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Domiciliary Oral Healthcare

Abstract: There is increasing demand for Domiciliary Oral Healthcare (DOHC) and the skills and equipment required to provide a quality, patient-centred service with careful assessment and management in a sometimes compromised situation. Commissioning of DOHC needs to be set in the context and current agenda of equality, diversity and human rights in both health and social care. Effective marketing and community engagement are required to promote awareness of how to access services amongst people confined to home and their families and carers.

Training for the whole dental team should be available in order to address the concerns and problems encountered regarding the provision of DOHC.

Clinical Relevance: Members of the dental team should be aware of the skills required for DOHC and be familiar with using effective care pathways in relation to the provision of DOHC.

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It is over ten years since the last article in this journal on the subject of domiciliary care.[1] During that time the British Society for Disability and Oral Health's *Guidelines for the Delivery of a Domiciliary Oral Healthcare Service*[2] have been revised and offer the following:

- They alert Primary Care Trusts (PCTs) and Local Health Boards and Boroughs (LHBs) and service providers to the need for making available Domiciliary Oral Healthcare Services (DOHCS);
- They provide guidance to establish standards for the delivery of high quality DOHCS; and
- They offer guidance for the commissioning of appropriate DOHCS.

Definition

Domiciliary oral healthcare (DOHC) has been described as a service that reaches out to care for those who cannot reach a service themselves.[1] It encompasses oral healthcare and dental treatment carried out in an environment where a patient is resident either permanently or temporarily, as opposed to that care which is delivered in dental clinics or mobile units. These environments will normally include residential units and care homes, hospitals, day centres and patients' own homes. Whilst domiciliary care includes preventive oral healthcare, it excludes dental screening procedures.

Although the majority of people who require DOHCS are older adults, the service may also be required by people of a younger age, and should not be considered as the last resort. It should be offered amongst the routine options for dental care for people who are mostly confined to home or for whom leaving or travelling from home can cause unwarranted upheaval and distress.

Aim

The aim of DOHC is to deliver appropriate oral healthcare in accordance with the requirements of the *Disability Discrimination Act* (DDA) (1995),[3] the *Mental Capacity Act* (2005),[4] the General Dental Council (GDC) Standards[5] and the NHS Constitution[6] to patients whose circumstances make it impossible, unreasonable, or otherwise impracticable for them to receive that care in a fixed clinic, a hospital site or from a mobile dental clinic.[7]

Objectives

The objectives of a DOHCS are primarily to:

- Establish a system which will identify individuals in the community who have an oral healthcare need and for whom domiciliary provision is the only reasonable option.
- Provide an oral healthcare service to address patients' needs, taking into account their personal circumstances and their wishes, consistent with the most appropriate use of resources.
- Deliver high quality oral healthcare in a person-centred way that respects the dignity of the individual receiving it.

The GDC recommends that dental treatment provided on a domiciliary basis should be appropriate within that setting, taking into account the nature of the problem, the facilities available and the welfare of the patient.[5] Surgery-based care remains the best option for irreversible procedures but, where this is not reasonable or possible, patients should not be unduly disadvantaged by having to receive domiciliary oral healthcare.

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	Number of Domiciliary Visit Claims				
Age in years	**Band 1 treatments**	**Band 2 treatments**	**Band 3 treatments**	**Other treatments**	**Total**
0–17	978	144	18	67	1,207
18–24	567	50	12	44	673
25–34	739	128	26	73	966
35–44	1,403	266	80	145	1,894
45–54	1,903	507	222	245	2,877
55–64	3,217	1,008	649	492	5,366
65–74	6,699	2,087	1,856	1,029	11,671
75+	43,735	11,476	13,458	5,877	74,546
Totals	**59,241**	**15,666**	**16,321**	**7,972**	**99,200**

Table 1. Number of domiciliary visit claims England and Wales April 2008 to March 2009.[10]
Data source: NHSBSA DSD report.

Ideally, they should have equitable oral health outcomes in terms of self esteem, appearance, social interaction, function and comfort. However, this requires careful assessment and treatment planning which takes account of all associated factors, including the skills required to manage delivery of care in a sometimes compromised situation[8]. In a recent report from Scotland, *The Scottish Dental Needs Assessment Programme (SDNAP) Domiciliary Dental Care Needs Assessment Report*, it was recommended that all new residents in care homes should have an examination by a dentist within three months of admission and once every two years thereafter.[9]

Need

The need for DOHC is great (Table 1), with over 99,000 claims in total for courses of treatment in England and Wales on a domiciliary basis in the year April 2008 to March 2009.[10] There were over 86,000 claims for patients over the age of 65 years and in excess of 74,000 for over 75-year-olds. The majority of these (43,735) were for Band 1 treatments which include an examination, hygiene and prevention and advice. A significant number of people over the age of 75 (11,476) had Band 2 treatment, which includes restorations and extractions and slightly more people (13,458) had Band 3 treatment, which includes dentures and possibly crowns. These are more indicative of demand than need and it is probable that the need will be higher than the domiciliary care provided.

In Scotland, 6,653 courses of treatment were completed on a domiciliary basis during 2007–2008 by the GDS and just over 6,000 by the CDS, totalling approximately 12,653.[11]

Whilst the majority of disabled people live at home and are functionally independent, others are dependent on regular support but still live independently or with their families. A relatively small proportion, nevertheless a significant number, of older people live in care homes, accounting for 5% of all older people. However, this proportion increases with age from 20% of people aged 85 years and over to 84% of those aged 95 and over.[12] These people are amongst those with more complex disabilities and are likely to require specialist skills and management to have their oral healthcare needs met.[13]

Functionally dependent older people have higher rates of tooth loss, greater prevalence of denture related problems, greater prevalence and severity of caries, higher prevalence of periodontal disease and are less likely to have seen a dentist in the last 5 years.[14] The need to meet their oral healthcare is well recognized and the Department of Health has recently described people with disability at the highest level of need and dependency as being at the apex of the pyramid of need.[15]

Demand for DOHC is increasing as a result of a growing population of older people who are more likely to become functionally dependent and who are increasingly dentate, as well as through legislative pressure. The increase in the number of people requiring DOHC services is partly attributable to advances in medical science, enabling people to survive more illness and disability. Although longevity is increasing, physical or mental disability and other chronic diseases often reduce mobility and the ability for self-care, making it difficult for many disabled or older people to access mainstream dental services for treatment.

People who have mental illness or dementia frequently become disorientated and confused when in an unfamiliar environment (such as the dental surgery) and, even when ambulant, benefit from dental care in a familiar environment, such as their place of residence.

Access

The Strategic Review, commissioned by the DOH in 2005 recommends '*Oral healthcare should be available to all people regardless of their age or circumstances*'. For some people, this is only achievable with DOHCS.[13] It also concluded that PCTs should commission comprehensive and appropriate oral healthcare services for older people that include domiciliary services and specialist care, as identified by their needs assessment (see section on commissioning for further information). This should include provision within the NHS dental contract to allow for dentists to provide continuity of care for their older patients as their circumstances change, for example if they are no longer able to access the surgery and require domiciliary care.

Liaison with health and social service professionals, carers and the voluntary sector to develop appropriate local referral pathways will enable clients who require a domiciliary service to access care. In this way, oral healthcare and/or dental treatment become part of any package of healthcare measures for older people who are confined to home,[13] with

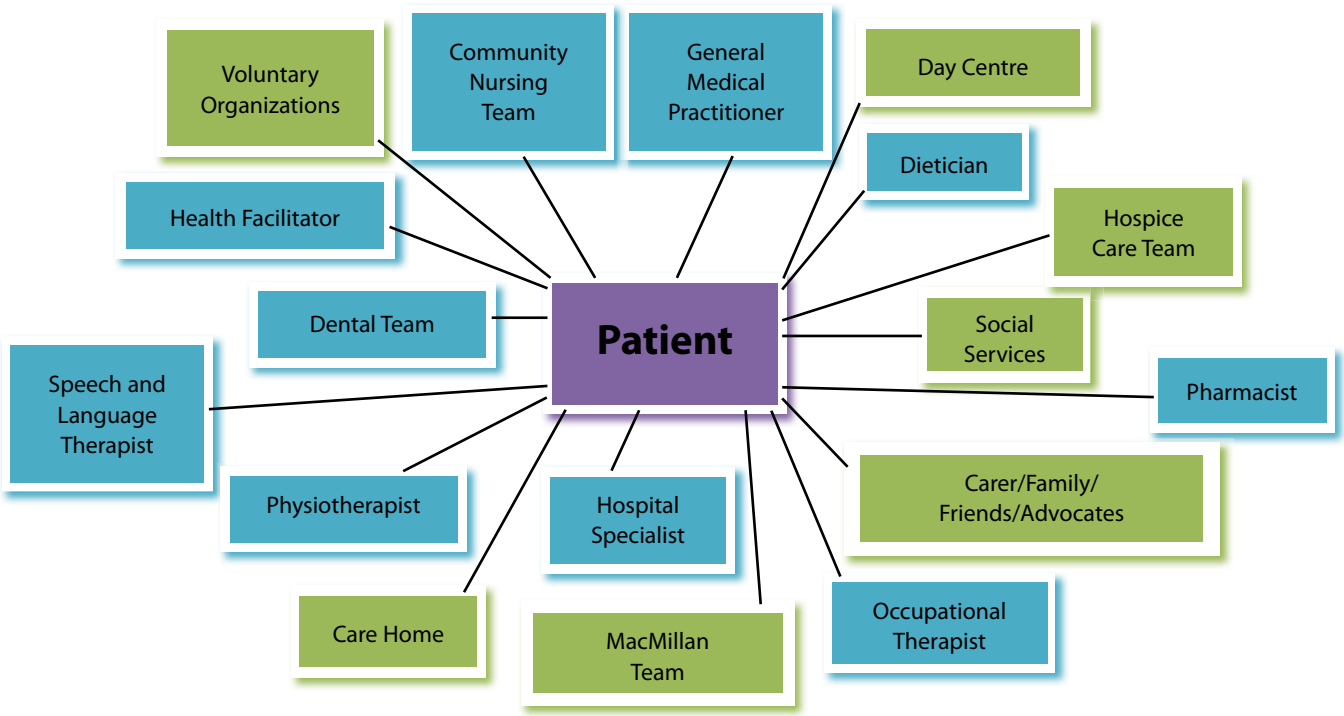

Figure 1. Members of the multidisciplinary care team.

patients able to be referred by any member of their multi-disciplinary care team (Figure 1).

Oral health services should be organized and developed to provide continuous adequate care and not be provided just in response to demand.[16] The BDA report *20–20 Vision*[17] predicted that domiciliary services will be essential to provide professional advice and treatment to residents of nursing and care homes, as well as to the increasing numbers of frail people living at home or in sheltered housing. It went on to suggest that each dental practice could be contracted by its local health commissioning body to provide domiciliary care to a small number of local care homes. This would share public responsibility and result in virtually all care homes having a relationship with a nearby dental practice.

Disability Discrimination Act 2005

Increasing awareness about equal opportunities for people with disabilities has led to legislation. The Disability Discrimination Act (DDA) in the UK[3] has implications for dentists and the provision of DOHC as it makes the removal of barriers to disabled people in society a legal requirement. It expects service providers to be fair and flexible in taking action to remove any barriers that exclude disabled people. The Act requires the practitioner to provide a reasonable alternative means of access to dental treatment if a person is unable to access a service because of disability, for example, through the provision of domiciliary care. Where it is possible, making improvements to physical access to dental practices may reduce the need for domiciliary visits, long journeys to specialized facilities or the long wait for specialized services to provide DOHC. However, it will not always be possible to make these adjustments and practices will be required to make alternative arrangements for some of their disabled patients through the provision of DOHCS.

The Disability Equality Duty 2006

The *Disability Equality Duty* (DED) is part of the Disability Discrimination Act 2005[18] that was introduced in December 2006. It requires that any public body (including dental service providers) should look actively at ways of ensuring that disabled people are treated equally. It suggests tackling disability discrimination in a practical way by introducing policies that actively promote opportunities and so prevent discrimination occurring in the first place. This duty is about inclusiveness; developing and putting into place disability equality plans; and embedding equality for disabled people through the promotion of equal opportunities, elimination of discrimination, and encouragement of positive attitudes. The easiest way to achieve this is to include disability equality in all aspects of practice life, by making it integral to practice design, policies and staff induction and training, rather than focusing on individualized responses to specific disabled people.[19] This helps mitigate civil claims or claims to the Equality and Human Rights Commission (replacing the Disability Rights Commission from October 2007), which might otherwise be levied against a practice by a disabled person who considers (s)he has been discriminated against[19]

Current provision

Access to, and availability of, DOHCS for disabled older people is relatively low. Fewer than 40% of dentists in

general dental practice provide home visits and this figure is falling.[20] Some of these dentists restrict their domiciliary practice to prosthodontics, and a proportion of these restrict it further to complete dentures only. A UK study of availability of domiciliary dentistry indicated that only 21% of dentists who were willing to do domiciliary work would undertake restorative dentistry.[20] The salaried primary care dental service (SPCDS) acts as a safety-net for people who are unable to obtain care within the general dental services. Even so, a recent study in Scotland of over 2000 dentists (both General Dental Practitioners and Community Dental Officers)[21] showed that 24% of community dentists and 34% of GDPs were non-providers of domiciliary care, with 19% of them stating that they would never consider doing so. An Irish study showed only 4% of GDPs provided domiciliary care on a routine basis, on an emergency basis, 36% provided domiciliary care to older people in residential care, 19% in day care centres and 30% in patients' own homes. The Health Service Executive salaried dental service is the main provider of Domiciliary Dental Care in Ireland and less than half provide domiciliary dental care to older people on a routine basis. Nearly all did so on an emergency basis.[22]

The range of DOHC provided varies as a result of several factors, including the personal views and attitude of dentists,[21,22,23] as well as the availability of appropriate domiciliary equipment and difficulties transporting it. Domiciliary oral healthcare can be demanding, both physically and mentally. Interestingly, a relationship between a dentist's age and the tendency to provide DOHCS has been found, with older dentists being less willing to provide DOHCS.[24,25]

The published literature cites other deterrents to the provision of DOHC as:

- Feeling inadequately prepared or up-to-date in this area;[26]
- A perception that patients would be too difficult to manage;[23]
- Poor financial remuneration;[21]
- Lack of time;[21,22,23,25]
- Inability to provide a high standard of work;[27]
- Concerns about adequate infection control;[21] and
- Concerns about access to emergency drugs.[21]

Apart from financial remuneration, these concerns can be addressed through training, preparation and robust patient triage. Financial remuneration can be addressed through appropriate commissioning. These issues will be addressed in the course of this paper.

A recent critical appraisal carried out by **www.dentistryresearch.org** identified that primary research is needed to look at the subject of access to dental care of frail elderly people in the UK. They concluded that similar barriers to accessing care for this group of people are still being reported today as those reported 20 years ago.

Training needs

As more people retain their natural teeth into old age, this presents challenges to the dental profession in providing care to medically compromised, multiply disabled and older people who may require a wide range of interventions in a heavily restored dentition, at a time in their lives when they are less able to cope with treatment. Additionally, as dentate older people become disabled, they are more likely to use dental services more regularly than edentate older people. Therefore, the demand will increase for DOHC, as will the requirement for the skills and equipment to provide a more comprehensive service than solely the provision of dentures in a domiciliary environment. With the advent of completely portable dental equipment, all dental procedures, except for radiography, can be accomplished in a patient's home or care home.

Whilst the deterrents to providing domiciliary care are very real, they are not insurmountable. Most dentists are capable of providing DOHC, although some people will find it easier than others to work outside the traditional surgery/practice environment. These issues can be addressed through training. There is a necessity for improved training programmes both pre- and post-qualification[28] for all members of the dental team. If experience of DOHC is gained early on in an individual's career, such as during vocational or general professional training, it is likely to lead to an increase in confidence and willingness to provide such care. One of the best ways of developing the knowledge and skills required is to observe an already established DOHC team at work. The host team may have a range of domiciliary equipment which can be tried out. Alternatively, manufacturing companies may be prepared to allow 'road testing' of their portable units.

Criteria for DOHC

Illness, confinement to bed, incontinence, mental confusion or agoraphobia may make journeys to the dental surgery difficult or impossible. Therefore, although it may be more cost-effective and straightforward to provide a surgery-based service, it is preferable to provide treatment at home for some client groups. In a study by Lester *et al*, the majority of older people said they would prefer to receive dental treatment at home.[29] Preference alone is not reason enough for the provision of DOHC and, although assessing a client's need for DOHC can be difficult, it is necessary in order to target services on the basis of genuine need rather than personal choice dictated by convenience.

Where possible, patients should be treated in a surgery, with a 'mix and match' approach being adopted for some patients. This is when more complex treatments are carried out in the surgery and other procedures for the same patient are provided at home. For example, extraction of teeth for someone on Warfarin being undertaken in the surgery, followed by denture construction on a domiciliary basis.

A robust triage system using appropriate questioning assists identification of those patients who need a domiciliary visit. It may turn out that appropriate transport is all that is required, in which case this can be arranged through the patient's GP or, alternatively, some Salaried Services arrange their own transport. Questions indicating how often a person goes out and how they do so include:[30]

- Do you attend your doctor, and how do you get there?
- If you have a hospital appointment how

do you get to the hospital?
- When was the last time you were able to go out of the house, and where did you go?
- Do you have someone who can bring you to the surgery?
- Do you attend a day hospital, and how do you get there?
- Do you attend a day centre, and how do you get there?
- Do you attend your hairdresser, and how do you get there?

Depending on the dental premises concerned, it may also be prudent to ask how far an individual can walk without requiring a rest, and/or is the individual able to manage steps/stairs.

People referring to a DOHC service should be periodically reminded of the acceptance criteria.[7]

Requirements of the dental team

For those who enjoy variety, DOHC can provide a pleasant change and some private general dental practitioners provide solely domiciliary care, indicating that it is possible to provide such a service when there is provision for adequate remuneration. However, DOHC does require the dental team to transfer their professional standards and skills to a non-clinical environment. The clinician (dentist, dental therapist or hygienist) must be chaperoned at every visit by another member of the team in the interests of personal and patient safety.

Key skills

Many skills are required in order to deliver a professional DOHCS, with *teamwork* and *flexibility* being essential. The acronym 'CAMPING' can be used as an aide memoire for the other key skills required to deliver an effective DOHC service (Table 2).

It has been suggested that a great deal of the procedure and process of domiciliary visiting is similar to camping. Time is spent preparing and packing the equipment and kit required. This is then taken to the visit and time is spent unpacking and setting up for the necessary treatment. Afterwards, everything needs to be dismantled, ready to pack away again. The dentist can become a central figure in the social network of a person confined to home, and the established rapport can lead to the individual feeling supported by the healthcare provider. In turn, this can have a positive impact on the immediate and long-term well-being of the patient.[31]

Domiciliary equipment

The equipment and materials required depend on the number and type of visits planned and the resources available to purchase them. The principle to remember in assembling a domiciliary kit is to keep it simple. The basic kit should include:
- An examination kit;
- A prosthetic kit, including a portable handpiece, right-angled handpiece (Figure 2) and burs; and
- A small box of hand instruments, an adhesive filling material and a means of drying the teeth.
- It is also prudent to carry local anaesthetic equipment and a selection of extraction forceps and light source;
- Dental mirrors with a light attached to the mirror head offer a simple and effective source of light (Figures 2 and 3), or a headlight offers a handsfree alternative.

A convenient method of housing the equipment is a baby-care box or compartmentalized trolley-bag. This kit can be made up and restocked after each visit so it is ready for anyone in the practice to pick up and use. Domiciliary dental units vary in performance as well as weight. One unit can be transported in its own backpack or in a case on wheels.

Several portable scalers are available. A portable suction system is also

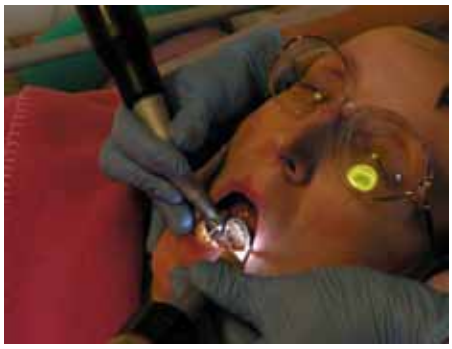

Figure 2. Portable rechargeable handpiece with straight and contra-angled attachments and light mirror.

Figure 3. Headlight supported on frame and light mirror.

Acronym: CAMPING	Components of CAMPING
C	Communication
A	Assertiveness and Anticipation
M	Manual handling
P	Planning, including time management
I	Improvization
N	Networking and liaison with family, carers and other members of the multidisciplinary team (Figure 1)
G	Gerodontology – knowledge of and experience in the field, including a knowledge of medical conditions, associated problems and management of medical emergencies

Table 2. Key skills of domiciliary oral healthcare.

Acronym: CAMPING	Telephone Tick List
C	Check full address and helpful directions
A	Appointment – to be sent in writing if possible
M	Medical history and consent – may need to liaise with relevant people
P	Parking facilities
I	Information about who will be present at the visit – carer, relative, neighbour
N	Name of dentist visiting – provided for security
G	Gain access to any special instructions or requirements, eg need to collect key from neighbour, dog barks but doesn't bite, etc

Table 3. Telephone checklist – preparation for a domiciliary visit.

an essential item of equipment.

For further details on domiciliary equipment, examples of content of kits, manufacturer's details and prices, see **www.bsdh.org.uk** *Guidelines for the Delivery of a Domiciliary Oral Healthcare Service.*[2]

Preparation for the initial visit

Careful preparation prior to the initial visit helps ensure that all the necessary information is available. Time invested in planning this visit will be paid back through its contribution to the success of the visit. It is less easy to plan for emergency visits. However, it is prudent to telephone ahead to clarify the dental demand and the need for a visit. For elective visits, and where possible for emergency visits, the *Telephone Checklist* set out in Table 3 is helpful. It uses the acronym 'CAMPING' once again, as an aide memoire.

Risk assessment

It is important that all work environments are risk assessed. The domiciliary environment is no exception to this rule. However, as it is to a large extent outside the control of the dental team and is liable to change between visits, it should become routine to assess for risk the domiciliary setting at the start of every visit.[7] Table 4 sets out the main factors for consideration.

Taking a commonsense approach to the delivery of care and employing safe practice are essential tactics. Examples of safe practice include:

- Using a warm air heater and avoiding the use of naked flames;
- Transporting equipment and materials on a trolley when possible;
- Staff trained in moving and lifting for occasions when use of a trolley is not possible;
- Having the facilities available to deal with medical emergencies, such as portable suction apparatus, oral airways, attachments to provide intermittent positive pressure, a source of portable oxygen and emergency drugs;
- Staff trained to respond to medical emergencies, in the use of emergency drugs and conversant with current guidelines issued by the Resuscitation Council (UK).[33]
- Other health and safety issues that necessitate consideration include ergonomics, manual handling and infection control and prevention.

Ergonomics

Dentists doing more than the occasional domiciliary visit need to give careful consideration to their working posture. Whenever possible, patients should be seated in a straight-backed chair and the dentist should be positioned behind or to one side of the chair. Some chairs will recline and/or have height adjustment and it may be possible to get behind these. Also, specialized beds for people with a physical disability are fully adjustable and allow easier access to the patient than does a standard hospital bed. If taking lower impressions, or the patient is in a low chair or bed and cannot be moved, the dentist/hygienist should kneel in front or to one side, which will put them at a height where good posture and comfort can be maintained. A knee cushion pad, as used for gardening, is useful in this situation.

Manual handling

All members of the domiciliary dental team should be trained in the methods of moving and lifting patients. If working in a care home, staff can be asked to move the patient. Patients at home can often tell you how they are usually moved, ie whether it takes more than one person, if they use a hoist, etc. A judgement needs to be taken as to whether the dental team would be able to do this safely and, if not, from either the patient or the team member's perspective, the patient should not be moved.

Infection control and prevention

The same principles apply to infection control in the domiciliary setting as those that are applied in the surgery, including:

- Identify the most appropriate working area – ensuring a clear pathway from this area to the sink;
- Use the principle of zoning for identification of clean and working areas;
- Cover work surfaces with clinical sheets, or similar, and confine clinical work to the covered area, disposing of covers at the end of treatment;
- Most surfaces may be wiped with disinfectant wipes;
- Hands can be cleaned with alcohol gel;
- Clinical waste needs to be placed in yellow bags – make use of yellow bags in hospitals and care homes;
- Other non-clinical waste can be placed in the patient's waste bin;
- Dirty instruments should be transported in sealed, rigid, plastic containers;
- Sharps should be disposed of in puncture resistant sharps boxes – make use of those in hospitals or care homes, and they will also be available in some individuals' homes;
- Alternatively, sharps can be left assembled, stored safely in a sealed, rigid,

Risk Assessment Criteria	Examples for Consideration
Privacy	In care homes/day centres request use of private room if not provided
Confidentiality	Ensure patient is happy for discussions to take place in front of carer, relative, neighbour
Can the patient understand and communicate at an acceptable level?	Assess capacity using the Mental Capacity Act (2005) process[32]
Does the medical history indicate any infectious risk or other potential health problems?	For example: ■ Angina – ensure medication is to hand ■ Diabetes – ensure food and medication is taken as normal
Is the physical environment safe for the procedures intended?	Consider cleanliness, state of electrical wiring, etc
Access to water and electricity	Consider proximity of these facilities to work area – consider using the medical room in a care home or the kitchen in a private home
Are there any special risks arising from the treatment planned?	Patient taking Warfarin requires extraction(s) – check pre-op INR, give post-op and emergency instructions, ensure mechanism to check on patient
Is there an appropriate level of social support and after care if treatment is to be provided at home?	Liaise with necessary people and/or services

Table 4. Risk assessment criteria.

plastic container and returned to the surgery for disposal.

It may seem like there is much to consider for the provision of domiciliary care. Actually, there is no more, or very little more, than that for the provision of dental treatment in the dental surgery. The difference is that for most dental team members the latter is routine and done automatically, whereas the former requires careful thought at every visit until it becomes routine. As part of this routine the team will become familiar with using effective oral care pathways in order to target DOHC properly (Figure 4).

Commissioning

Domiciliary services are necessary to provide professional advice and treatment to residents of nursing and care homes, as well as to the increasing numbers of frail people living at home or in sheltered housing.[17] In order to meet the dental needs of these groups, Primary Care Trusts (PCTs) and Local Health Boards and Boroughs (LHBs) will have to commission comprehensive and appropriate oral healthcare services that include domiciliary services and specialist care, as identified by their local needs assessment.[2] Consideration also needs to be given to the financial remuneration to provide treatment for people with disabilities and additional needs, who are likely to require additional skill and time to treat.[1]

Commissioning of services needs to be set in the context and current agenda of equality, diversity and human rights in both health and social care. It is helpful that *Our Vision for Primary and Community Care*[34] brings together the main conclusions of *The Next Stage Review* for community-based NHS services, including primary dental care. It sets out an agenda based on four key areas:

1. Shaping services around people's needs and views;
2. Promoting healthy lives and tackling health inequalities;
3. Continuing improving quality; and
4. Ensuring change is led locally.

Since April 2006, PCTs and LHBs have had a statutory responsibility for commissioning services, devolved commissioning budgets and a system of local contracts with dental providers.[35] Commissioning for 'additional and specialist services' including domiciliary services, has grown from these reforms.

World Class Commissioning

The current World Class Commissioning (WCC) agenda[35] requires all PCTs to develop a five-year strategic plan, setting out their vision and priorities and how these will be delivered. It includes the high level 'patient offer', which sets out what the PCT is accountable for delivering to its local community. The strategic plan explains:

- What services will be provided;
- Where they will be available; and
- Who will provide them.

Both the PCT's strategic and operating plans should address how the PCT will improve its primary care services and, where there is a need, this should include domiciliary oral healthcare services. It has also been suggested that domiciliary equipment could be made available on loan.[17]

This view of WCC fits well with the four aims of the commissioning strategy set out in *The Commissioning Tool for Special Care Dentistry*[8] which are:

- A patient-centred service, which aims to provide and maintain the optimum oral health for the individual or group;
- Integrated front line delivery, which is organized around the needs of the vulnerable adult rather than professional boundaries;
- Integrated processes, which lead to

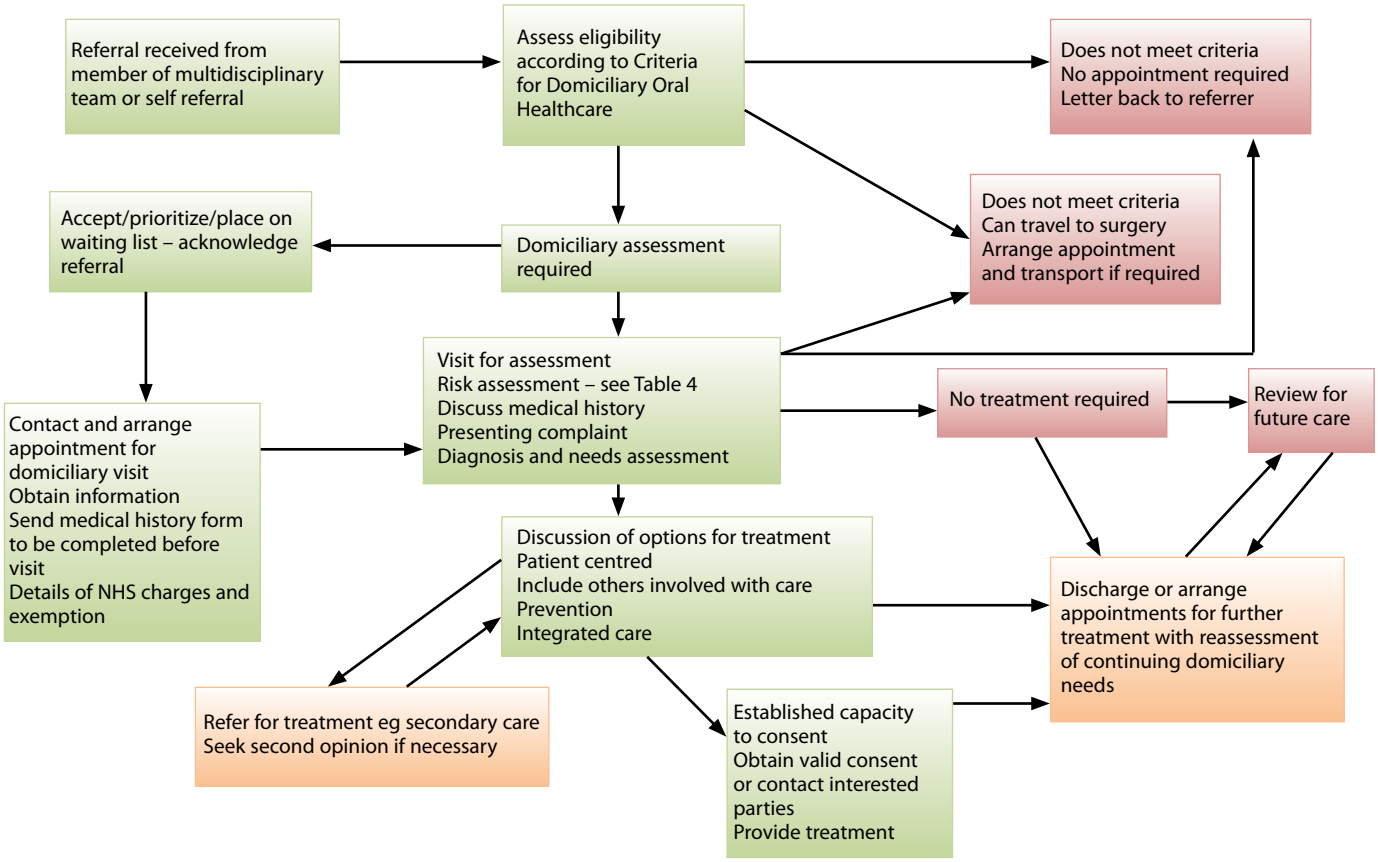

Figure 4. Care pathway for domiciliary oral healthcare. This care pathway is underpinned by audit, appraisal and staff training. Source: Wessex Domiciliary Care Group 2006.

effective joint working; and

- Joint planning and commissioning.

Use of this guidance document in combination with *Primary Care and Community Services: Improving Dental Access, Quality and Oral Health*[35] will lead to the provision of a robust strategy and operational plan to meet the needs of people requiring domiciliary oral healthcare services. Whilst the annual cycle of the WCC assurance process holds PCTs to account, PCTs need to be able to provide clear assurance that the services being accessed provide safe and effective care and good patient experience, in line with the objectives of *High Quality Care for All*.[36]

Mapping the baseline

In order to make improvements to primary care services, including domiciliary oral healthcare, a baseline needs to be established using the three key stages of:

1. Assessing needs;
2. Mapping existing services; and
3. Identifying what needs to change.

This exercise identifies service gaps, the potential for redesigning services, and the level of resources required.

Assessment of local needs

This is usually done through a Joint Strategic Needs Assessment (JSNA) which entails having a clear understanding of:

- The diversity of the local population (including associated patterns of oral health and service demand);
- Specific communities with unmet or comparatively greater health needs (such as older people in residential care or confined to home); and
- How these needs compare with similar populations elsewhere, through benchmarking.[35]

Obtaining patient feedback and assessing levels of patient satisfaction are essential to the commissioning process and part of the public and patient engagement duty. Assessing oral health needs and demand for dental services are essential elements of the process. *Valuing People's Oral Health – Best Practice Guidance for Improving Oral Health in Disabled Children and Adults*[15] contains useful information on needs assessment.

Assessing demand for dental services is not straightforward, and the current access indicator (of the number of people using services within a two-year period) is not an accurate proxy for levels of unmet need or demand. The simplest way of gauging unmet demand may be to set up a well-publicized dental access helpline for people both seeking urgent care and those seeking a regular NHS dentist, and to monitor the nature of the requested needs as well as the ability to offer services to meet them.[35] This approach

needs to be sensitive to the needs of easily overlooked groups, such as older people and people with disabilities, who may require domiciliary care.[35] Effective marketing and community engagement are required to promote awareness of how to access services amongst these groups and their families and carers. For example, for older people confined to the home, this may include targeting local social services, home-meals and shopping services, and facilities such as day centres and care homes.

Mapping existing services

This provides an understanding of how services are currently delivered, their quality, and any gaps that need to be addressed. To achieve this requires drawing together data related to: the capacity, range and type of current services; their effectiveness and safety; the patient experience; and access and choice.[35] The last point should include an estimate of the number of people unlikely to be able to leave home to attend a dental practice and the current commissioned domiciliary oral healthcare service capacity.

Identification of what needs to change

This results from a comparison of the needs assessment with existing service provision. Whilst this will differ amongst commissioners, common themes are likely to include:

- Levelling access and improving choice for the segments of the population who cannot access or have difficulty accessing services;
- Addressing areas of poor health;
- Developing specialist services; and
- A stronger focus on commissioning preventive services.[35]

Dental services for people who require domiciliary care and for people with disabilities need to be considered in each of these parameters. Additionally, an assessment of complexity of treatment is essential so that the appropriate workforce can be commissioned in a co-ordinated way to provide the most appropriate skills mix of the primary care dental team (including hygienists), dentists with a special interest, and specialist input. The Department of Health publication, *National Guidelines for the Appointment of Dentists with a Special Interest (DwSI) in Special Care Dentistry*'[37] provides guidance to PCTs on the appointment of dentists with a special interest in special care dentistry, including the competency framework for the scope of treatment that can be undertaken. *Commissioning Tool for Special Care Dentistry*[8] sets out the quality assurance criteria for a specialist in special care dentistry alongside those of a generalist dental practitioner and the dentist with a specialist interest in special care dentistry, in order to facilitate the commissioners' ability to identify what level of care is required to meet the identified need in their area.

Developing the vision

Developing the vision whereby commissioners have a clear patient offer (ie what people can expect from NHS dental services and what their responsibilities as patients are) and a clear strategic commissioning plan to deliver the patient offer, then becomes possible. The vision needs to take account of the NHS 2009 Constitution,[6] in particular that the NHS provides a comprehensive service, available to all with a social duty to promote equality through the services it provides.

How to make it happen

This is set out in *Primary Care and Community Services: Improving Dental Access, Quality and Oral Health* through commissioning levers under nine broad headings. Used intelligently, they can deliver rapid improvement and the reader is referred to that document for further information.[35]

Conclusions

The population requiring DOHC guidelines is increasing. In order that its oral healthcare needs can be met, dental team members require adequate training and more opportunities to gain experience to develop the necessary knowledge and skills to provide DOHC; PCTs and LHBs must meet their duty of care through appropriate local commissioning of services, including remuneration to reflect the additional time required for the delivery of home-based care; and DOHC provision should be properly targeted using effective oral care pathways.

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Professor Richard Ibbetson, Dental Dean, Royal College of Surgeons of Edinburgh

The Editorial Board and all at George Warman Publications wish to congratulate Richard on his election to Dean of the Faculty of Dental Surgery at the Royal College of Surgeons of Edinburgh. As well as his role as a Consultant in Restorative Dentistry and Director of the Edinburgh Postgraduate Dental Institute, Richard has been a member of the Editorial Board of *Dental Update* since 1996. We congratulate Richard on his election, and wish him well in this new role, which we are sure he will fill with enthusiasm, style and good sense.

We also hope that he doesn't have any disagreements with the College in Lincolns Inn Fields, where his wife, Kathy Harley, also a *Dental Update* Editorial Board member, is the elected Dental Dean!!

FJT Burke May 2011