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# Clinical guidance: unscheduled urgent and non-urgent dental care March 2025

**Version 1**

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## Contents

## Foreword

Unscheduled dental care necessitates the need for simple, rapid access to a dental professional within and outside of normal working hours.

This guidance describes the delivery of care in accordance with current best practice for patients seeking unscheduled dental care. It aims to ensure equitable access to unscheduled dental care in England. Care should be timely, safe, effective, and tailored to individual needs.

Unscheduled dental care provision can vary, from in-person treatment to remote advice as part of initial triage. Local systems should have commissioned services, infrastructure, and a workforce in place to effectively address these needs.

Furthermore, it is essential that local unscheduled dental care systems can adapt to changing local and national circumstances, ensuring delivery of care through various unplanned events that may negatively impact care delivery or more local issues such as major power failures and outages.

## Delivery of the 2025/26 urgent dental care commitment

This guidance is intended to support the clinical management of patients with an unscheduled care need and the *National Service Specification for Urgent and Non-urgent Unscheduled Dental Care.* It also supports the government's manifesto commitment of 700,000 additional urgent care appointments during 2025/26, covering the alleviation of dental problems which are triaged to a 24-hour to 7-day disposition.

For the delivery of the 700,000 additional appointments, care included is that required to address the presenting complaint of the patient and initial disease management of underlying risk factors as outlined in section 5, which would constitute a single course of urgent treatment in line with the Regulations. Where a patient requires ongoing treatment ("stabilisation") to address their oral health needs as encapsulated in either a Band 2 or Band 3 course of treatment, this would not count towards delivery of the 700,000 appointments. Additionally, triage via remote advice on self-management prior to a face-to-face assessment will also not count towards delivery of the 700,000 appointments.

# 1. Introduction

This clinical guidance supports the effective delivery of unscheduled dental care services in England, available during and outside normal working hours.

It has been produced specifically to support the *National Service Specification for Urgent and Non-urgent Unscheduled Dental Care*. It supersedes and replaces the Clinical Standard for Urgent Dental Care released by NHS England in November 2023.

Unscheduled dental care should be of high quality and individuals with unscheduled dental needs should be seen in the right place, by the right person delivering the right care at the right time. Care must be accessible to all patients, including children and adults, those with additional needs, and those not currently receiving treatment in primary dental services. Patients must not be denied access to unscheduled dental care where they do not have an NHS number or GP registration. Patients must also not be denied access to an unscheduled urgent care appointment if they are not undergoing current treatment or are not known to a practice.

There should be streamlined access to unscheduled dental care, personalised support for complex needs, and a proactive approach to prevention. These are principles that align with the "Fuller Stocktake," a report commissioned by NHS England.

# 2. Defining unscheduled dental care

## 2.1 Unscheduled dental care

As defined in the 'Management of Acute Dental Problems' guidance document produced by Scottish Dental Clinical Effectiveness Programme (SDCEP), patients requiring unscheduled dental care can be categorised into one of the following three categories:

- **Emergency unscheduled care (immediately life threatening and oral & dental conditions)**: patients who may require clinical triage by an appropriately trained clinical triage professional within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition.

- **Urgent unscheduled care**: patients who may require clinical care within 24 hours or as soon as practically possible, unless the condition worsens; or

- **Non-urgent unscheduled care**: patients requiring dental care within 7 days, unless the conditions worsens

Please see Figure 1 within the appendix for a summary diagram of these pathways.

## 2.2 Emergency unscheduled care

Emergency unscheduled care (which includes/involves life threatening conditions) in most cases is not covered within this clinical guidance or the national service specification but has been highlighted to recognise its integration within the unscheduled dental care system. It may need to be considered for provision under a different pathway.

Some emergency care treatments (life-threatening oral and dental needs conditions listed below) may be appropriate to be provided under this service, in line with clinical need and maintaining patient safety. Practices should be prepared to consider undertaking emergency unscheduled dental treatment, which may need to be provided on a case-by-case basis, where dental teams are sufficiently skilled and competent to do so. For example, instances of tooth avulsion or spreading dental infection where timely intervention is critical. This will help to maintain clinical outcomes.

Emergency conditions comprise scenarios that require appropriate clinical triage within a 60-minute timescale. Examples include:

- Life threatening conditions:
    - oro-facial swelling that is spreading (**with or likely to cause airway compromise**)
    - dental conditions resulting in acute and severe systemic illness
    - oro-facial fracture

- Emergency dental need:
    - bleeding that cannot be controlled with local measures
    - management of avulsed permanent teeth

### 2.3 Urgent unscheduled care

This defines conditions that require urgent attention but are not life-threatening. Urgent dental care incorporates the triage and management of these conditions either within or outside of normal working hours and is usually within a **24-hour period or as soon as practicably possible**. Examples of urgent conditions include:

- oro-facial swelling or infection that is spreading, recurrent or continuing (**without airway or intracranial compromise**)
- severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice including analgesia
- dentoalveolar injuries, such as fractured teeth and severe luxation injuries affecting oral function
- avulsed ~~primary~~ teeth
- significant facial trauma requiring urgent referral or review
- bleeding which can be controlled with local measures
- severe gingival bleeding requiring urgent treatment or acute conditions of the gingivae or oral mucosa, including therapy for pericoronitis or for rapidly progressive/necrotising periodontal disease and viral (e.g. herpetic) lesions, and any necessary oral hygiene advice/coaching in connection with such treatment

Once the patient's urgent unscheduled care needs are addressed, but further non-urgent dental presentations remain, it is appropriate to signpost to on-going routine care or transition into high needs personalised care pathways.

### 2.4 Non-urgent unscheduled care

This represents those patients requiring face-to-face professional care within 7 days and can include the following:

- mild or moderate pain: that responds to pain-relief measures

- minor dental trauma which may require a professional review without clinical intervention
- intra-oral bleeding that the patient can control using self-help measures
- loose or displaced crowns, bridges or veneers that are not a risk to the airway
- fractured or loose-fitting dentures and other appliances
- fractured posts
- mild swelling
- fractured, loose or displaced fillings
- treatment of sensitive cementum or dentine
- significantly loose teeth that are not a risk to the airway

The category of unscheduled care disposition for endodontic therapy for the immediate alleviation of pain (extirpations, pulpectomy or vital pulpotomy) or managing deep carious lesions, will be dependent upon the extent and nature of pain experienced by the patient and its ability to be managed by pain-relief measures, as listed in the urgent and non-urgent categories above.

The above lists, which are not exclusive nor exhaustive, should align with patient eligibility criteria as defined in Section 6 of the national service specification.

Within non-urgent unscheduled care (care required between 2-7 days), we can identify two key care flows/cohorts:

- reparative and episodic care typically requiring a single discrete course of treatment, and
- higher needs unscheduled care where there is generalised unmanaged progressive disease, predominantly caries and periodontitis, requiring care provision including behaviour change, prevention, and initial disease management beyond the initial management of the presenting complaint.

However, most patients accessing unscheduled dental care services require simple episodic reparative care that is usually a single appointment discrete course of treatment, when there is no evidence of active disease or clear risk factors i.e.

- lost fillings
- displaced crowns and bridges
- fractured or broken teeth
- un-restorable teeth requiring extraction
- localised periodontal conditions

Treatment using clinically appropriate restorative materials, exodontia, extirpation or drainage should aim to provide immediate stability while the patient seeks ongoing care. Importantly, preventive advice and guidance should be provided to address risk factors for progressive oral disease where clinically indicated.

## 2.5 Determing the urgency of treatment

Establishing the nature of unscheduled care required may require assessment of multiple factors, as identified through triage and clinical assessment, expanded upon in Sections 3 and 4 of this guidance.

This may include the extent of pain, swelling, compromised immediate or long-term function, the duration of symptoms and the level/lack of response to appropriate medication needed to address symptoms.

The expressed needs of patients should also be considered, in conjunction with clinical findings, to determine the urgency of unscheduled treatment. This will help establish an appropriate disposition aligned with the three unscheduled care categories described above.

Further information on managing patients needing unscheduled NHS intervention after self-funded treatment is also available here.

# 3 Access to care

## 3.1 Access to care

Unscheduled oral and dental care services should be inclusive and accessible to everyone and there should be no physical, language, cultural, social or other barriers to accessing care, including lack of NHS number or GP registration. Services should be able to meet the unscheduled dental needs of the following groups:

- children with dental trauma as per the criteria listed in section 2
- people with complex medical needs
- people with physical or sensory disability
- people with safeguarding concerns
- people with specific access problems such as homeless people, and refugees or asylum seekers
- people living in remote and rural locations or in prisons or care home settings

Treatment slots should be of sufficient length to manage individual unscheduled care needs and provide, wherever possible, appropriate treatment for the presenting complaint or condition.

Patients should be able to access ~~urgent~~ unscheduled oral and dental care in the most suitable environment in line with this clinical guidance, and as per Paragraphs 7 and 8 of the National Service Specification.

Patients' appointments should be booked where possible into the unscheduled oral and dental care service, through direct booking, a general dental practice, or signposting patients into an unscheduled care network, referring into a service with an appropriate mix of skills, training and resources to provide the required care. This should be in line with unscheduled care timescales outlined in Section 2.

Where patients may present in person to emergency or urgent care departments, triage protocols as per Section 5 below, should be implemented to establish the disposition of care required. Subsequent initial management, where possible, and signposting to unscheduled care networks should be undertaken if services within the immediate department or care facility are not available.

# 4 Clinical triage

## 4.1 Purpose and process

The purpose of clinical triage is to enable consistent prioritisation of patients in line with unscheduled oral and dental care dispositions, ensuring appropriate patient pathways are followed based on the presenting clinical need.

Healthcare professionals assessing patients who present with unscheduled oral and dental care needs are required to identify the nature of the problem and the appropriate disposition directing them to an appropriate setting to receive the initial management required. Oral and dental healthcare professionals must ensure teams have the appropriate clinical triage training, experience and skill mix to undertake this approach. To support all members of the team in performing triage processes, it is advisable to use patient pathway guidance, for example SDCEP, supporting appropriate management for patients presenting with unscheduled urgent and non-urgent dental care scenarios. Triage may include remote advice on self-management prior to a face-to-face assessment but this will not count as an unscheduled dental care appointment as described in the National Service Specification for Urgent and Non-urgent Unscheduled Dental Care. Please see Figure 2 within the appendix for a summary flowchart diagram.

Mnemonic aids, such as SOCRATES, can be used by healthcare professionals involved in triaging patients to undertake pain assessment:

- **S**ite - where is the pain located?
- **O**nset - does/did it arise acutely or gradually?
- **C**haracter – what is the nature of the pain?
- **R**adiation – does the pain spread elsewhere?
- **A**ssociations – are there any other symptoms related to the pain?
- **T**ime course – how long does the pain last?
- **E**xacerbating/relieving features – does anything make it better or worse?
- **S**everity – how bad is the pain (e.g. on a scale of 1-10, 10 being the worst)?

Some patients may present with more than one symptom. In this case, the main or first reported symptom can be used as the starting point of the pain assessment or complaint.

Further guidance on the management of acute dental problems produced by SDCEP can be found here.

### 4.2 Pain management

Careful identification of the nature of the problem through triage is crucial to managing the patient in line with an appropriate unscheduled care disposition. This will include confirmation of the source of pain affecting the patient and ruling out those derived from non-dental sources.

Where pain is a result of, or associated with, other factors, such as trauma, swelling, signs of systemic involvement or deterioration or loss of function, then managing and addressing these signs may take precedent over pain in instances where they could present a greater risk to the patients' systemic health in the immediate or longer term. As above, the SDCEP management of acute dental problem guidelines provides decision pathways to help healthcare teams in their assessments of acute dental problems.

# 5 Initial disease management

## 5.1 Unmanaged progressive disease

This section provides further advice on the management of patients who present with unscheduled oral and dental care needs and who also have generalised unmanaged progressive disease.

Initial disease management is intended to support improvements in oral health in patients with unmanaged progressive dental caries and/or periodontal disease, facilitating greater control over their oral condition, ahead of more definitive care and to help prevent reattendance at unscheduled care services.

Oral healthcare team members should be mindful of addressing risk factors common to the development and progression of both the major non-communicable oral diseases (dental caries and periodontal disease).

To deliver effective initial management it is crucial that the dental team:

- Advise the patient of:
    - the causes of acute current oral and dental conditions.
    - of management processes and pathways, including those for ongoing care needs.
    - effective self-care and how to prevent further deterioration in oral health through tailored advice on prevention.
    - the need for ongoing management and monitoring of progressive disease as further banded courses of treatment.
- Undertake chairside preventative actions, such as the application of fluoride varnish, ensuring cavities are cleansable and/or the use of a clinically appropriate restorative material, removal of obvious plaque and calculus which could interfere with self-care and advise on brushing, use of interdental aids and mitigation of other risk factors as described in Delivering Better Oral Health.
- Utilise a suitable behaviour change model, such as the Com-B behaviour change model.

The initial management of such patients may involve a treatment episode that can be delivered in one and possibly up to two unscheduled care appointments. This could involve addressing acute presentations in the first visit and raising awareness of the causative modifiable risk factors with the patient. The subsequent visit would involve assessing the implementation of personalised prevention principles tailored to the identified risk factors and the adoption of self-care behaviours, alongside a review of resolution of the initial acute presenting complaint. Reviews of patient response to initial management can be undertaken via face to face or remote appointments, in line with NHS England guidance on online consultations.

For the avoidance of doubt, a comprehensive assessment of unmanaged disease would not be expected within an unscheduled appointment, with a focus placed upon assessing and addressing the presenting acute complaint, alongside a brief summary assessment of remaining unmanaged disease.

# 6 Antimicrobial intervention and stewardship

## 6.1 Appropriate use and resources

To reduce the risk of antimicrobial resistance, providers should follow antimicrobial stewardship and prescribing guidance, including helping patients understand when antibiotics are appropriate.

The Faculty of Dental Surgery (FDS) of the Royal College of Surgeons England, in conjunction with the College of General Dentistry (CGDent) have published Good Practice Guidelines on antimicrobial prescribing in dentistry for managing oral and dental infections. Further guidance can be found in the form of the Dental antimicrobial stewardship (AMS) toolkit produced by the UK Health Security Agency (UKHSA), as well as the those published by the Royal College of Surgeons (England) signposted above.

## 6.2 Patient assessment

Early recognition and management of oral and dental infections is critical as patients (particularly children, clinically vulnerable and immunocompromised patients) can become systemically ill within a short space of time. Untreated local infections may spread, causing significant morbidity and even life-threatening consequences.

An assessment of the patient and subsequent diagnosis should be recorded in the clinical records, which includes where appropriate:

- A comprehensive medical and dental history as per NHS England guidance found here.
- Assessment of the presence of fever (> 38°C), malaise, fatigue or dizziness (NB: antipyretic effect of patients taking analgesics may temporarily lower the temperature).
- Measurement of the patient's pulse and temperature (normal temperature range is 36.2°C - 37°C).
- Definition of the nature, location and extent of the swelling, and any lymphadenopathy.
- Identification of the cause of the infection.
- Assessment of presence of sepsis using a decision support tool, e.g. NICE Sepsis: Risk stratification tools.

Following this assessment in primary care, the clinician should decide whether treatment can be provided in line with urgent unscheduled care needs or whether referral to an emergency disposition provider such as a hospital specialist is necessary, particularly if there is/are:

- Signs of septicaemia, such as grossly elevated temperature (above 39.5°C), lethargy, tachycardia, tachypnoea and hypotension.
- Signs of severe sepsis or septic shock (see sepsis decision support tool).
- Spreading cellulitis.
- Swellings that may compromise the airway, cause difficulty in swallowing or closure of the eye.
- Dehydration characterised by lethargy, dizziness and headache.
- Significant trismus associated with a dental infection.
- Failure of resolution of infection following previous treatment.
- A patient who is unable to cooperate with necessary and appropriate care

# 7 Quality improvement

## 7.1 Quality improvement of services

Providers of unscheduled care services should be encouraged to continuously improve the quality of care delivered to service users. This should include monitoring of significant events, annual antimicrobial audits and seeking feedback to improve the quality of services.

Resources to support involving people and communities can be accessed on the Get involved section of NHS England's website or by emailing the NHS Public Partnership Team: england.peopleandcommunities@nhs.net

Patient reported outcome and experience measures should be included in the specification:

- A suggested patient reported outcome measure is 'was the problem resolved by your visit to the urgent dental care service?'
- A suggested patient reported experience measure is 'did you understand what treatment you needed?'

Further feedback tools inlcudes the use of the friends and family test (FFT), which supports the fundamental pricnicples of ensuring users of NHS services should have the opportunity to provide feedback on their experience. Primary dental services providers in England will need to complete and submit the form each month via the NHS Business Services Authority (BSA) website.

As part of the service monitoring and quality improvement process an evaluation of the service should be undertaken by the commissioners. This is particularly relevant prior to any re-procurement or extension of the service. Dental Public Health advice and support should be sought to support any service evaluation.

# Appendix

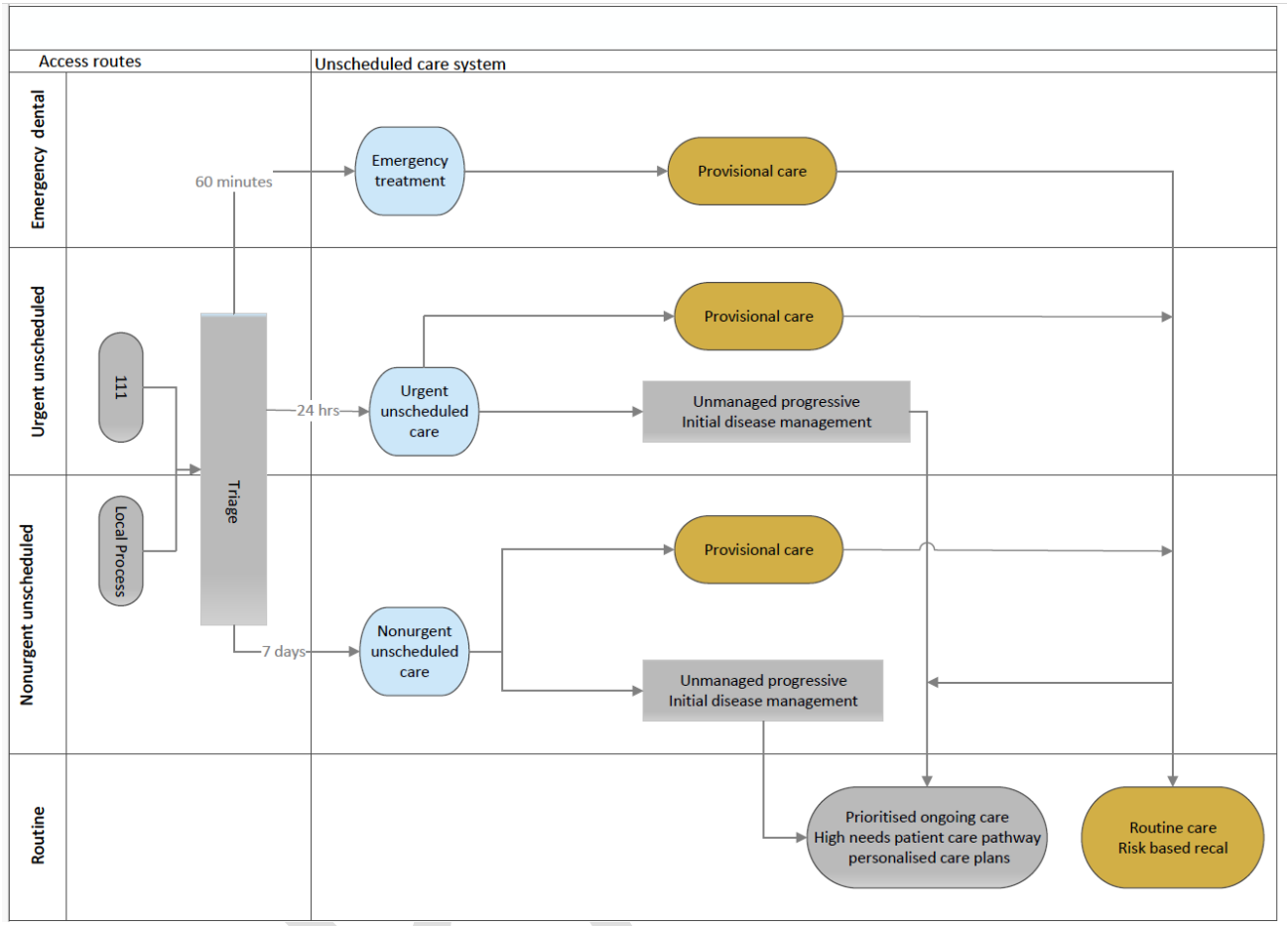


**Figure 1:** Management pathways within the unscheduled care system.

'Provisional care' in this diagram is defined as the treatment of the initial presentation using clinically appropriate restorative materials, and other clinical interventions.

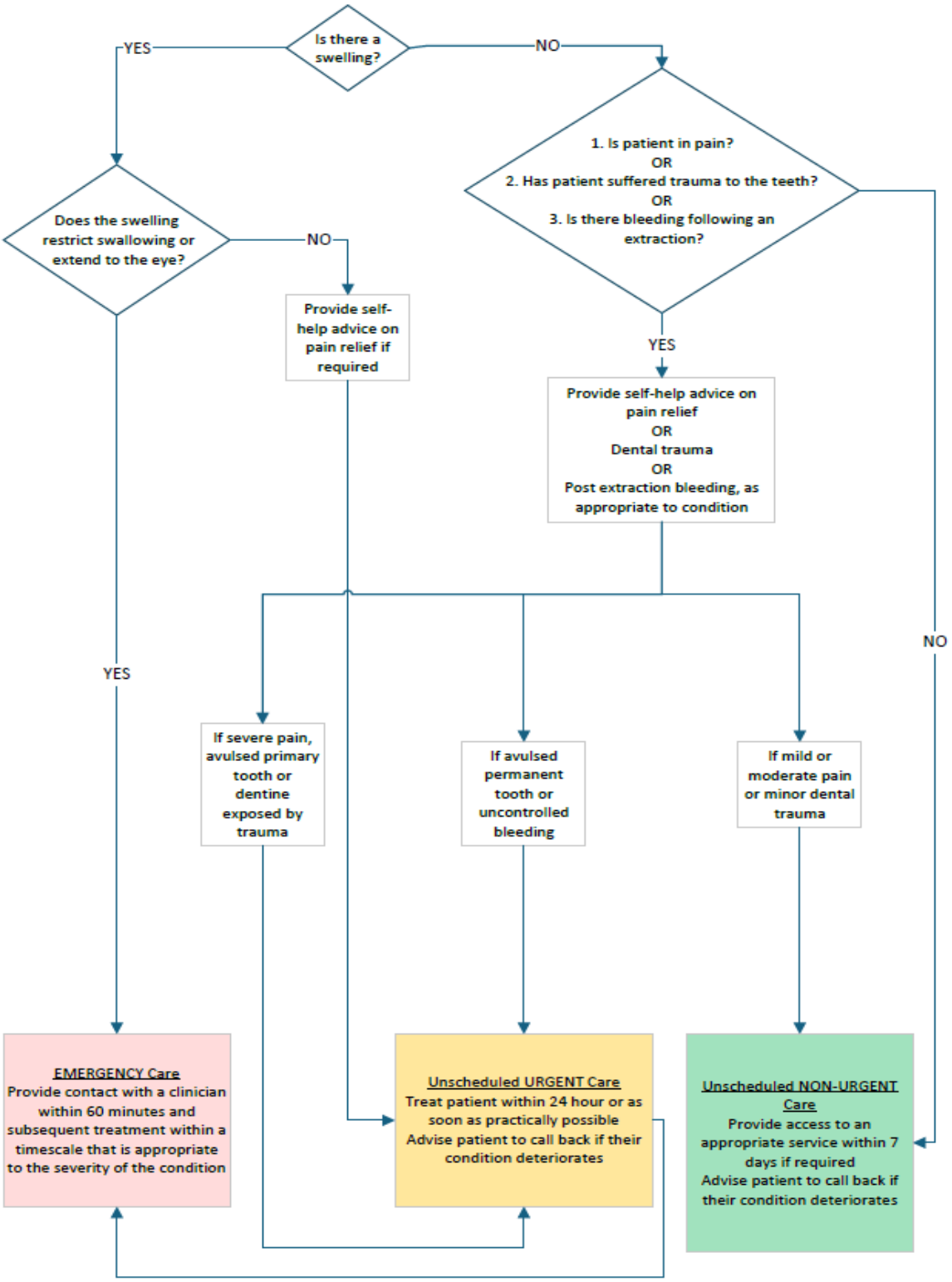


**Figure 2:** Unshceduled care flow diagram for general dental practice, adapted from; Untitled-2 (sdcep.org.uk).