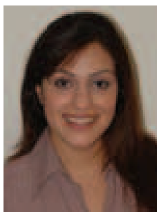

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NICE Guidelines and their Relevance to the Dental Team

Abstract: The National Institute for Health and Clinical Excellence (NICE) of the National Health Service (NHS) produces guidance for the health sector on a range of issues. Specific guidance on dental subjects has been issued in relation to third molar removal, dental recall interval and HealOzone therapy. In addition, there are examples of more generic guidance which may also be relevant to dental practice. This paper discusses the background and functions of NICE and summarizes the guidance of relevance to the dental team.

Clinical Relevance: NICE guidance provides an authoritative summary of the current state of knowledge on certain clinical issues and gives guidance for healthcare workers. The authors discuss how this guidance should impact upon clinical practice.

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The National Institute for Health and Clinical Excellence (NICE) of the National Health Service (NHS) produces guidance for the health sector on a range of subjects. Specific guidance on dentistry has been issued in relation to third molar removal, dental recall interval and HealOzone therapy. This paper discusses the background and functions of NICE, summarizes the guidance of relevance to the dental team and discusses how such guidance should relate to clinical practice.

Background and role of NICE

The National Institute for Health and Clinical Excellence (NICE) was formed on 1 April 2005 through the merger of the National Institute for Clinical Excellence (also called NICE) and the Health Development Agency.[1] The origins of NICE go back to the NHS reforms of 1997 in England, which contained a strong commitment to improving quality of care, specifically the white paper *The New NHS: Modern, Dependable.*[2] NICE was part of a number of new quality initiatives which included National Service Frameworks (NSF) and the Commission for Health Improvement (CHI). The stated role of NICE was

…to give a strong lead on clinical and cost-effectiveness, drawing up new guidelines and ensuring they reach all parts of the health service…

In other words, NICE would develop and disseminate clinical guidance, whereas the role of CHI would be to oversee the implementation of good practice. The context to these developments was ongoing concern over the quality of care within the NHS and the evidence basis for prioritization decisions. These problems were brought into sharp focus by the `Child B' case, which triggered an intense media debate in 1995 about how healthcare resources are rationed.[3] The child at the centre of this case had suffered a relapse of her leukaemia and opinion was divided between clinicians, the Health Authority, the private sector and her father over whether further treatment was in her best interests, particularly alternative treatment in the private sector. The media often projected this complex and emotive issue as a simple case of a child being refused life-saving treatment by NHS managers because of cost, a situation that still arises.

The consultation document *A First Class Service*[4] set out proposals for addressing quality issues in the NHS in more detail. More recently, the Department of Health published *Standards for Better Health* (2004, 2006)[5] which stated:

National Service Frameworks (NSFs) and National Institute for Clinical Excellence (NICE) guidance are integral to a standards-based system. They have a key role in supporting local improvements in service quality. Organisations' performance will be assessed not just on how they do on national targets but increasingly on whether they are delivering high quality standards across a range of areas, including NSFs and NICE guidance.

The present day role of NICE is to provide national guidance on a range of health issues, including both health promotion and treatment of disease. The guidance is intended not just for those working in the NHS, but includes local authorities and the private sector. The merger with the Health Development Agency means that NICE now has a role in the development

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of guidance on public health issues, in addition to the more clinical guidance with which it is commonly associated. This public health role was confirmed in the 2004 public health white paper *Choosing Health*[6] and the 2006 amendment to *Standards for Better Health*.[5] The Scottish Medicines Consortium (SMC) undertakes some of the role of NICE in Scotland, particularly in relation to the appraisal of new drugs,[7] meaning that advice for the NHS in Scotland may be different from England and Wales, for example the recent controversy over drugs for wet age-related macular degeneration. Clinical guidance in Scotland is also developed by the Scottish Intercollegiate Guidelines Network (SIGN).[8] The NHS in Northern Ireland has recently formalized links with NICE.[9]

NICE guidance is developed with assistance from a wide range of contributors, including NHS staff, healthcare professionals, patients, carers, industry and the academic world. NICE has attracted considerable criticism in the past, understandably so given that the guidance affects commissioning and clinical decisions. Particular attention has been drawn to NICE guidance on new drugs and NICE has been challenged by both patient groups[10] and the pharmaceutical industry[11] for the decisions reached and the time taken to reach them. NICE has recently responded to these concerns in its 2006/7 annual report,[1] including the development of faster processes for appraising new technologies.

Guidance	Main conclusions and recommendations of interest to general dental practice:
Service guidance on improving outcomes in head and neck cancers	Patients presenting with head and neck cancer may have complex medical and social needs alongside their cancer
	Early diagnosis allows for a good prognosis
(These guidelines were inherited by NICE from the NHS Cancer Plan)	There are marked regional variations in cancer incidence and an association with deprivation, yet head and neck cancers are largely preventable since many are caused by tobacco, alcohol and poor diet
See also NICE clinical guidelines CG27	The low incidence of oral cancer would make population screening inefficient. More research is needed on screening high risk groups and opportunistic screening
Issued Nov 2004	Arrangements for referral at each stage of the patient journey should be streamlined. There should be a designated head and neck cancer clinician at referral centres to whom patients with suspect cancer can be referred
	A wide range of support services should be provided, including restorative dentistry

Table 1. NICE Cancer Service Guidance of relevance to the dental team.

NICE guidance

NICE produces guidance in three areas of health:

Public Health – guidance on health promotion for those working in the NHS, local authorities and the wider public and voluntary sector;

Health Technologies – guidance on the use of new and existing medicines, treatments and procedures within the NHS; and

Clinical Practice – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

The guidance is published under the following headings:

Cancer service guidance

This includes a range of NHS guidance originating from the NHS Cancer Plan for England and analogous plans for Wales, subsequently inherited by NICE. The intended audience of this guidance is commissioners of services, but aspects of the guidance are relevant for health professionals, particularly where they are involved in planning and organizing services. The Department of Health has not asked NICE to develop any more cancer service guidance at present and there is no further guidance under development. Examples of guidance include children and young people with cancer, sarcoma and palliative care.

Clinical guidelines

These guidelines make recommendations on the management of people with specific diseases and conditions within the NHS in England and Wales. They are primarily intended for healthcare professionals. Examples of guidance include obesity, postnatal care and depression.

Interventional procedures

These guidelines review the safety and effeciveness of procedures used for diagnosis or treatment. This includes surgery, endoscopy and use of x-rays and lasers. This is the largest category for published guidance with over 200 sets of guidance issued. Examples of guidance include liver transplantation, cryotherapy for prostate cancer and robotically assisted coronary artery bypass grafting. There is also a patient leaflet for those undergoing interventions where the risks or benefits are uncertain.

Public health intervention guidance

This category contains guidance relating to interventions that reduce risk for disease in target groups, including advice, support and some service provision. At the time of writing, there were only five published guidelines under this heading, including smoking cessation in primary care.

Public health programme guidance

Whilst public health *intervention* guidance deals with specific targeted interventions, public health *programme* guidance addresses broader aspects of health promotion, such as health in the workplace. At the time of writing, there were no examples published but eight were under development, including maternal and child nutrition and

the optimal provision of smoking cessation services, with particular reference to priority and hard to reach groups.

Technology appraisals

These focus on new and existing medicine and treatments. Whilst interventional procedures guidance focuses on specific interventions, these guidelines take a slightly broader view of the management of specific conditions and the role of new drugs and treatments. The distinction is sometimes a fine one and there is also some overlap with health promotion. Examples include new drugs for bipolar disorder, surgery for obesity, statins for cardiovascular disease and Trastuzumab, better known as Herceptin, for breast cancer.

In addition to guidance published under these headings, NICE has published *Principles For Best Practice in Clinical Audit* (2002). This book details the methods, tools, techniques and activities at each stage of a clinical audit, drawing on a systematic review of audit literature. There are sections on: preparing for audit, selecting audit criteria, measuring levels of performance, and making and sustaining improvements in care.

Guidance of relevance to the dental team

Tables 1–5 summarize the main guidance of relevance to the dental team. The NICE website has a specific page for mouth and dental guidance and a `mouth and dental' summary compilation, dated September 2005. This directs visitors to a number of interventional procedures which are of interest more to oral and maxillofacial surgeons than primary care dental practitioners, but which may be useful when referring patients to specialized services. The guidance we have summarized is wider than this list and includes cancer and public health guidance.

Smoking cessation and cancer referral

The smoking cessation guidance (PHI1, TA39, TA123) supports the approaches set down in the new Department of Health guidance *Smokefree and Smiling,*[12] though the latter gives more detailed guidance for the dental team and includes users of smokeless tobacco in its scope. The cancer referral guidance (CG27) superseded the NHS referral guidelines issued in 2000,[13] but neither was specifically targeted at dentists, even though head and neck cancers were included.[14] Early detection of oral cancer is a priority, given the excellent prognosis of early stage disease,[15] and there are apparently ongoing problems with delays in referral, though patient delay remains the greatest factor.[16] The guidelines give good general advice, such as the importance of good communication with patients and specialists, investigating unexplained symptoms, listening to parents' concerns over their children and having a high index of suspicion. Regular oral examination for everyone is recommended and readers are directed to the NICE dental recall guidelines (CG19). The guidance in relation to oral cancer has been criticized, particularly for the exclusion of unexplained pain as a reason for referral.[14] The sections on malignant melanoma provide a useful reminder of the higher incidence of head and neck lesions and the sections on giving patients bad news raise the issue over whether dentists should be the givers of such news and, if so, whether they have access to suitable training. The paucity of fundamental knowledge on the presentation of cancer, and effective ways to reduce referral delay, is reflected in the research recommendations. The guidelines are tailored to general medical practice and more specific guidelines for the dental team, linked to guidance on how and where to refer may be the way forward. This is particularly important, as it would facilitate appropriate rapid referral within the NHS 2-week standard for those with suspect cancer. Such guidance would require local development, however, perhaps based around cancer clinical networks.

Dental recall (Clinical Guideline 19)

The context of this guidance was the Department of Health strategy document *Options for Change,*[17] which anticipated comprehensive oral health assessments under proposed new arrangements for the commissioning and remuneration of NHS dental care in England. Whilst the extent to which the comprehensive examination aspect has occurred is arguable, the guidance can stand alone in bringing to dentists' attention the factors they should consider when setting recall intervals.

The fundamental principle within the guidance is that patients should have an individualized recall interval rather than returning at intervals set by group or service considerations. In order to determine the appropriate recall interval for a patient, a comprehensive history and examination is required to identify risk factors for future disease. Considerable judgement and organization is required from the dental team to interpret this information, alongside knowledge gained at subsequent reviews, and it is vital that information from previous visits is available and reviewed. The guidance emphasizes the role of the patient in agreeing an appropriate recall interval. The guidance does *not* cover recall intervals for scaling and polishing, prescription and timing of dental radiographs, intervals between examinations relating to ongoing courses of treatment, emergency dental interventions or intervals between episodes of specialist care.

The guideline has a comprehensive checklist of factors to consider when undertaking a check-up (*oral health review* or OHR in the guidance). Both the potential health impacts of oral disease and the relative risk of developing oral disease are considered. For example, it might be appropriate to see a patient with a bleeding disorder more frequently than would otherwise be the case if, for example, they were judged purely on the basis of their risk of developing oral disease. The checklist also provides space for recording whether the dentist's clinical advice was modified by the patient's views. The recall interval should be reviewed again at the next OHR, to learn from patients' responses to the oral care provided and the health outcome achieved. For this reason, the recall interval for an individual patient may vary over time and the guidance recommends that patients are informed of the reasons for this, since this may differ from their experience to date.

In developing these guidelines, NICE has recognized the lack of a research basis for many aspects of dental recall. It is disconcerting that we still do not know much about progression rates and risk for basic oral disease processes. The guidance also recommends research into dental attendance patterns to assess the impact of these guidelines.

Despite some controversy over these guidelines being highly prescriptive,

Guidance	Main conclusions and recommendations of interest to general dental practice:
CG19 Dental Recall Issued Oct 2004	The recommended interval between oral health reviews should be determined specifically for each patient and tailored to meet their needs on the basis of an assessment of disease levels and risk of or from dental disease The recommended shortest and longest intervals between oral health reviews are as follows: • The shortest interval between oral health reviews of all patients should be 3 months • The longest interval between oral health reviews for patients younger than 18 years should be 12 months • The longest interval between oral health reviews for patients aged 18 years and older should be 24 months • 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, or 3, 6, 9, 12, 15, 18, 21 or 24 months if he or she is aged 18 years or older The recall interval should be reviewed again at the next oral health review, in order to learn from the patient's responses to the oral care provided and the health outcomes achieved
CG27 Referral for suspected cancer Issued June 2005	Dentists should monitor all patients for oral cancer as part of routine dental examination and advise all patients, including those with dentures, to have regular dental checkups Refer urgently patients with: • an unexplained lump in the neck, of recent onset, or a previously undiagnosed lump that has changed over a period of 3 to 6 weeks • an unexplained persistent swelling in the parotid or submandibular gland • an unexplained persistent sore or painful throat • unilateral unexplained pain in the head and neck area for more than 4 weeks, associated with otalgia (ear ache) but a normal otoscopy • unexplained ulceration of the oral mucosa or mass persisting for more than 3 weeks • unexplained red and white patches (including suspected lichen planus) of the oral mucosa that are painful or swollen or bleeding For patients with persistent symptoms or signs related to the oral cavity in whom a definitive diagnosis of a benign lesion cannot be made, refer or follow up until the symptoms and signs disappear. If the symptoms and signs have not disappeared after 6 weeks, make an urgent referral. Refer non-urgently a patient with unexplained red and white patches of the oral mucosa that are not painful, swollen or bleeding (including suspected lichen planus)
CG2 Infection Issued June 2003 **CG4 Head Injury** Issued June 2003 Partial update Sept 2007	This guideline focuses on using a 'standard approach' for preventing infections, this includes hand hygiene protocol, use of personal protective equipment (gloves and aprons, etc) and use and disposal of needles and sharp instruments Dental practitioners should refer patients who have sustained a head injury to a hospital A&E department, using an ambulance service if deemed necessary, where the following is present: Glasgow Coma Scale < 15 at any time since injury; loss of consciousness; suspicion of skull fracture or penetrating head injury; amnesia; persistent headache since injury; any seizures since injury; history of bleeding or clotting disorder or on current anticoagulant therapy; age greater or equal to 65 years; suspicion of non-accidental injury
Clinical guidelines under development: Prophylaxis for infective endocarditis, Suspected child abuse	

Table 2. NICE Clinical Guidelines of relevance to the dental team.

coming as they did at a time of great change and anxiety for dentists over new contractual arrangements, in reality they are educational and not authoritarian. Dentists may, however, be required to demonstrate some evidence for the basis of their decisions over recall for individual patients and to record the reasoning in the notes. This is a highly complex issue, not least because patients may well change their risk behaviour, sometimes unconsciously, between recalls.

Wisdom tooth removal (TA1)

As the number suggests, this was

Guidance	Main conclusions and recommendations of interest to general dental practice:
IPG28 Exposed customised titanium implants for orofacial reconstruction Issued December 2003	As its title implies, this guidance covers customised implants for facial reconstruction. The evidence base is too small to allow efficacy to be proven. Use should be confined to formal research programmes
IPG42 Cyanoacrylate instillation for occlusion of parotid sinuses Issued February 2004	This is an unusual procedure which aims to seal abnormal tracts between the parotid salivary gland and the outer surface of the cheek. There is a lack of adequate research data to support the use of this procedure which may only have been performed once
IPG149 Division of ankyloglossa (tongue tie) for breastfeeding Issued December 2005	There are no major safety concerns about this procedure and some limited evidence that it can improve breastfeeding
IPG124 Radio-frequency ablation of the soft palate for snoring Issued May 2005	Whilst there are no major safety concerns with this procedure, there is limited evidence on short-term efficacy and long-term outcomes are uncertain
IPG85 Stereotactic radiosurgery for trigeminal neuralgia using the gamma knife Issued August 2004	The current evidence on safety and efficiency appears adequate to support use
IPG218 Therapeutic sialendoscopy Issued May 2007	The current evidence on safety and efficiency appears adequate to support use for management of salivary duct obstruction
IPG196 Patient safety and reduction of risk of transmission of Creutzfeldt-Jacob disease (CJD) via interventional procedures Issued November 2006	General dentistry was specifically excluded from this guidance as it was being considered by the Department of Health and the Health Protection Agency. Maxillofacial surgery was considered under medium- or low-risk procedures Effective methods of removing CJD infectivity from instruments are likely to be available in 5 years For medium- and low-risk procedures, there is no evidence to support a move to single-use instruments

Table 3. NICE Interventional Procedures Guidance of relevance to the dental team.

the first NICE guideline produced. Wisdom tooth removal is one of the most common surgical procedures performed in the UK and it has been suggested that a significant proportion of interventions in the past may have been inappropriate and that this continues to be the case despite publication of Royal College guidance. The NICE guidance recognizes the lack of reliable research

Guidance	Main conclusions and recommendations of interest to general dental practice:
PHI1 Brief interventions and referral for smoking cessation in primary care and other settings Issued March 2006	Brief interventions include opportunistic advice to stop smoking, an assessment of a patient's commitment to stop and an offer of support Everyone who smokes should be advised to quit People who smoke should be asked how interested they are in quitting Dentists should refer people who smoke to an intensive support service. If the individual is unwilling or unable to accept this referral, practitioners with suitable training should offer a prescription of pharmacotherapy in line with NICE technology appraisal guidance 39 and additional support Where possible, the smoking status of those who are not ready to stop should be recorded in clinical records and reviewed with the individual once a year

Table 4. NICE Public Health Intervention and Programme Guidance of relevance to the dental team.

evidence and strikes a balance between the risk of future problems versus the potential morbidity associated with wisdom tooth removal. However, the greater difficulties presented by older patients requiring wisdom tooth removal means that a degree of controversy will continue on the relative merits of prophylactic removal versus watch and wait as a population strategy.

Guidance under development – antimicrobial prophylaxis

In February 2006, the British Society for Antimicrobial Chemotherapy (BSAC) released new guidelines on antimicrobial prophylaxis for infective endocarditis,[18] which were different from those in the contemporary British National Formulary. Therefore, the Department of Health has asked NICE to review this, the anticipated date of publication being March 2008.

The impact of guidance on clinical practice

Knowledge of NICE guidance does not replace general clinical knowledge and judgement. However, well-developed clinical guidelines can assist with clinical decision-making, especially in emerging or contentious areas of practice, and be helpful from the medico-legal perspective.[19,20] The absence of high quality research makes developing and using such guidance problematic and the advice they contain often has to be balanced against other information available to the clinician. Even where high quality research evidence is available, the effects seen in clinical trials might not translate into clinical practice. There will also be individual patients for whom evidence-based guidelines are not appropriate, whilst applicable to population groups.

NICE is not the only source of clinical guidance for dentists. The guidance produced by the Faculty of General Dental Practitioners[21-25] are obvious examples, but there is also guidance produced by specialist societies, most notably the policy statements and clinical guidelines produced by the British Society of Paediatric Dentistry.[26] NICE arrangements, however, ideally provide a robust and reliable process through which guidance can be developed and disseminated.

The impact of clinical guidance on practice can also be problematic from a policy perspective; the production and dissemination of guidance does not automatically result in changes in clinical practice, even where the evidence is widely known within professional circles.[27] In addition, there may be wider system barriers that limit the impact of guidelines.[28,29] Therefore, it could be argued that clinical guidelines are only as good as the arrangements to ensure that they are used to inform practice and that the benefits for patients are realized. This is now the responsibility of the Healthcare Commission.[30] Determining whether guidance has produced changes in practice is a complex matter; for example, it can be argued that the guidance on wisdom teeth simply embodied what was already accepted behaviour[28,31] and that subsequent practice was also affected by changes to the regulations surrounding provision of general anaesthesia.[32]

Summary

The National Institute for Health and Clinical Excellence (NICE) of the National Health Service (NHS) produces guidance for the health sector on a range of issues. Specific guidance on dental subjects has been issued in relation to third molar removal, dental recall interval and HealOzone therapy. In addition, there are examples of more generic guidance which may also be relevant to dental practice. The rigour of the development process means that NICE is an authoritative source of guidance, though on a more limited number of subjects than covered by other published guidance that reflects professional bodies' views about best practice. The use of guidance to inform the management of individual patients is a complex issue and dental team members will need to bear in mind the other factors that should be considered when making clinical decisions.

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Guidance	Main conclusions and recommendations of interest to general dental practice:
TA1 Wisdom teeth removal Issued April 2000	Impacted wisdom teeth that are free from disease (healthy) should not be operated on. There are two reasons for this: there is no reliable research to suggest that this practice benefits patients and patients who have healthy wisdom teeth removed are being exposed to the risks of surgery Patients who have impacted wisdom teeth that are not causing problems should visit their dentists for their usual check-ups Only patients who have diseased wisdom teeth, or other problems with their mouth, should have their wisdom teeth removed. Examples include untreatable tooth decay, abscesses, cysts or tumours, disease of the tissues around the tooth or where removal of the tooth facilitates a wider treatment plan
TA92 Tooth decay – HealOzone Issued July 2005	HealOzone is not recommended as a treatment of tooth decay. The reason for this was that there was not enough reliable evidence that HealOzone is more effective than existing treatments for decay of the occlusal surfaces and roots of the teeth HealOzone is not recommended for use unless as part of a clinical trial
TA39 Smoking Cessation – bupropion and nicotine replacement therapy Issued March 2002	Nicotine replacement therapy (NRT) and bupropion are recommended for smokers who have expressed a desire to quit smoking. They are normally only prescribed where the smoker makes a commitment to stop smoking on or before a particular date (target stop date) Second prescriptions should be given only to people who have demonstrated that their attempt to quit smoking is continuing on reassessment Bupropion is not recommended to smokers under the age of 18 years, as its safety and efficacy have not been evaluated for this group. Women who are pregnant or breastfeeding should not use bupropion If a smoker's attempt to quit is unsuccessful with treatment using either NRT or bupropion, the NHS should normally fund no further attempts within 6 months. However, if external factors interfere with an individual's initial attempt to stop smoking, it may be reasonable to try again sooner There is currently insufficient evidence to recommend the use of NRT and bupropion in combination
TA123 Smoking Cessation – Varenicline	Varenicline is recommended as a possible treatment to help smokers who have said they want to stop smoking. It should normally be used only as part of a programme that includes advice from a healthcare professional or other types of support
Technology Appraisals under development: Sleep apnoea – continuous positive airway pressure (CPAP), Head and neck cancer – cetuximab	

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