's responses to the oral care provided and the health outcomes achieved. This feedback and the findings of the oral health review should be used to adjust the next recall interval chosen. Patients should be informed that their recommended recall interval may vary over time.

The interval may be maintained at the same level if it is achieving its aims. For someone with low disease activity, it may be possible to gradually extend the interval towards the 24-month maximum period – once the patient and the dental team are confident that this is satisfactory. Patients whose disease activity continues unabated may need a shorter interval and may need more intensive preventive care and closer supervision.

Patients should be encouraged to seek advice from a dentist before their next scheduled review if there are any significant changes in their risk factors. They also need to understand that (as is the case with the current 6-month recall regimen) there is no guarantee that new disease will not develop between recall visits.

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, after a period of consultation.

3 Implementation in the NHS

3.1 *In general*

Local health communities should review their existing practice for dental recall against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1, the people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

This guidance contains tools and suggestions to facilitate implementation and review (see Appendix E). These are designed to help NHS dental practices and their patients get used to what will be for many a new way of planning and receiving routine NHS dental care. A poster and leaflet for the public are also available (see Section 5).

NHS clinical care pathways

NHS clinical care pathways are being developed to further the aims outlined in the Department of Health's strategy document *NHS Dentistry: Options for Change* (2002). The first clinical care pathway for NHS dentistry is being developed by the Dental Health Services Research Unit at the University of Dundee and deals with the initial oral health assessment and subsequent oral health reviews (see diagram in Appendix D). It is being tested by NHS Options for Change field sites, which include dental practices, primary care trusts and strategic health authorities who volunteered to test the modernisation proposals outlined in *Options for Change*. The pathway accommodates the NICE recommendations on recall intervals and this should help a seamless move into modernised, preventive NHS dental care.

3.2 *Audit*

Patient records should show that appropriate recall intervals have been identified, based on the assessment of risk in discussion with the patient. The following criteria can be used to audit adherence to the guideline recommendations.

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- 3.2.1 At the end of each oral health review there is a record for each patient of an assessment of disease and disease risk.
- 3.2.2 At the end of each oral health review, or at completion of treatment, there is a record for each patient of the recall interval recommended by the dentist for the next oral health review.
- 3.2.3 The interval agreed each time, for each patient is:
- 3, 6, 9 or 12 months for patients younger than 18 years, or
 - 3, 6, 9, 12, 15, 18, 21 or 24 months for patients aged 18 years or older.
- 3.2.4 Where there is disagreement between the dentist and the patient over the recall interval, the reason for this is recorded.

Further information on local and national audit is available in the [full guideline](#).

4 Research recommendations

While developing this guideline, the research evidence in a number of areas was found either to be inconclusive or not to exist. Research in the following areas would help in updating this guideline and implementing it in general dental practice.

- Dental attendance patterns should be examined for changes after the publication of the guideline.
- After publication of the guideline, information will be needed on whether patients visit the dentist at the agreed interval, and their reasons for this.
- Research is needed on the long-term clinical and cost effectiveness of one-to-one oral health advice and whether this may depend on:
 - the frequency with which it is delivered
 - the physical or oral health of the patient
 - other characteristics of the patient (for example, age, sex, social class, occupation)
 - the medium used to deliver the advice
 - who delivers the advice.
- Research is needed to examine the effects of varying dental recall intervals on oral health, and on which aspects of the oral health review influence oral health.
- Research is needed to examine the impact of oral health (relating to gingivitis, caries, periodontal disease and mucosal disease) on quality of life.
- Research is needed to examine the effects on periodontal health of routine scale and polish treatment (in conjunction with oral hygiene instruction) in different populations. Specifically, research is needed to examine the clinical effectiveness and cost effectiveness of providing this intervention at different time intervals.

Research designs will need to accommodate the mix of arrangements (NHS, private and mixed configurations) under which dental primary care is provided.

5 Other versions of this guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Acute Care. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

There is more information about [how NICE clinical guidelines are developed](#) on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is [available](#).

Full guideline

The full guideline, 'Dental recall: recall interval between routine dental examinations', is published by the National Collaborating Centre for Acute Care; it is available on the NICE [website](#).

Information for the public

This guideline is different from other guidelines in that the whole population is affected. NICE has produced [information for the public](#) explaining this guideline. We encourage NHS and voluntary sector organisations to use text from this booklet information in their own information materials. A [poster](#) explaining the guidance is also available. This is a good starting point for explaining why a patient's recommended recall interval may have changed.

6 Related NICE guidance

There is no related NICE guidance.

7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

Appendix A: Grading scheme

The recommendation grading scheme and hierarchy of evidence used in this guideline are adapted from the Scottish Intercollegiate Guidelines Network (*SIGN 50: A guideline developers' handbook*), and summarised in the tables below.

Recommendation grade	Evidence
A	At least one meta-analysis, systematic review, or randomised controlled trial (RCT) rated as 1 ⁺⁺ (see table on page 17), and directly applicable to the target population, or A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1 ⁺ , directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2 ⁺⁺ , directly applicable to the target population, and demonstrating overall consistency of results, or Extrapolated evidence from studies rated as 1 ⁺⁺ or 1 ⁺
C	A body of evidence including studies rated as 2 ⁺ , directly applicable to the target population and demonstrating overall consistency of results, or Extrapolated evidence from studies rated as 2 ⁺⁺
D	Evidence level 3 or 4, or Extrapolated evidence from studies rated as 2 ⁺ , or Formal consensus
D (GPP)	A good practice point (GPP) is a recommendation for best practice based on the clinical experience of the Guideline Development Group
Level of evidence	Type of evidence
1 ⁺⁺	High-quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias

1 ⁺	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1 ⁻	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2 ⁺⁺	High-quality systematic reviews of case-control or cohort studies High-quality case-control or cohort studies with a very low risk of confounding, bias or chance, and a high probability that the relationship is causal
2 ⁺	Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance, and a moderate probability that the relationship is causal
2 ⁻	Case-control or cohort studies with a high risk of confounding, bias or chance, and a significant risk that the relationship is not causal
3	Non-analytic studies (for example, case reports, case series)
4	Expert opinion, formal consensus

Appendix B: The Guideline Development Group

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Clinical Research Fellow, West Midlands Health Technology Assessment Collaboration, University of Birmingham

Dr Ralph Davies

General Dental Practitioner, Nottinghamshire; British Dental Association

Ms Karen Elley

Consultant in Dental Public Health, Rowley Regis and Tipton Primary Care Trust, West Midlands

Mr Stephen Fayle

Consultant in Paediatric Dentistry, Leeds Dental Institute, Leeds Teaching Hospitals Trust; Faculty of Dental Surgery, Royal College of Surgeons of England

Mrs Eleanor Grey

Patient Representative; formerly Chair of the Lay Advisory Group, Faculty of General Dental Practitioners (UK)

Dr Kathryn Harley

Consultant in Paediatric Dentistry and Honorary Senior Lecturer, Edinburgh Dental Institute

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Mr Carlos Sharpin

Senior Information Scientist and Systematic Reviewer, NCC-AC

Ms Louise Thomas

Research Associate, NCC-AC

Mr David Wonderling

Health Economist, NCC-AC

Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows:

Mr Peter Robb (Chair)

Consultant ENT Surgeon, Epsom and St University Hospitals and the Royal Trusts

Mrs Joyce Struthers

Patient Representative, Bedford

Dr Peter Duncan (Deputy Chair)

Consultant in Anaesthetics and Intensive Care Medicine, Royal Preston Hospital, Preston

Mrs Anne Williams

Deputy Director of Clinical Governance, Kettering NHS Trust, Northamptonshire

Appendix D: NHS England clinical care pathways: overview of oral health assessment and oral health review

The [full guideline](#) contains a care pathway and overview of oral health assessment oral health review.

Appendix E: Implementing the guideline recommendations

The [full guideline](#) contains information about implementing the guideline recommendations.

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Acute Care. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

The recommendations in this guideline were graded according to the quality of the evidence they were based on. The gradings are available in the [NICE guideline](#) and are not shown in this web version.

We have produced [information for the public](#) explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also [available](#).

Changes after publication

January 2012: minor maintenance

December 2013: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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