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(SDNAP)

NHS SCOTLAND

Domiciliary Dental Care

Needs Assessment Report

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SDNAP Domicilary Dental Care Needs Assessment Report
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Introduction

The Domiciliary Dental Care Needs Assessment was undertaken by Scottish Dental Needs Assessment Programme (SDNAP), formally known as SNAP (Scottish Needs Assessment Programme).

The Domiciliary Dental Care Needs Assessment was undertaken to assess the current and predicted need for domiciliary care and to aid the planning of dental services for an ageing population. This was conducted against the background of a perceived decline in the provision of domiciliary dental care by General Dental Practitioners at a time of demographic change in the population. There has recently been an increase of six percent in the population of pensionable age group and it is projected that the rise in this age group in Scotland will be more rapid in the future (GRO, 2008).

Aim and Objectives

- To describe the historical and current provision of domiciliary dental care in Scotland.
- To identify probable gaps in service and to highlight difficulties experienced by individual patients, care homes and dental service providers.
- To make recommendations for the future on the basis of best practice.

Method

The health needs assessment (HNA) used a variety of sources to obtain information on domiciliary dental care service in Scotland. These included a number of evidence sources, such as:

- Current literature.
- Policy documents.
- Data on domiciliary visits in General and Community Dental Services.
- Government reports and statistics.
- Data on different care settings.
- Survey of General Dental Practitioners.
- Focus group with General Dental Practitioners.
- Survey of Community Dental Directors.

Key Findings

- The number of domiciliary visits carried out by General Dental Practitioners is decreasing. There is believed to be a steady increase in the number of domiciliary visits carried out by Community Dental Services, but the available data do not show this.
- It has been noted that there are no clear guidance, policies or standards for oral care provided in care homes, hospitals and in the home care setting.
- The HNA methodology identified gaps in the following areas of the service:
  - Prevention of oral disease.
  - Service provision.
  - Good practice.

For each of these areas, the report outlines recommendations as follows.

Recommendations

Policy Recommendations

Due to the paucity of evidence to reflect current activity and practice, the following recommendations are made on the basis of "best practice". The following recommendations have been divided into those for high level policy and those for good practice points.

Prevention

- There should be targeted prevention of dental disease and maintenance of oral health in the 40-60 year age group of the general population, for dentate and edentulous patients, to reduce the likelihood and severity of future dental problems.
- Targeted prevention of dental disease and maintenance of oral health should also be provided for the older age group (60 years and over) of the general population.
- Awareness and knowledge of oral health should be priorities for care home managers, care staff, day centres, and other organisations looking after those in their care.
- Oral health risk assessments should be undertaken by care staff to establish a daily oral health maintenance plan for all new care home residents, as recommended by NHS Qualith Improvement Scotland (NHS QIS). An example of a carer-led oral health risk assessment and care plan is shown in Appendix 1.
- Work should be undertaken to ensure the NHS QIS Best Practice Statement (NHS Quality Improvement Scotland, 2005) is fully implemented.
- An assessment of clients' ability to carry out day-to-day oral hygiene should be integral to the 'Single Shared Assessment'.
- To prevent loss of dentures in care settings, all existing dentures should be marked with the person's name. Inclusion of patient identification markers should be adopted as routine for all newly constructed NHS dentures.
- Free personal and nursing care should clearly state that basic oral hygiene support from carers is included.
- Increased application of fluoride should be considered to reduce the incidence of root decay (2800 or 5000ppm fluoride toothpaste, as prescribed by dentist) (Innes & Evans 2009).
- Water fluoridation would benefit all age groups in the population and should be considered.
- NHS Boards are encouraged to develop oral health care programmes for care homes, as part of Scottish Dental Action Plan (Scottish Executive, 2005).

Service Provision

General Dental Services/Salaried Dental Services Interface

- General Dental Practitioners (GDPs) should continue to provide routine and basic domiciliary dental care (e.g. examinations, dentures).
- Those practitioners with a special interest in domiciliary care should be encouraged to continue to provide appropriate domiciliary care.
- A complementary Salaried Dental Service (SDS) should be available to assume the responsibility for cases when more complex treatments (e.g. restorations, extractions) are required.
- Expansion of the Salaried Dental Service should be considered to deliver domiciliary dental care, with an appropriate level of service delivery to meet the needs of the target group. Membership of the team should also be extended to include Dental Hygienists, Dental Therapists, and Clinical Dental Technicians to make best use of all skill levels.

Domiciliary Visits

- All new residents in care homes should have an examination by a dentist, ideally within three months of admission. The Scottish Dental Clinical Effectiveness Programme (SDCEP) are developing a new comprehensive oral health assessment for use by dentists, which may be of use. Care homes have obligations to arrange required treatment for residents. Improved systems are required to inform care homes as to which dentists and services would care for new residents.
- The initial visit by the dentist in the domiciliary setting should include consideration of the possible need to transfer patients to a fixed or mobile dental surgery for a range of complex treatments and when a patient's medical condition demands.
- All residents in care homes should have an examination by a dentist at least once every two years, in line with the minimum frequency recommended by the National Institute of Clinical Excellence (NICE), or more frequently dependent on individual needs. The examinations may be conducted by the GDPs or SDS, the outcomes of which should be recorded in the medical notes. It is recognised that there may be issues with obtaining consent for patients without capacity.
- To reduce the need for domiciliary dental care for special needs patients, support workers, and family members where possible, should be available to accompany patients to the dental surgery.
- The Scottish Ambulance Service Patient Transport System will service dental appointments at SDS clinics to allow people with a medical need to attend for treatment which cannot be carried out in a domiciliary setting. This information should be made available to SDS managers to allow the service standardised across Scotland. District Nurses may be able to facilitate in the arrangements for individual patients. Transport and associated costs should also be included in future care home funding settlements.
- Joint working with local authorities should be encouraged to facilitate the provision of parking permits to aid parking in difficult locations.

Financial Aspects

- Consideration should be given to alternative means of remunerating GDPs in the domiciliary setting.
- As part of the new Statement of Dental Remuneration (SDR), the arrangements for domiciliary visits should be reconsidered to take account of GDPs providing this service on a sessional basis.
- NHS Boards should consider employing GDPs on a sessional basis to undertake domiciliary care for specific target groups.
- Grants and allowances should be considered to support GDPs in the additional costs of purchasing specific equipment for domiciliary care and disposable instruments to aid cross-infection control in the domiciliary setting.
- It is strongly recommended that administrative burden associated in identifying those patients who are required to pay for dental care is reduced. Systems should be put in place in care homes to assist this process.

Information Needs

- Domiciliary care activity in the Salaried and Non-salaried Dental Services should be monitored nationally in a standard way. This could be via developments to the GP17 form.
- Data on the oral health of all adult patients (including older adults and those who receive domiciliary care) should be collected in a routine way. This could be based on the comprehensive oral health assessment and standardised via the GP17 form.
- Mechanisms need to be developed to identify housebound individuals throughout Scotland, to assess whether they are registered with a dentist, and to determine their current oral health needs. The Single Shared Assessment should be considered as a means of collecting this information at an individual level and should be adapted to incorporate oral health.
- Data on the changing proportions of the older population who are fit and those who require additional services, such as domiciliary care, would be of benefit.
- Information systems should be developed to allow NHS Boards to support care homes in determining the dental registration status of new residents, with a view to ensuring continuity of care by either the GDPs or SDS.

Training

- Training in domiciliary care should be offered to dentists and Dental Care Professionals (DCPs). This should include education on carrying out risk assessments for domiciliary visits in line with General Dental Council Scope of Practice (GDC, 2009).
- Where opportunities present themselves, students should be given experience in the provision of domiciliary dental care, e.g. in outreach teaching.
- Vocational Training should be seen as the main opportunity to include exposure to domiciliary dental care.

- Training of care home staff and other carer groups should include oral health promotion and competence in assisting patients with oral hygiene, although it is recognised that this will have cost and time implications.

General

- Formal guidance on best practice should be developed on the prevention of dental disease in older people, especially those in care homes, and provision of dental services for older people. This might be carried out in conjunction with SDCEP.
- Links should be established between the Care Commission and the NHS to ensure access to dental services for care home residents.
- These recommendations should be subject to evaluation.

The Working Group exhorts the Scottish Government Health Department and NHS Boards to consider the recommendations of this report.

Recommendations for Good Practice

Practitioners are referred to the recent British Society for Disability and Oral Health (BSDH) Guidance for good practice (BSDH, 2009). In addition to the BSDH Guidance, the Working Group has agreed these 'best practice points' for highlighting.

- At domiciliary visits, there should always be a second appropriately trained person present to chaperone, to assist in the provision of care, including maintenance of infection control, and to facilitate CPR when required.
- Mobile phones should be made available to staff conducting domiciliary visits to promote staff safety.
- An adequate light source must be available to facilitate dental examinations and treatment in domiciliary settings (BSDH, 2009).
- To aid the initial assessment and any subsequent treatment, care homes should provide a room for use by visiting healthcare professionals and ensure that emergency oxygen is available where possible. The dentist is responsible for ensuring that the place of treatment is safe and adequate.
- The General Dental Council now recommend Continuing Professional Development on core topics to be undertaken, including medical emergencies. Explicit reference to the use of emergency drugs in the domiciliary setting should be included.
- Local guidance should be developed in line with BSDH guidance (BSDH, 2009) to determine which treatments can be safely and effectively undertaken at domiciliary visits. This information should be made available to care homes. This guidance should include a clinical risk assessment. A model clinical risk assessment form and mobility plan is shown in Appendix 2.
- Local guidance should be developed concerning transportation of contaminated instruments and used sharps.
- Referrals for domiciliary dental treatment should be monitored locally by the use of standardised databases which could also allow prioritisation of patients for treatment. A model referral form is given as an example in Appendix 3, with questions to help determine eligibility in Appendix 4.
- All people entering care homes should have form HC1 or HC1 (SC) completed on their behalf on admission and updated annually. Support staff should ensure that the correct paperwork is in place prior to the dentist's attendance.
- Day centres should be encouraged to accommodate visits by dentists and Dental Care Professionals for prevention and treatment to help reduce inequalities in oral health treatment provision.

2.1 Definition

Domiciliary oral healthcare can be described as a service which reaches out to care for those who cannot reach a service themselves. Domiciliary dental care is defined as the provision of dental care in an environment where the person is resident, either permanently or temporarily, as opposed to dental care delivered in a fixed or mobile dental clinic. It will normally include dental care delivered in care homes, hospitals, day centres and the patient's own home (BSDH, 2009).

It is most frequently, but not always, older people who require domiciliary dental care. It is important to note that the scope of dental treatment which can be provided under domiciliary arrangements is limited by the physical environment of the location.

2.2 Aim of Report

This report aims to describe the historical and current provision of domiciliary dental care in Scotland, to identify probable gaps in service and to highlight difficulties experienced by individual patients, care homes, and dental service providers. This report will then make recommendations on the basis of best practice.

Health needs assessment is a systematic method of identifying the unmet health care needs of a population and making changes to address these unmet needs. Needs assessment is used to improve health and other service planning, priority setting and policy development.

2.3 Literature Review

Several studies have highlighted difficulties with the provision of domiciliary dental care. One study showed that dentists feel unable to deal with the provision of routine dental procedures in the home setting and also feel that the level of remuneration offered for domiciliary care is inadequate (Simons, Kidd & Beighton, 1999). Another study indicated that there are also issues with the quantity and cost of equipment required (Burke et al., 1995).

A recent survey in Scotland (Sweeney et al., 2007) found that the types of treatment provided on a domiciliary basis were mainly examinations and the provision of dentures. Simple extractions and temporary dressings were also commonly carried out. In contrast, few dentists undertook fillings on domiciliary visits. This study showed again that there were particular problems in the General Dental Services providing domiciliary dental care, especially with regard to equipment and training. The survey also identified barriers to the provision of domiciliary care, including time required, poor remuneration and concerns about infection control and the use of emergency drugs. As a result, the provision of domiciliary dental care in Scotland was found to be problematic.

2.4 Policy Documents

A number of dental organisations have published policy documents in recent years which encompass domiciliary dental care. Most recently, the British Society of Disability and Oral Health (BSDH, 2009) has published updated guidance on the provision of domiciliary dental care, which supersedes a previous document from 2000. A Special Interest Group in Wales has also published guidance (All Wales Special Interest Group – Special Oral Health Care, 2006) specifically on domiciliary dental care. The present report does not seek to reproduce this work, but rather to build on it and make recommendations for the future provision of domiciliary dental care in Scotland.

In addition to guidance specifically on domiciliary dental care, there have also been policy documents regarding oral health care for older people, which may include aspects of domiciliary oral healthcare. These include the British Dental Association document 2020 vision (Wylie & BDA, 2003), NHS Quality Improvement Scotland (QIS) Best Practice Statement (NHS Quality Improvement Scotland, 2005) and publications from the British Society for Gerodontology on oral healthcare for frail dependent older people (Department of Health, United Kingdom, 2005) and those with dementia (Fiske et al., 2006), to which the interested reader is referred.

There is currently no clear evidence of organised fundamental oral health maintenance in care settings. The commonest dental diseases (dental decay, periodontal disease) are preventable. However, this necessitates regular daily attention by individuals and their carers to attain high standards of oral hygiene and appropriate dietary behaviours. Poor standards of oral hygiene and high levels of frailty will have a major impact on the individual need for restorative care. As an individual's ability to maintain oral hygiene decreases, so their need for restorative care is likely to increase. Neither approach is mutually exclusive of the other; however, this report focuses on the needs for restorative and surgical dental treatment. Older people have been identified as priority group in the Scottish Dental Action Plan 2005 (Scottish Executive, 2005), therefore a further working group (National Older People's Oral Health Improvement Group) will address the need for preventive programmes for older people. It is important to state at the outset of this report that adequate prevention of dental disease will determine the future need for domiciliary dental treatment.

3.1 Provision of Treatment by the General Dental Services (GDS)

The provision of domiciliary care by General Dental Practitioners (GDPs) has reduced over recent years. This may be due to several factors, including lack of suitable equipment, inadequate remuneration, and the requirement, following the publication of the National Dental Advisory Committee (NDAC) Emergency Dental Drugs Recommendations (National Dental Advisory Committee, 1999), to carry oxygen and emergency drugs. As an increasing proportion of older people retain their natural dentition, this presents a new range of treatment needs which previously have not presented in the domiciliary setting. (See Section 4.2)

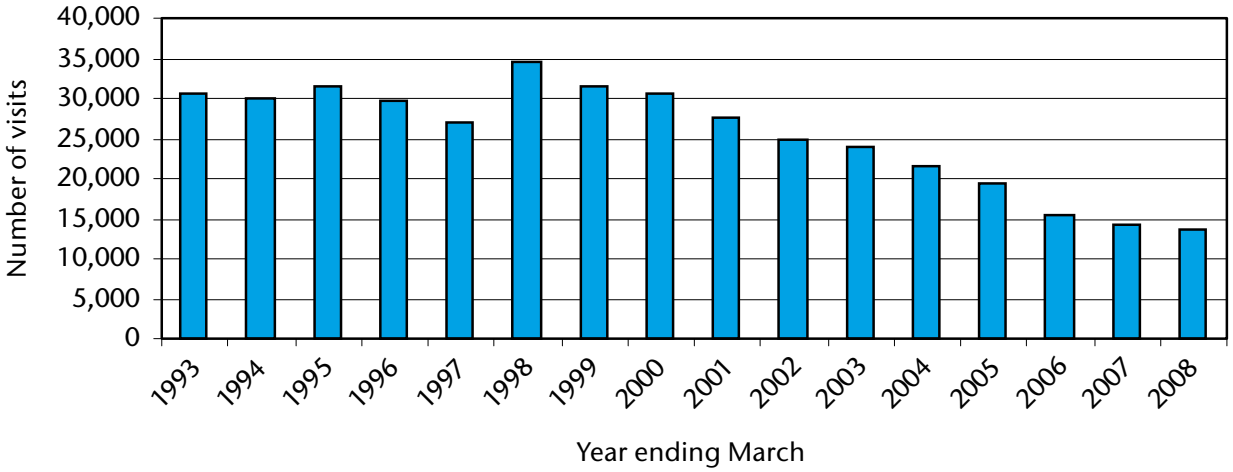
Data collected by the Scottish Dental Practice Board (SDPB) show the number of domiciliary visits and the number of courses of treatment. It is important to note that some courses of treatment may entail more than one visit, e.g. the provision of dentures, and that the amount of treatment carried out may vary considerably. Also, only domiciliary visits carried out under NHS terms and conditions are considered in this report, and so domiciliary visits carried out under a private contract have not been taken into account.

Feedback from care home managers, obtained during an oral health needs assessment in one NHS Board area, indicated that care homes have difficulty in finding local dentists willing to do domiciliary visits (NHS Ayrshire and Arran, 2009).

3.1.1 Number of GDS Domiciliary Visits

Data from the SDPB show that the number of domiciliary visits undertaken by GDPs in Scotland was constant in the years from 1992/3 to 1999/2000, at around 30,000 visits per year. However, since 2000, the number of visits has fallen steadily, to 13,771 in 2007/8. Figure 1 shows this reduction for the whole of Scotland, with data for individual NHS Boards being displayed in Appendix 5.

Figure 1 Number of domiciliary visits undertaken by GDPs



Source: Practitioner Services GP17 dental remuneration system MIDAS (Management Information and Dental Accounting System). The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

Separate data on Salaried GDPs have been available since 2000 (see Section 5.2.2 for the emerging role of the Salaried GDP). The number of domiciliary visits carried out by Salaried GDPs has risen from 396 in 1999/2000 to 1,246 in 2007/8, as shown in Table 1. However, this is still a relatively small proportion of the overall GDS provision of domiciliary dental care.

Table 1 Number of domiciliary visits undertaken by GDPs, Non-salaried & Salaried, for year ending March

Year	Non-salaried	Salaried	All
2000	30,316	396	30,712
2001	27,108	366	27,474
2002	24,494	266	24,760
2003	23,495	342	23,837
2004	21,008	511	21,519
2005	18,915	333	19,248
2006	14,898	446	15,344
2007	13,272	933	14,205
2008	12,525	1,246	13,771

Source: Practitioner Services GP17 dental remuneration system MIDAS (Management Information and Dental Accounting System). The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

Data on the number of dentists carrying out at least one domiciliary visit per year show that the number of Non-salaried GDPs carrying out such treatment is falling year on year, as shown in Table 2. In contrast, the number of Salaried GDPs undertaking at least one domiciliary visit per year, while small, is rising. Please note that these are the number of Salaried GDP posts and not necessarily the number of whole time equivalents.

Table 2 Number of GDPs undertaking at least one domiciliary visit per year ending March

Year	Non-salaried	Salaried	All
2000	1,292	28	1,320
2001	1,187	22	1,209
2002	1,149	20	1,169
2003	1,094	19	1,113
2004	1,044	15	1,059
2005	992	24	1,016
2006	852	27	879
2007	804	43	847
2008	750	68	818

Source: Practitioner Services GP17 dental remuneration system MIDAS (Management Information and Dental Accounting System). The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

3.1.2 Number of GDS Courses of Treatment

Some treatments, e.g. the provision of dentures, may entail more than one domiciliary visit by the dentist. When data on the number of courses of treatment are examined, these also show a fall in activity in recent years. These have been reduced from 12,207 courses of treatment in 1999/2000 to 6,653 in 2007/8. The data for individual NHS Boards are given in Appendix 6.

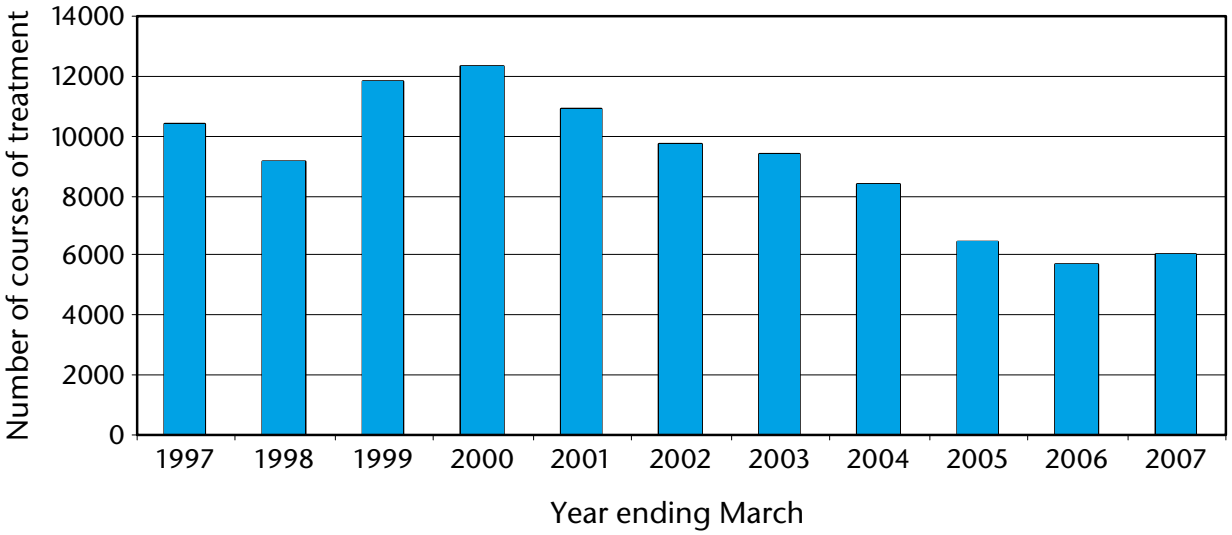
3.2 Provision of Treatment by the Community Dental Services (CDS)

It should be noted that there are areas of CDS data deficit between the years 2003 and 2007 because of issues with the central recording system (SMR13), particularly since 2003. There are major instances of under-reporting of activity, with some Boards no longer completing SMR 13 forms, as well as variations in the accuracy of reporting between NHS Board areas that complete SMR 13. In addition, some CDS providers in Scotland are transporting patients to dental clinics for more complex treatment, limiting the nature of work carried out on a domiciliary basis thereby reducing the amount of domiciliary treatment undertaken. There have also been CDS workforce shortages within some areas, which may have impacted on the services provided. Therefore, the data presented below should be examined bearing in mind these caveats.

3.2.1 Number of Completed CDS Domiciliary Courses

The SNAP Community Care and Oral Health Report found the provision of domiciliary dental care provided by the CDS to have increased more than five-fold between 1990/1 and 1998/9, from just over to 2,000 courses of domiciliary treatment per annum to around 12,000 (Sweeney et al., 2002) More recently, figures from Review of the Primary Care Salaried Dental Service (Scottish Executive, 2006c) showed a small decline back to approximately 9,000 courses in 2002/3. The data obtained for the current report show that the reduction in the number of courses of treatment has continued, falling to just over 6,000 completed courses in 2006/7 (but see caveat in Section 3.2 above). The trends over recent years are shown in Figure 2, while the data for individual NHS Boards are given in Appendix 7.

Figure 2 Number of courses of treatment provided by CDS

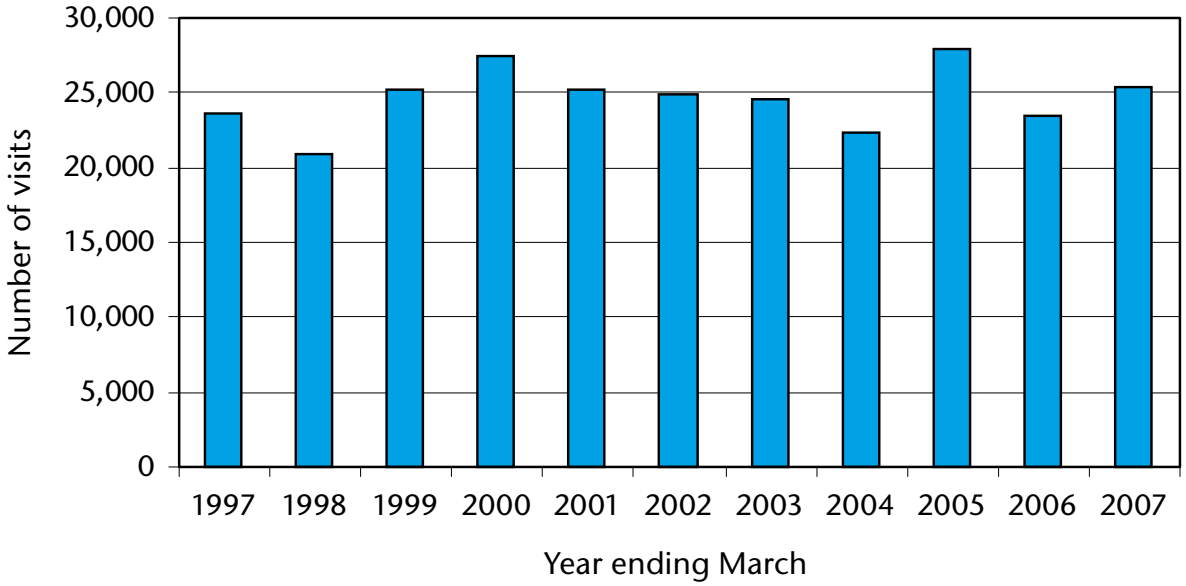


Source: SMR13 database. The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

3.2.2 Number of CDS Domiciliary Visits

In contrast to the falling number of courses of treatment, the actual number of domiciliary visits carried out by the CDS across Scotland, shown in Figure 3, has stayed relatively steady between 1996/7 and 2006/7, averaging around 25,000 visits per year. Information at NHS Board level is shown in Appendix 8. The same caveats which apply above should also be considered with regard to these data (see Section 3.2).

Figure 3 Number of domiciliary visits undertaken by CDS



Source: SMR13 database. The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

As the number of visits has stayed fairly constant while the number of courses of treatment has decreased, this may indicate that as people keep their teeth for longer, the treatment being carried out is becoming more complex and involved, requiring a greater number of visits. This is also the case for most categories of CDS patients.

Data on the number of Community Dentists carrying out at least one domiciliary visit per year show that the number is rising year on year, as shown in Table 3 (but see caveat in Section 3.2 above).

Table 3 Number of Community Dentists undertaking at least one domiciliary visit per year ending March

Year	Number of dentists
1997	180
1998	192
1999	201
2000	197
2001	201
2002	202
2003	237
2004	246
2005	235
2006	244
2007	240

Source: SMR13 database. The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

3.3 Demand for Treatment

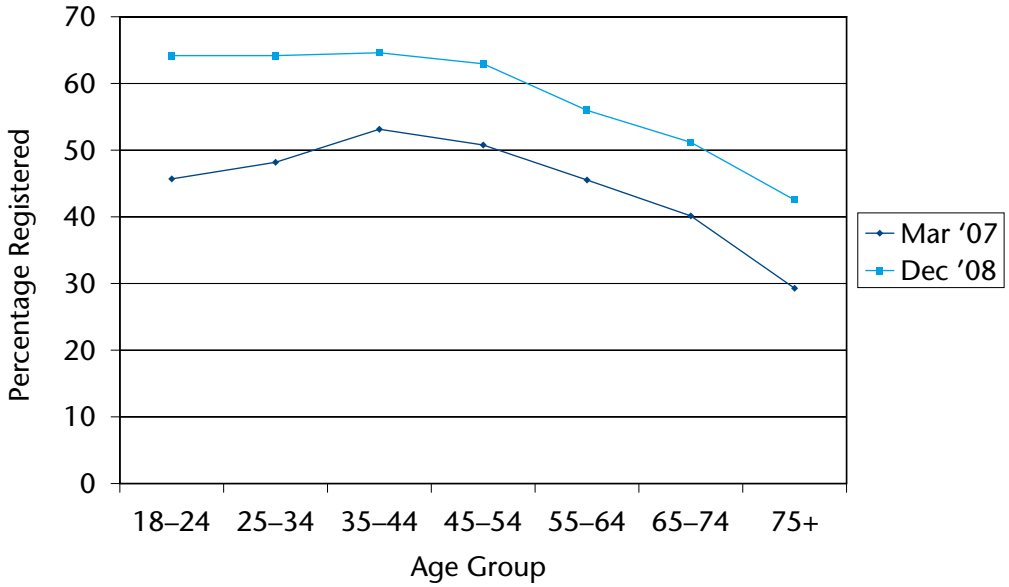
Demand is considered to be no less than need. There is anecdotal evidence from the SDS that the demand for domiciliary dental care is rising and is predicted to rise further, this being a consequence of the growing population of older people, an increasing proportion of which is dentate with many complex restorative needs.

3.3.1 Dental Registration Rates

On 31st March 2007, 46% of the adult population of Scotland was registered with an NHS dentist (Scottish Dental Practice Board, 2008). NHS dental registration falls with increasing age, as shown in Figure 4. Adult registration rates peak in the age group 35-44 years, then fall to 29% in the 75 years and over age group. Registration rates had not changed significantly for this age group over the years, having risen from just 27% in 2000/1.

More recent data from December 2008 available on the ISD website (www.isdscotland.org/isd/4680.html) show an increase to 43% for the 75 years and over age group. However, it is evident from Figure 4 that registration rates have risen for all age groups in the adult population since March 2007, which is likely due in part to the increase of the registration period from 15 months to three years (from April 2006).

Figure 4 Percentage of the population registered with an NHS dentist by standard age groups



Source: ISD Scotland 2009

A national survey of all GDPs and SDS staff was undertaken in 2003 to estimate the level of domiciliary dental care in Scotland and to examine barriers to the provision of such care (Sweeney et al., 2007). This highlighted various problems with the provision of domiciliary dental care (Section 2.3) and indicated that service planning and development were required. This SDNAP report seeks to build on that recent work and to estimate the future level of need for domiciliary dental care.

4.1 Demography

Currently, approximately one third of the UK population of 60.2 million is aged over 50. There are 9.6 million people aged 65 and over, and 4.6 million aged 75 and over. Projections anticipate that the number aged 65 and over will increase by 60% in the next 25 years. People aged 75 and over will account for over 10% of the population by 2023 and the number of people aged 85 and over will double in the next 25 years (Rossall, 2006).

Within Scotland, the Kerr Report (Scottish Executive, 2005) acknowledges that future decades will see an ageing population. In 25 years, the proportion of the population over 65 will increase to one in four, and there will be more people of retirement age than there will be children. The biggest growth will be in the 'oldest old' (i.e. those aged over 80), with numbers doubling from 200,000 to 400,000. This has implications for the health care system as, generally, older people suffer more ill health, resulting in increased demand for health care. More recently, the Scottish Government's Action Plan 'Better Health, Better Care (Scottish Government, 2007) has continued the focus on anticipatory care and the impact of long-term conditions.

A number of publications from organisations such as GRO, ISD (Wood & Bain, 2001) and the Range and Capacity Review Group: Second Report - The Future Care of Older People in Scotland (Scottish Executive, 2006b) have considered the growth of the ageing population, providing information to enable strategies to be put in place. It is clear that dental services must also plan for the care of an ageing population, including the provision of domiciliary dental care. The GRO website is updated regularly as new data become available, and information is shown at local authority and NHS Board level (www.gro-scotland.gov.uk/statistics/publications-and-data/popproj/index.html).

4.2 Dental Health Status

Adult dental health is monitored by the decennial UK surveys. However, there are currently constraints on the oral health data available for adults in the UK as the 2008 Adult Dental Health Survey (ADHS) has not been reported, with the most recent being in 1998. The 2008 Scottish Health Survey (SHS) (National Statistics Publication for Scotland, 2009) gives some more up-to-date oral health information, although the methodology used is different. The 1998 ADHS showed that, overall in Scotland, the prevalence of total tooth loss in adulthood was decreasing, from 26% in 1988 to 18% in 1998. The SHS confirmed this trend was continuing, with only 12% having no natural teeth in 2008. The ADHS, reporting on various age groups, showed the proportion of the Scottish population aged 65 and over without any natural teeth (edentulous) had fallen from 87% in 1972 to 56% in 1998 (Kelly et al., 2000). The SHS appears to confirm that the rate of edentulousness is falling over time, while highlighting differences between males and females, e.g. in the age group 75 years and over, 43% of men and 57% of women had no natural teeth.

Not only has there been a decrease in the proportion of the population who have experienced total tooth loss, those who are dentate retain a larger number of teeth than previously. Thus the result is an increasing proportion of the older population being susceptible to periodontal disease and decay, especially root decay. These diseases are preventable, but when they are allowed to progress, older people may require increasingly complex dental treatment.

Future projections of the total tooth loss are also included in the Adult Dental Health Survey. Table 4 shows that a decreasing proportion of older adults will be edentulous in future years.

Table 4 Current and projected total tooth loss among older adults in the UK (% of those with no remaining natural teeth)

Age Band	1998 (%)	2008 (%)	2018 (%)
65–74	35.9	23	12
75–84	52.5	39	26
85+	80.9	57	44

Source: Kelly et al., 2000

This will change the nature of denture services required by older people. In addition, the expectations and attitudes of patients are changing, with more people wishing to retain teeth rather than have them extracted.

The oral health of people aged 65 years and over was examined as part of the National Diet and Nutrition Survey in 1995 (Steele et al., 1998). The sample included older people living at home as well as those cared for in a residential setting. The findings confirmed those of previous studies which have demonstrated poorer oral health among dependent older adults, including a higher incidence of periodontal disease, coronal and root caries, higher levels of oral pathology and poor oral and denture hygiene. Significant associations between the severity of disability and levels of tooth loss among dependent older adults were also seen. The presence of a physical disability also affected the patients' ability to manage their oral care.

4.3 Domiciliary Dental Care Settings

Domiciliary dental care may be required to be carried out for patients in a number of different settings.

4.3.1 Care Home Residents

Care Home Statistics

In 2007, there were 1,456 care homes in Scotland (National Statistics Publication for Scotland, 2007a). Care homes cater for older people, and also younger people with

physical disabilities, mental health problems, learning disabilities and other client groups who can no longer lead independent lives. Care homes are required to be inspected regularly by the Care Commission.

The number of care homes exclusively for older people in 2005 was 944. The 944 homes had places for 37,301 older people and had 33,173 residents. This figure is falling over recent years (Wood & Bain, 2001). This is in part due to the difficulty experienced by some homes in meeting new standards, and also to the demand from potential residents for single rooms, en suite facilities etc. Such pressures have resulted in a number of care homes closing in recent years.

Over the past thirty years the dependency profile of residents of most care homes has changed quite dramatically. In the seventies, it was not unheard of for some older people who were isolated within their communities and suffered either poor health or depression to go into a residential home 'for the company', on the recommendation of their GPs, despite the fact that they might only be aged between 65 and 70 years of age. They might then have spent the last 20 years or more of their lives in care.

During the 1990s, long term care provision for older people moved from NHS long-stay geriatric wards to nursing home care. In more recent years, the Scottish Executive's policy was to encourage older people to remain at home as long as they are able (Scottish Executive, 2007a). As a result, those entering care homes are now much frailer than previously found and tend to be the most vulnerable.

The average length of stay in a residential home has gone down over the years. These data were collected as part of the Scottish Care Home Census in March 2006 (National Statistics Publication for Scotland, 2007b). Of the 32,577 long-stay residents in care homes for older people, 18% had spent more than 5 years in their current care home. The average length of stay in a nursing care home is 2.6 years, but this figure is higher for those requiring residential care (National Statistics Publication for Scotland, 2005). This has implications for service planning.

The Kerr Report (Scottish Executive, 2005) continued to encourage the trend of individuals receiving 'care at home'. As a result, planning was required to determine the need for beds in care homes, which predicted that during the following five years the need for beds would remain static, and then an increasing number of 'the older old' would need a place in a care home. Through time, local authorities might consider placing a person in a care home is less expensive than caring for someone in their own home, although there is no firm evidence that care homes are a less expensive option. Therefore, as time progresses since the publication of the Kerr Report, it is expected that the increase in care home bed requirement is to rise significantly.

The proportion of the older population living in care homes does increase with age (National Statistics Publication for Scotland, 2007b), rising from 11% of those aged 65-74 to 49% of those aged 85 and over. In addition, the care needs of those living in care homes appears to be increasing over time, with residents becoming more dependent, as shown by data from the Scottish Care Resource Utilisation Group (SCRUGS).These data need to be interpreted with caution, as initially homes were split into either nursing and residential homes, but now are merged under the one umbrella term 'care homes'.

Nevertheless, figures over the five year interval from 2001-2006 show:

- There is an increase of 4% in the number of people with special care needs.
- There is an increase in the number of people with continence care needs.
- There is an increase of 2% in residents requiring to be fed at mealtimes.
- There is an increase of 2% of residents requiring to be prompted to use the toilet, and there has been increase of 17% in those who are dependent on others for their toileting needs.
- There is an increase in the number of people requiring assistance with transferring from a wheelchair to a chair, or to another room and there is also an increase of 4% in those who require the help of one person and an increase of 8% in those who require the help of 2 people.
- There is also an increase of 9% in those who require 2 or more people to help them to move.
- There is an increase of 3% in moderate dependency of ADLs (Activities of Daily Living) and a 6% overall increase in those with high dependency ADL needs.

(Source: SCRUGS)

These figures indicate that the levels of dependency of people living in care homes are increasing.

Free Personal and Nursing Care

In Scotland personal care and nursing care are available without charge for everyone aged 65 and over who needs it, whether at home, in hospital, or in a care home. None of these allowances is means tested, and are available to all, even those whose assets require that they pay towards their own residential care. The types of personal care provided will vary based on the outcome of the Single Shared Assessment (SSA). The SSA is carried out by Social Work.

An additional allowance might be given by the local authority for enhanced care where required, e.g. 'elderly mentally incapacitated' (EMI), 'very dependent elderly' (VDE). These allowances are available to social work-funded clients but not self-funded residents.

The financial arrangements for paying towards residential care are complex, and residents with assets often have to contribute towards the cost of their care, but are left with a weekly personal allowance of £21.15 (from 7/4/08).

Routine and Daily Oral Health Care in Care Homes
A national care home contract has been developed for use by all local authorities. The contract states toiletries should be provided to residents at no charge. Although toothbrushes and toothpaste are not mentioned specifically, anecdotal feedback indicates that some care homes do supply basic toothbrushes and toothpaste to their clients (COSLA, 2006). However, if a particular 'brand' of toiletries is requested by the resident, then they are expected to meet that cost themselves.

A local oral health needs assessment in one NHS Board area (NHS Ayrshire & Arran, 2009) has identified that many dentures are not marked with the resident's name. Many residents in care homes suffer from forgetfulness and frequently mislay their own dentures resulting in requests for new replacement dentures to be provided. Many of these residents are infirm and less likely to adapt to new dentures (Murray et al., 2007).

Dental Treatment in Care Homes
The National Care Standards (Scottish Government, 2007b) provide a regulatory framework for care home inspections. These Standards indicate that residents should continue registration with their own dentist where possible. If this cannot be the case, then the care home should help residents to register with a dentist in the local area.

Residents in care homes are not per se exempt from NHS dental treatment charges. This situation differs from those who are in hospital care, where no charge for dental treatment is levied (Section 4.3.2). Eligibility for free personal or nursing care will not guarantee eligibility for free dental treatment. The grounds for exemption are discussed in Section 5.1.

Facilities that are available to provide dental treatment in care homes are not always ideal. Increasingly, patients require to be transferred to the dental surgery for treatment. This creates a need to provide transport for residents. Care homes are entitled to make a charge for transport and carer time, but this is not universally applied.

4.3.2 NHS Hospital In-Patients

Dental treatment in hospitals in urban areas is mainly undertaken by the SDS. In rural settings, greater input may be required from GDPs. Good communication between hospitals and the various branches of dental primary care is, therefore, important. Hospital in-patients do not require to pay for their dental treatment.

It should be noted that the standards for emergency dental care, whereby patients should be seen within 24 hours, also apply to hospital patients (Scottish Executive, 2003).

Delayed discharge of patients may have implications for dental services, with an increased chance of patients being referred for dental treatment during their

lengthened hospital stay. Figures from the Scottish Government in July 2007 (ISD Scotland, 2007) indicated that 423 patients had been ready for discharge for more than six weeks but had remained in hospital. This figure had reduced by 32.5% from 627 in July 2006 and has continued to fall, with the most recent census of patients ready for discharge having reduced to zero (ISD Scotland, 2008). If this figure remains low, delayed discharge and its impact on the need for domiciliary dental care may become less of a concern.

As an alternative to treating patients in a hospital setting, or when there is no dental surgery available within the hospital, arrangements can be made to transfer patients to a dental clinic using hospital transport. However, this may have to be factored in to the dentist's appointment schedule, as the clinician waits for the patient to be transferred to and from the dental appointment.

4.3.3 Day Centre Clients

The Census of Day Centre Services, undertaken in March 2007 (National Statistics Publication for Scotland, 2007c), showed there are 633 day care centres in Scotland, providing 17,563 places per week to 23,011 people with a variety of care needs. The majority of day centres are intended for older people and provide 39% of all day centre places. There are a smaller number of centres for people with learning disabilities, although these provide 45% of the total day centre places. People with learning disabilities use day care services more frequently than any other client group, averaging 3.6 days per week.

Access for dentists to day centres can be difficult, as the clients who attend often have busy schedules. Since the publication of 'The Same as You' (Scottish Executive, 2000), visits by dentists to learning disability day centres have been discouraged, as it is felt that clients should seek routine care in the same way as the rest of the population. However, when clients from day centres are expected to come to the dental surgery, there can be a low attendance rate because of difficulties with the availability of transport to the dental surgery.

4.3.4 Home Care Service Users

All local authorities in Scotland provide home care services to give people the support, help and personal care needed to live in the community as independently as possible. At March 2007 (National Statistics Publication for Scotland, 2007d) data indicated there were 70,710 home care clients. Of these, 80% were aged 65 and over, and 78% had physical disabilities (including frailty associated with old age).

As stated previously, current policy is to encourage older people to remain at home for as long as they are able (Scottish Executive, 2007a). This policy has been underpinned with funding (in addition to their pension) for free personal care (as described in Section 4.3.1) which is presumed to include day-to-day oral hygiene practices, but not the cost of dental treatment.

Home carers require training to enable them to provide oral health care for older people living at home and to encourage their charges to register with a dentist. They

should also be able to assist with the arrangement of dental appointments, either at the surgery or within the home setting. Work with home carers is ongoing in several NHS Board areas in Scotland, including Ayrshire & Arran, Lanarkshire, and Highland.

As care staff will be required to be qualified and registered with the Scottish Social Services Council (SSSC) by 2012, there is potential for oral health training to be included in their generic training, which would raise awareness of the importance of oral health, the prevention of dental disease, and the relevance of routine asymptomatic dental visits. However, there may well be significant costs associated with this, including cover for staff while they attend training sessions, and training materials.

4.4 Other Client Groups

This list is not intended to be exhaustive, but will cover the main groups who are likely to require domiciliary dental care. Although these include mainly adults, it should be noted that some children may also require domiciliary dental care, e.g. those with learning difficulties, autism, or other special needs.

4.4.1 People with Learning Disabilities

The provision of oral health care and dental treatment for people with learning disabilities has changed in recent years as a result of the closure of long stay accommodation and 'normalisation' into the community. Care and treatment were organised and provided in the setting where individuals were resident. It was considered advantageous to treat those with challenging behaviour in familiar surroundings, such as their own home, where cooperation might be better. However, the onus is now on individuals and their carers to seek oral healthcare. This has led to less frequent dental attendance and altered treatment patterns, as found by Stanfield et al. (2003).

Adults with Down's Syndrome have high levels of periodontal disease, although the prevalence of dental decay may be the same or lower than that of non-Down's Syndrome peers (Allison et al., 2001). There are now many more older people with Down's Syndrome, which may have implications for domiciliary dental care. In the 1950's, life expectancy for a person with Down's Syndrome was 15 years. This has now increased to over 60 years, although their care needs may be the same as those of a much older person. (source: www.dsscotland.org.uk)

4.4.2 People with Mental Health Problems

Mentally ill patients often avoid dental care and their oral hygiene may be impaired as a result of side-effects of medication (e.g. xerostomia which leads to the increased risk of dental caries). Barriers to dental treatment include fear and anxiety, which can be compounded by their inability to comprehend the need for treatment, the need to attend with a carer, and difficulty in physically accessing the dental premises (Davies et al., 2000). Thus these patients may require domiciliary dental care.

4.4.3 Physical Disability

Physical disability affects a proportion of the population of all ages. Approximately 1% of the population of children under the age of 16 are estimated to have limitations affecting locomotion (Bone & Meltzer, 1989). Mobility is affected by different types of disability (e.g. physical, visual, and cognitive impairments). Over 4 million adults have mobility problems, and around 2.5 million are reported to have difficulty with personal care. Where practices cannot physically be accessed, the dentist should make alternate arrangements, which might include domiciliary care or referring to the Salaried Dental Service. The prevalence of disability increases with age, with impaired mobility affecting approximately 20% of the 60-74 age group and rising to 46% in the population aged over 75 years. These restrictions have implications for access to services and the management of oral self-care.

Young Physically Disabled (YPD) is a generic classification used by local authorities. It frequently refers to an older person who has not reached pension age but still requires care/nursing care, which will also have implications for the provision of dental care. Limited access to dental premises is a problem, as well as the problems encountered by people with disabilities in relation to travel (Lewis & Gilmour, 2004). Those with sensory impairment may also have difficulty in accessing dental services and may require domiciliary dental care.

4.4.4 Palliative Care

Those patients in palliative care may also require dental treatment in a domiciliary setting (Walls, 2005). In general, this group appears to be well looked after, with the importance of oral care being well recognised, e.g. the Liverpool Care Pathway for terminally ill patients includes mouth care guidance (www.mcpcil.org.uk/liverpool-care-pathway/), In addition, palliative care patients in hospitals and hospices are not expected to contribute financially towards the cost of their dental treatment.

5.1 General Dental Services – Background Information

GDPs are independent contractors to the NHS, and are paid from a Statement of Dental Remuneration (SDR) laid down by the Scottish Government. The SDR defines items of treatment and determines the fees that each item generates. Supplementary domiciliary fees are payable by circuit but are restricted to no more than two claims per day. The fees are banded according to total distance travelled (Scottish Executive, 2006a). However, even patients who pay routine charges are exempt from paying this supplementary domiciliary fee. GDPs decide on an individual basis whether they offer domiciliary care and the range of treatment provided. Where practitioners have inaccessible premises, there is currently no requirement on them to arrange treatment or to visit a patient wherever he or she is resident.

NHS treatment charges are applicable to all patients of the General and Salaried Dental Services, with patients contributing 80% of the cost unless exempt, e.g. pregnant women, people on Income Support. While younger people aged between 0–17 years are exempt from paying, older people receiving pensions and residents of care homes are not automatically exempt, unless in receipt of some form of Pension Tax Credit; e.g. individuals in receipt of the state retirement pension and a 'guarantee credit' are fully exempt from patient charges.

Patients who believe they may be entitled to either total or partial exemption from NHS dental fees are required to complete form HC1. Once this form is processed, patients may then be issued with either a HC2 certificate which indicates full exemption from dental costs or a HC3 certificate which indicates partial exemption from dental costs. These certificates are valid for one year from the date of issue. Care home managers can also apply on behalf of residents funded by the local authority, by completing the short form HC1 (SC).

To process payments, and to record the treatment carried out, form GP17 is used by GDPs, and patients indicate on this if exemptions apply. Care management can sign this form on behalf of their clients, or delegate the responsibility to other care staff, and it should be noted that this does not indicate liability for payment.

As would be expected, the number of domiciliary visits claimed for each of the standard age groups rises with age. Of the 13,771 visits claimed by GDPs in 2007/8, 10,191 were for the age group 75 years and over. Table 5 gives a detailed breakdown of the number of visits per age group since 2000. Additionally, Appendix 9 shows GDS domiciliary visits over the past five years for all ages, based on distance travelled.

Table 5 Number of GDS domiciliary visit claims, by age group for year ending March

Age Group	2000	2001	2002	2003	2004	2005	2006	2007	2008
0–2	23	22	3	14	6	4	14	6	16
3–5	41	18	6	7	9	23	6	3	5
6–9	29	31	21	19	10	10	12	9	8
10–14	35	55	38	32	45	28	23	13	15
15–17	21	67	52	50	32	42	27	9	8
18–24	80	48	47	48	49	40	36	42	52
25–34	255	240	154	127	102	70	61	71	64
35–44	403	287	258	300	285	203	188	140	148
45–54	853	783	734	680	629	562	321	371	356
55–64	2,063	1,732	1,529	1,374	1,363	1,211	888	739	819
65–74	5,240	4,685	4,085	3,826	3,468	3,270	2,442	2,055	2,089
75+	21,669	19,506	17,833	17,360	15,521	13,785	11,326	10,747	10,191
Total	30,712	27,474	24,760	23,837	21,519	19,248	15,344	14,205	13,771

Source: GP17 forms. The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

The number of visits made in 2000 by the GDS to adults aged 65 years and over was 26,909. The population aged 65 years and over has increased from 799,485 in 2000 to 845,613 in 2007. If domiciliary visits had continued at the same rate as in 2000, then the expected number of GDS visit claims would have been 28,462 in 2007. However, this figure had actually fallen to 12,802.

Table 6 below shows projections for the number of GDS visits, based on the rate of GDS visit claims in 2000 and 2007. With the increasing proportion of older people in the population, the number of GDS claims is expected to rise. This may have financial implications, as well as impacting on workforce development and service planning.

However, the certainty of these projections will depend on the status of service profiles and there is a very strong likelihood that services profiles will change with time.

Table 6 Projected visits for year 2017 and 2027 using 2000 and 2007 visits data

	Total 65 + population	Projected GDS visits using 2000 claims data	Projected GDS visits using 2007 claims data
2017	1,031,239	34,709	15,612
2027	1,260,455	42,424	19,082

Source: GRO 2006-based projected population by sex and single year of age, Scotland 2006–2031 © Crown Copyright 2007.

5.1.1 GDS Survey

A questionnaire (Appendix 10) was sent to 100 GDPs in Scotland in late 2006. Of these practitioners, 50% had submitted the greatest number of claims for domiciliary circuits in the previous year and 50% had submitted the lowest number of claims for domiciliary care. Practitioners who submitted no claims at all in the previous 12 months were excluded. There was an 80% response rate.

The majority of referrals for domiciliary care made to GDPs were reported to be from care homes. Amongst the perceived barriers were the need to carry portable oxygen, the logistics of travelling and parking, the absence of suitable portable equipment, time away from the dental surgery and the level of financial remuneration for providing domiciliary care. The detailed results are given in Appendix 11.

5.1.2 GDP Focus Group

A GDP focus group was convened within NHS Ayrshire & Arran to discuss the topic of dental provision for older people, including domiciliary dental care. This was independent of the national questionnaire reported above and reached similar conclusions relating to facilities, transport, and suitable equipment. The focus group also highlighted the need for training of Dental Care Professionals (DCPs) and the unrealistic expectations of relatives as a concern when treating older people.

5.1.3 Discussion

As evidenced from the results of the questionnaire, there is presumed to be an increasingly unmet need because of decreasing provision of domiciliary care within the GDS. Even in the group who historically provided the greatest number of domiciliary visits, their willingness to continue to do so was reducing. A range of reasons for this were stated, including the implications of more rigorous cross infection control procedures and the transportation of contaminated instruments and sharps. However, capital investment in new ground floor surgeries by NHS Boards and GDPs is a positive contributing factor in reducing the number of domiciliary dental care visits.

GDPs believe that the remuneration rates for carrying out domiciliary visits do not adequately compensate for time away from their surgeries. They consider the opportunity costs to be too great. The current financial recompense is not considered by GDPs to reward suitably the additional complexity of treating this group of patients under less than ideal conditions. The adoption of an appropriate risk assessment tool to identify what treatment should realistically be provided in a domiciliary setting would be advantageous (BSDH, 2009).

The current perceived understanding from the NDAC Emergency Dental Drugs Recommendations (National Dental Advisory Committee, 1999) that oxygen and emergency drugs should be taken to every domiciliary visit appears to be a disincentive to many who might otherwise undertake a small amount of domiciliary care. If there is only one emergency kit/oxygen available in the surgery, this restricts the domiciliary care which can be carried out during the working hours. In addition, drivers carrying oxygen in their vehicles are required to inform their insurance company and display the appropriate warning notice. It would appear that dentists would welcome further clarity on the issue of oxygen and emergency drugs for domiciliary visits. However, recent guidance from the Scottish Dental Clinical Effectiveness Programme (SDCEP) Drug Prescribing For Dentistry (NDAC-Scottish Dental Clinical Effectiveness Programme, 2008) does not refer specifically to domiciliary visits.

In general, these findings support the results of other studies, particularly the recent survey by Sweeney et al (2007).

5.2 Community Dental Services - Background Information

The role of the CDS was reviewed in the recent Review of the Primary Care Salaried Dental Service (Scottish Executive, 2006c), which indicated that the main spheres of activity were:

1. Public Health functions including National Dental Inspection Programme.
2. Clinical treatment services for those patients who do not obtain treatment from the GDS.
3. Health Education and Oral Health Promotion.
4. Training.

The CDS traditional role has been in treating children and priority adults. Historically the CDS also has undertaken a large amount of domiciliary care in patients' own homes as well as in care homes, day centres and other residential establishments such as community housing for people with special needs. As this service is provided on an NHS Board-wide basis, it is more likely that the CDS has access to portable equipment for carrying out domiciliary dental treatment, and is often better placed

than GDPs to carry out a variety of treatments in a non-clinical setting. However, it should be noted that even with portable equipment, the treatment which can be provided is restricted to simple interventions.

The number of domiciliary visits undertaken by the CDS for each of the standard age groups again rises with age. Of the 25,444 visits by CDS in 2006/7, 11,324 were for the age group 75 years and over. Table 8 gives a detailed breakdown of the number of visits per age group since 2000 (see caveat in Section 3.2).

Table 7 Number of CDS domiciliary visits undertaken, by age group for year ending March

Age Group	2000	2001	2002	2003	2004	2005	2006	2007
0–2	135	125	128	197	174	213	94	420
3–5	66	36	60	57	64	164	81	1,234
6–9	190	147	159	71	114	118	379	1,768
10–14	76	131	233	106	108	82	415	1,457
15–17	105	41	50	64	61	79	84	768
18–24	537	416	442	419	316	322	247	368
25–34	1,099	904	857	654	417	725	439	767
35–44	1,204	1,237	1,123	1,234	948	1,223	918	850
45–54	1,395	1,404	1,384	1,338	1,123	1,959	1,463	1,028
55–64	1,496	1,639	1,474	1,673	1,666	2,181	1,444	2,111
65–74	3,760	3,576	3,552	3,391	3,002	3,476	2,996	2,848
75+	17,243	15,419	15,354	15,293	14,123	17,233	14,574	11,324
Unknown	201	162	103	114	177	210	300	501
Total	27,507	25,237	24,919	24,611	22,293	27,985	23,434	25,444

Source: SMR13 database. The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

The number of visits made by the CDS in 2000 to adults aged 65 years and over was 21,003. As explained in Section 5.1, the population aged 65 years and over has increased from 799,485 in 2000 to 845,613 in 2007. If domiciliary visits had continued at the same rate as in 2000, then the expected number of CDS domiciliary visits in 2007 would have been 22,214. However, this figure had actually fallen to 14,712.

Table 8, below, shows projections for the number of CDS visits, based on the rate of CDS domiciliary visit in 2000 and 2007. It can be seen that the number of CDS domiciliary visits is expected to rise. Again, this may have implications on workforce development, service planning, as well as a financial impact.

Table 8 Projected visits for year 2017 and 2027 using 2000 and 2007 visits data

	Total 65 + population	Projected CDS visits based on 2000 visit data	Projected CDS visits based on 2007 visit data
2017	1,031,239	27,091	17,283
2027	1,260,455	33,113	21,125

Source: GRO 2006-based projected population by sex and single year of age, Scotland 2006-2031 © Crown Copyright 2007.

5.2.1 CDS Survey

A questionnaire (Appendix 12) was sent to the Clinical Dental Directors of the CDS across Scotland in 2006, which received 100% response rate. Only a minority of five CDS services have a dedicated domiciliary care team(s). The range of equipment which was taken to support domiciliary care was variable across Scotland. The availability of portable motorised suction was restricted. There was a wide variation in the number of domiciliary visits undertaken by various services ranging from 10 patients per month to 200 patients per month. The CDS reported receiving referrals from General Medical Practitioners (GMPs) and district nurses as well as GDPs. The detailed results can be found in Appendix 13.

5.2.2 Discussion

A very complex range of factors is influencing the provision of domiciliary care. Historically, in the period 2000-2005, there was a reduction in the number of GDPs providing NHS care. As a result, there was an increasing demand for the CDS/ Salaried "safety net function"; that is the provision of dental services to mainstream adults who are unable to register with an independent GDP. This limited the time available for domiciliary care and, as a result, time-consuming domiciliary visits were at risk because of conflicting demands on the SDS.

The emerging role of the Salaried GDP, often managed as part of the SDS, seeks to fill this safety net function, allowing the SDS to concentrate on priority groups such as children, special care dentistry, and older people. However, it is important to note that the role of the Salaried GDP varies between NHS Boards, with some providing mainstream NHS dental services, while those in other Boards undertake more specific roles e.g. domiciliary care, sedation, oral surgery. The data in Table 1 confirm that the number of domiciliary visits carried out by Salaried GDPs in Scotland is increasing, while data from Table 2 indicate that the actual number of Salaried GDPs undertaking domiciliary care is also rising. This is against a background of an increasing total number of Salaried GDP posts in Scotland in recent years, rising from 103 posts at 31st March 2005 to 270 posts by 31st March 2007. (SDPB Report 2006/7)

NHS treatment charges are applicable to patients of the Salaried General Dental Services but have been limited to certain items of treatment in the Community or Hospital Dental Services and are rare. The Review of the Primary Care Salaried Dental Services will also have implications for patient charges, with former CDS patients in future being required to pay for treatment, unless exempt.

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Appendix 1

Model Oral Health Risk Assessment

A response in red with a dashed underline – contact dentist
A response in yellow with continuous underline – may require more intensive oral health input, consider seeking advice.

Name of Resident	D.O.B			Date of Assessment
	Circle which is appropriate			Suggested outcome/actions
1 Does the resident have any of their natural teeth?	No	Yes	Don't know	Encourage independence with cleaning teeth morning and night. Use a small headed toothbrush and fluoride toothpaste.
2 Does the resident wear dentures? Specify:	No	Yes Upper Lower	Don't know	Supervise/help with cleaning dentures morning and night with unperfumed soap and water; rinse dentures after meals. Gently clean oral mucosa with moist gauze. Leave dentures out overnight if acceptable to resident and soak in sodium hypochlorite.
a) If YES, are dentures labelled?	No	Yes		Use kit for marking denture.
b) If YES, how old are dentures?	less than 5 years	more than 5 years	Don't know	Consider referral to dentist for replacement of old dentures.
3 Does the resident need help to clean teeth/dentures?	No	Yes		May need supervision/help with mouth care.
4 Does the resident complain of suffering any oral problems? *Please tick:* ☐ Facial swelling ☐ Painful natural teeth ☐ Non-healing ulcers ☐ Decayed/broken teeth ☐ Bleeding gums ☐ Lost dentures ☐ Denture problems	No	Yes		Discuss with resident/family and if resident/family are in agreement make an appointment for resident to see their own high street dentist or complete a referral form to Salaried Dental Service.
5 Date of last dental treatment?	Less than 2 years	More than 2 years	Don't know	Consider referral to dentist for check up if the resident wishes.
6 Registered for dental care? If YES, record name and address of dentist	No	Yes	Don't know	Consider referral to dentist for check up if the resident wishes.
7 Is the resident taking medication?	No	Yes		Note drugs which have oral side effects. Check with pharmacist for any oral side-effects.
8 Does the resident complain of a dry mouth?	No	Yes		Clean lips and oral soft tissues with water moistened gauze and protect with water-based lubricating gel. Offer frequent fluids and/or iced water. If symptoms persistent refer to dentist.
9 Does the resident smoke?	No	Yes		Note amount per day Consider smoking cessation
If further investigation required, please refer to dentist	Referred to dentist? ☐ Yes ☐ No Advice from dentist? ☐ Yes ☐ No Resident refused referral? ☐ Refused			

Signed _____ Date |_|_|_|_|_|_|

This form was originally obtained from BSDH and has been modified for local use.

Appendix 1 (continued)

Oral Care Plan
(including monthly review of care plan)

Following the initial assessment, please complete the care plan using tick boxes and note extra information in line below. After the monthly review assessment, please complete new care plan using tick boxes and note extra information in line below.

	Teeth	Dentures	Dry mouth	Lips	Tongue and soft tissues	Other problems, e.g. swallowing	Other problems, e.g. nutrition
	Brush twice a day	Clean twice a day, rinse after meals, soak in sodium hypochlorite	Offer frequent fluids	Apply water-based gel	Clean with moist gauze	Clean teeth and oral cavity after each meal	May require two-hourly mouth care
1	☐	☐	☐	☐	☐	☐	☐
	Initial assessment |_|_|_|_|_|	Any other information (e.g. smoking, medication, dexterity or cognitive function; ulcer, pain or referral to dentist):				Signature:	
2	☐	☐	☐	☐	☐	☐	☐
	Monthly review assessment |_|_|_|_|_|	Review notes (e.g. changes in smoking, medication, dexterity or cognitive function; ulcer, pain, or referral to dentist):				Signature:	
3	☐	☐	☐	☐	☐	☐	☐
	Monthly review assessment |_|_|_|_|_|	Review notes (e.g. changes in smoking, medication, dexterity or cognitive function; ulcer, pain, or referral to dentist)				Signature:	
4	☐	☐	☐	☐	☐	☐	☐
	Monthly review assessment |_|_|_|_|_|	Review notes (e.g. changes in smoking, medication, dexterity or cognitive function; ulcer, pain, or referral to dentist):				Signature:	
5	☐	☐	☐	☐	☐	☐	☐
	Monthly review assessment |_|_|_|_|_|	Review notes (e.g. changes in smoking, medication, dexterity or cognitive function; ulcer, pain, or referral to dentist):				Signature:	
6	☐	☐	☐	☐	☐	☐	☐
	Monthly review assessment |_|_|_|_|_|	Review notes (e.g. changes in smoking, medication, dexterity or cognitive function; ulcer, pain, or referral to dentist):				Signature:	

Appendix 2

Model Clinical Risk Assessment (Dental Care)

Assessment Details	
Patient's name:	Dentist name:
Address: Post code:	Base:
Telephone no:	Telephone no:
Reason for referral:	Persons performing assessment:

Description Of Treatment

Significant Hazards Dental / Medical / Behavioural / Environmental /Other Cognitive Impairment	**Access Difficulties** (If relevant)
	☐ **Low** ☐ **Medium** ☐ **High**

Level Of Risk (Tick appropriate risk category), e.g. carrying equipment
☐ **Low** (Risk controlled)
☐ **Medium** (Improvements required)
☐ **High** (Uncontrolled)

Recommended Action												
(*Enter date of visit, then tick either "yes" or "no" to identify recommended action*)	Date		Date		Date		Date		Date		Date	
	__/__/__		__/__/__		__/__/__		__/__/__		__/__/__		__/__/__	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Treat in domiciliary setting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Full resuscitation kit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Treat in clinic/hospital	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (Please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Signature of assessor(s) _____

Name(s) _____
(Printed in Capitals)

Appendix 2 (continued)

Model Mobility Plan

Date: ⌊ ⌋⌊ ⌋⌊ ⌋ Patient Name: _____

Date of birth: ⌊ ⌋⌊ ⌋⌊ ⌋ Height: _____ Weight: _____

Visual Impairment: _____

Hearing Impairment (which ear): _____

Verbal Communication: _____

Describe how much assistance patient needs: _____

_____

Mechanical Aids Used: _____

Prosthesis Used: _____

Walking ability/weight bearing:

Aids required ☐
☐ Walking stick
☐ Zimmer
☐ Mobilator
☐ Wheelchair

Ability to get on/off dental chair:
(if bringing to surgery for some aspects of treatment)

Not Applicable ☐

Aids required ☐
☐ Banana board
☐ Hoist
☐ One person
☐ Two people

Lying back on dental chair:
(if bringing to surgery for some aspects of treatment)

Not Applicable ☐

Sitting/Standing:

Does patient need support once in dental chair?

Other Information:

Appendix 3

Model Referral for Potential Domiciliary Dental Care

Name: _____ Address: _____ _____ Postcode: _____ CHI No: |_|_|_|_|_|_|_|_|_| DOB: |_|_|_|_|_| Tel: _____ ☐ Care home ☐ Hospice ☐ Own home ☐ Ward	Next of kin relationship: _____ Next of kin contact details: Name: _____ Address: _____ _____ Tel: _____
GMP: Dr _____ Address: _____ _____ Tel: _____	Person referring (please specify): Social/Key Worker/Community Nurse Key contact Name: _____ Address: _____ _____ Tel: _____
Key Medical History: 1. _____ 2. _____ 3. _____	
Medication:	
Social History: ☐ Lives alone ☐ Cared for	

Reason for referral:			
☐ Facial swelling	☐ Decayed broken teeth	☐ Bleeding gums	☐ Lost dentures
☐ Painful natural teeth	☐ Persistent ulcers	☐ Denture problems	☐ Other – please state _____

Sensory impairment:	Mobility:	Services:	Details:
☐ Hearing ☐ Vision ☐ Communication	☐ Walks unaided ☐ Needs assistance ☐ Wheelchair user ☐ Bedfast ☐ Own transport	☐ Comm Nurse ☐ Meals on Wheels ☐ Home care ☐ Day Centre/ Hospital	_____ _____ _____ _____ _____
When best to contact? Mon/Tues/Wed/Thurs/Fri			

HC2 certificate available? ☐ Yes ☐ No

Signature _____ Status _____

Date |_|_|_|_|_|_|

Appendix 4

Eligibility for Domiciliary Dental Care

Has patient/carer contacted a local dentist?
☐ Yes ☐ No ☐ Don't know

Is the patient able to get out at all?
☐ Yes ☐ No ☐ Don't know

When was the last time the patient was able to leave the house?

_____

_____

Does the patient attend her/his doctor?
☐ Yes ☐ No ☐ Don't know

If the patient has a hospital appointment, how does he/she get there?
☐ Ambulance ☐ Taxi ☐ Car ☐ Other

Does the patient have someone to bring them to the surgery?
☐ Yes ☐ No ☐ Don't know

Does the patient use a taxi for other activities?
☐ Yes ☐ No ☐ Don't know

Does the patient attend a hairdresser/chiropodist outside their home?
☐ Yes ☐ No ☐ Don't know

Mobility:
☐ Walks unaided ☐ Needs assistance
☐ Wheelchair user ☐ Housebound

Does the patient pay for their dental treatment or do they have any exemptions?
☐ Yes ☐ No ☐ Don't know

Complete HC1 form if eligible for exemptions

Additional Comments:

_____

_____

_____

Appendix 5

Number of **GDS domiciliary visit claims**, by NHS Board, for year ending March

NHS Board	1993	1994	1995	1996	1997	1998	1999	2000
Argyll & Clyde	3,911	3,633	3,813	3,330	3,071	3,993	3,452	3,507
Ayrshire & Arran	3,297	3,054	3,095	3,087	2,852	3,558	2,890	3,010
Borders	620	591	786	572	554	578	404	416
Dumfries & Galloway	519	603	780	839	694	692	622	630
Fife	1,950	1,949	2,232	2,013	1,786	2,589	2,442	2,263
Forth Valley	1,457	1,401	1,711	1,654	1,346	1,857	1,650	1,624
Grampian	1,826	1,735	1,337	1,382	999	1,449	1,505	1,183
Greater Glasgow	6,440	6,721	6,439	6,292	6,541	8,412	7,779	7,959
Highland	688	504	530	489	369	443	,385	361
Lanarkshire	3,231	3,105	3,621	3,330	3,077	4,010	3,745	3,740
Lothian	3,884	3,588	3,988	3,756	3,244	4,047	3,925	3,428
Orkney	93	84	85	53	40	71	60	64
Shetland	13	33	23	34	5	3	16	2
Tayside	2,764	2,986	2,968	2,745	2,317	2,778	2,562	2,462
Western Isles	59	33	54	61	91	106	68	63
Scotland	30,752	30,020	31,462	29,637	26,986	34,586	31,505	30,712

NHS Board	2001	2002	2003	2004	2005	2006	2007	2008
Argyll & Clyde	2,811	2,815	2,477	2,339	1,966	1,482	1,547	1,448
Ayrshire & Arran	2,879	2,688	2,760	2,413	2,228	1,595	1,350	1,630
Borders	317	318	356	237	217	195	169	139
Dumfries & Galloway	584	460	340	345	304	214	122	187
Fife	2,136	1,801	1,836	1,559	1,080	1,181	1,094	1,059
Forth Valley	1,159	975	843	795	641	433	517	301
Grampian	1,084	812	648	348	232	187	107	166
Greater Glasgow	7,067	5,862	6,242	5,856	6,200	5,165	5,005	4,766
Highland	329	303	307	224	138	78	101	138
Lanarkshire	3,778	3,821	3,577	3,576	3,099	2,537	2,246	2,075
Lothian	3,121	2,949	2,786	2,474	2,030	1,546	1,192	1,133
Orkney	64	64	46	0	8	4	60	51
Shetland	0	1	0	17	21	7	0	27
Tayside	2,115	1,877	1,610	1,332	1,083	719	695	651
Western Isles	30	14	9	4	1	1	0	0
Scotland	27,474	24,760	23,837	21,519	19,248	15,344	14,205	13,771

Source: Practitioner Services GP17 dental remuneration system MIDAS (Management Information and Dental Accounting System). The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

Data shown for NHS Argyll & Clyde for comparative purposes, although NHS Argyll & Clyde was absorbed into NHS Highland and NHS Greater Glasgow in April 2006.

Appendix 6

Number of **GDS domiciliary courses of treatment claims,** by NHS Board, for year ending March

NHS Board	2000	2001	2002	2003	2004	2005	2006	2007	2008
Argyll & Clyde	1,269	1,136	1,175	1,088	1,054	888	689	735	709
Ayrshire & Arran	1,174	1,140	1,126	1,188	1,034	997	749	640	791
Borders	182	170	162	169	123	127	107	99	92
Dumfries & Galloway	244	262	190	142	143	131	95	56	81
Fife	933	902	787	762	687	529	527	570	569
Forth Valley	692	507	471	407	404	348	214	286	176
Grampian	548	482	346	284	156	118	91	52	82
Greater Glasgow	3,262	2,952	2,563	2,778	2,743	2,853	2,486	2,486	2,316
Highland	197	171	161	177	129	94	50	63	80
Lanarkshire	1,265	1,242	1,246	1,241	1,228	1,109	938	874	824
Lothian	1,329	1,203	1,142	1,106	1,036	843	681	531	518
Orkney	40	44	39	20	0	7	3	40	36
Shetland	1	0	1	0	5	7	5	0	25
Tayside	1,042	936	881	779	634	551	375	378	354
Western Isles	29	11	9	5	2	1	1	0	0
Scotland	12,207	11,158	10,299	10,146	9,378	8,603	7,011	6,810	6,653

Source: Practitioner Services GP17 dental remuneration system MIDAS (Management Information and Dental Accounting System). The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

Data shown for NHS Argyll & Clyde for comparative purposes, although NHS Argyll & Clyde was absorbed into NHS Highland and NHS Greater Glasgow in April 2006.

Appendix 7

Number of **CDS courses of treatment for domiciliary visits,** by NHS Board, for year ending March

NHS Board	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Argyll & Clyde	501	433	470	485	460	488	635	1,097	1,112	879	970
Ayrshire & Arran	412	550	642	483	512	546	545	464	443	449	486
Borders	160	156	350	409	346	447	459	361	307	200	173
Dumfries & Galloway	148	285	350	298	225	188	190	210	2	13	12
Fife	196	207	442	623	922	919	1,159	1,140	1,059	923	866
Forth Valley	1,221	538	480	609	530	637	743	562	469	552	340
Grampian	1,254	1,143	1,052	1,386	1,063	1,019	683	619	535	573	437
Greater Glasgow	4,243	3,643	5,153	4,699	3,958	2,760	1,960	1,194	565	333	729
Highland	450	277	311	261	288	267	222	261	106	218	232
Lanarkshire	146	131	90	244	396	160	265	278	229	244	560
Lothian	936	649	1,161	974	715	839	861	580	404	467	434
Orkney	2	0	2	0	4	0	0	1	8	11	32
Shetland	18	5	1	8	1	19	20	1	10	21	18
Tayside	709	1117	1,280	1,396	997	735	969	1,045	686	253	291
Western Isles	7	9	8	24	13	22	27	14	17	15	11
Unknown	14	35	34	455	453	703	642	523	508	517	413
Scotland	10,417	9,178	11,826	12,354	10,883	9,749	9,380	8,350	6,460	5,668	6,004

Source: SMR13 database. The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

It should be noted that there are areas of CDS data deficit between the years 2003 and 2007 because of issues with the central recording system (SMR13).

Data shown for NHS Argyll & Clyde for comparative purposes, although NHS Argyll & Clyde was absorbed into NHS Highland and NHS Greater Glasgow in April 2006.

Appendix 8

Number of **CDS domiciliary visits**, by NHS Board, for year ending March

NHS Board	1997	1998	1999	2000	2001
Argyll & Clyde	1,636	1,269	1,426	1,339	1,500
Ayrshire & Arran	1,270	1,837	1,897	1,595	1,448
Borders	341	348	764	830	617
Dumfries & Galloway	351	626	620	613	407
Fife	658	690	1,616	2,472	3,575
Forth Valley	2,971	1,127	1,314	1,720	1,810
Grampian	3,907	3,469	3,339	4,035	3,042
Greater Glasgow	6,994	6,591	8,148	7,294	6,215
Highland	1,126	720	742	631	753
Lanarkshire	467	417	279	536	758
Lothian	1,762	1,202	2,166	1,835	1,688
Orkney	6	0	8	0	7
Shetland	68	22	14	22	1
Tayside	1,996	2,445	2,705	3,643	2,214
Western Isles	10	29	18	66	39
Unknown	37	139	125	876	1,163
Scotland	23,600	20,931	25,181	27,507	25,237

NHS Board	2002	2003	2004	2005	2006	2007
Argyll & Clyde	1,320	1,864	3,023	4,112	3,695	3,958
Ayrshire & Arran	1,633	1,341	1,201	3,345	2,558	1,518
Borders	843	906	701	1,233	458	386
Dumfries & Galloway	378	332	404	2	31	37
Fife	3,939	4,224	4,159	4,186	3,964	3,566
Forth Valley	1,876	2,312	1,648	2,649	2,787	1,720
Grampian	2,647	1,905	1,491	2,136	1,899	1,152
Greater Glasgow	4,983	3,626	2,460	1,917	1,195	3,149
Highland	678	531	679	448	1,157	785
Lanarkshire	473	695	851	1,476	1,080	4,246
Lothian	2,257	2,739	1,852	1,696	1,644	2,064
Orkney	0	0	1	22	33	75
Shetland	69	81	7	23	51	35
Tayside	1,959	2,385	2,368	2,698	1,082	1,313
Western Isles	64	106	37	129	54	24
Unknown	1,800	1,564	1,411	1,913	1,746	1,416
Scotland	24,919	24,611	22,293	27,985	23,434	25,444

Source: SMR13 database. The accuracy of this analysis is dependent on data quality and may be affected by errors at source such as data entry, coding and scanning inaccuracies.

It should be noted that there are areas of CDS data deficit between the years 2003 and 2007 because of issues with the central recording system (SMR13).

Data (are) shown for NHS Argyll & Clyde for comparative purposes, although NHS Argyll & Clyde was absorbed into NHS Highland and NHS Greater Glasgow in April 2006.

Appendix 9

GDP domiciliary visits for past five years, based on distance travelled

Item	Description	All ages number of counts	All ages value (£)
2008/09			
35	Domiciliary visits	13,206	487,881
35a1	Domiciliary visit - less than 10 miles	11,454	403,660
35a2	Domiciliary visit - 10 to 40 miles	1,565	76,020
35a3	Domiciliary visit - over 40 miles	37	2,353
57a1	Domiciliary visit - less than 10 miles	112	3,938
57a2	Domiciliary visit - 10 to 40 miles	34	1,654
57a3	Domiciliary visit - over 40 miles	4	256
2007/08			
35	Domiciliary visits	13,771	495,519
35a1	Domiciliary visit - less than 10 miles	11,774	402,849
35a2	Domiciliary visit - 10 to 40 miles	1,696	79,911
35a3	Domiciliary visit - over 40 miles	66	4,081
57a1	Domiciliary visit - less than 10 miles	189	6,453
57a2	Domiciliary visit - 10 to 40 miles	42	1,975
57a3	Domiciliary visit - over 40 miles	4	250
2006/07			
35	Domiciliary visits	14,205	494,677
35a1	Domiciliary visit - less than 10 miles	12,337	410,056
35a2	Domiciliary visit - 10 to 40 miles	1,676	76,621
35a3	Domiciliary visit - over 40 miles	41	2,465
57a1	Domiciliary visit - less than 10 miles	118	3,926
57a2	Domiciliary visit - 10 to 40 miles	26	1,188
57a3	Domiciliary visit - over 40 miles	7	421
2005/06			
35	Domiciliary visits	15,344	521,154
35a1	Domiciliary visit - less than 10 miles	13,306	430,830
35a2	Domiciliary visit - 10 to 40 miles	1,889	84,257
35a3	Domiciliary visit - over 40 miles	26	1,515
57a1	Domiciliary visit - less than 10 miles	90	2,923
57a2	Domiciliary visit - 10 to 40 miles	22	984
57a3	Domiciliary visit - over 40 miles	11	645
2004/05			
35	Domiciliary visits	19,248	635,341
35a1	Domiciliary visit - less than 10 miles	16,453	514,530
35a2	Domiciliary visit - 10 to 40 miles	2,524	108,617
35a3	Domiciliary visit - over 40 miles	107	6,048
57a1	Domiciliary visit - less than 10 miles	91	2,835
57a2	Domiciliary visit - 10 to 40 miles	61	2,635
57a3	Domiciliary visit - over 40 miles	12	676

Source: ISD Scotland 2009

Appendix 10

Questionnaire for Domiciliary Dental Care provided by General Dental Practitioners

1 Have you personally provided domiciliary care within the last 6 months?

☐ Yes ☐ No

2 Do you personally continue to provide domiciliary dental care?

☐ Yes ☐ No

3 Please indicate which members of your staff you involve when providing domiciliary dental care.

Dental Nurses ☐ Yes ☐ No

Dental Hygienists ☐ Yes ☐ No

4 Do you take portable equipment? (Please tick all relevant boxes)

☐ Motor with straight handpiece ☐ Portable powered suction

☐ Motor with contra-angle handpiece ☐ Light source

Other (please specify): _____

5 Do you carry an emergency drug kit?

☐ Yes ☐ No

If yes, please detail what is carried:

_____

_____

If yes, does another emergency drug kit remain available for use by colleagues who continue to treat patients in the practice?

☐ Yes ☐ No

6 Have you received training which has relevance to providing domiciliary visits?

CPR ☐ Yes ☐ No

Emergency drug use ☐ Yes ☐ No

Gerodontology ☐ Yes ☐ No

Other ☐ Yes ☐ No

If other, please give details: _____

7 Do all members of the domiciliary team receive training for going on visits?

☐ Yes ☐ No

8 Please indicate the approximate number, per month, of:

domiciliary visits undertaken _____

patients seen (*may be the same as above, or different*) ____

9 Do you receive referrals for domiciliary care from any of the groups below? If so, please give approximate numbers per month.

GMPs	☐ Yes (approx. no. per month: ____)	☐ No
District nurses	☐ Yes (approx. no. per month: ____)	☐ No
Nursing homes	☐ Yes (approx. no. per month: ____)	☐ No

10 Do you use a proforma for recording referral information?

☐ Yes ☐ No

11 Do you have a protocol or guidance for those staff going on domiciliary visits?

☐ Yes ☐ No

12 Do you have any logistical problems to deal with regarding domiciliary visits? E.g. travelling time, city parking permits

☐ Yes ☐ No

If yes, please give details _____

_____

13 Do you undertake a risk assessment, e.g. for the premises or the work required?

☐ Yes ☐ No

14 Do you have any other comments to add concerning the provision of domiciliary care?

_____

_____

_____

Appendix 11

Results of GDS Questionnaire

For those carrying out a high number of domiciliary visits, 43 questionnaires were returned and for those undertaking a low number of visits, 37 were returned, resulting overall in an 80% return rate for the audit.

Those undertaking a high number of domiciliary visits

Of the 43 who responded, all continued personally to provide domiciliary care. When providing domiciliary care, most took a dental nurse or other staff member along with them. However, a minority said they attended domiciliary visits alone, with no ancillary staff support. When asked about portable equipment, two-thirds indicated they took a motor with a straight handpiece, but only a few took a motor with a contra-angle handpiece. Half carried a light source but only one reported taking portable powered suction. Four indicated that they took equipment specifically for denture work.

Only seven dentists reported carrying an emergency drug kit. Of these, all reported either leaving an emergency drug kit in the practice while on a domiciliary visit, or doing domiciliary visits outside normal practice hours.

When asked about training with relevance to domiciliary care, all but six respondents had received training in CPR and all but 12 training in emergency drug use. However, only eight reported that they had received training in gerodontology. Twenty four respondents indicated that all members of the dental team received training prior to going on domiciliary visits.

When asked about the number of domiciliary visits undertaken per month,

- Fourteen respondents indicated less than 5 per month
- Thirteen respondents indicated between 6 and 10 visits per month
- Ten respondents indicated between 11 and 20 visits per month
- Four respondents indicated more than 20 visits per month.

The actual number of patients seen per month reflected the same distribution.

Regarding referrals, GDPs received few referrals from GMPs or district nurses but a significant number from care homes, with 30 dentists receiving referrals each month from care homes. A proforma for recording referral information was only used by a few, although 17 reported using a protocol or having guidance for staff going on domiciliary visits. Ten dentists reported undertaking a risk assessment for the premises or the work required.

Fifteen respondents indicated they had logistical problems in attending domiciliary visits, citing mainly travel, time taken, parking problems and equipment required.

When asked if they had other comments to add concerning the provision of domiciliary dental care, many of the respondents indicated they only provided dentures or limited treatment on a domiciliary basis. A few others indicated that the fees given and time taken were not conducive to undertaking extensive domiciliary care and also cited excessive regulations as a problem.

Those undertaking a low number of domiciliary visits
Of the 37 respondents, 15 indicated they no longer continued to provide domiciliary dental care. Therefore, the following analysis is mainly concerning the remaining 22 dentists.

The majority took a dental nurse with them on domiciliary visits, but none indicated that hygienists were used. When asked about equipment, 16 reported they took a motor with a straight handpiece, and four a motor with a contra-angle handpiece. Only eight took a light source and no-one reported carrying portable powered suction. Once again, a small number (4) indicated they took specific denture equipment.

Only four dentists reported taking an emergency drug kit on domiciliary visits, with three of these indicating that this was the practice kit and, therefore, no emergency drugs remained in the practice during this time.

Nineteen of the 22 dentists reported receiving CPR training, and 18 training in emergency drug use. However, only three reported specific training on gerodontology, and only six indicated that all members of the team received some form of training.

As expected, the majority of these dentists reported seeing only around one patient per month. Again, few dentists received referrals from GMPs or district nurses. Eight respondents stated that the majority of their referrals came from care homes, although these were only in the order of one or two per month.

Only two dentists reported using a proforma and only three had a protocol for providing domiciliary dental care. Only four reported undertaking a risk assessment.

Logistical problems were reported by nine dentists, with the main themes again being travelling time, time out of the surgery, parking problems and difficulties with equipment.

The free text comments indicated that many dentists felt domiciliary care was no longer cost-efficient because of the fees paid and the time taken. Many stated that they only undertook denture work or emergency treatment on a domiciliary visit. These dentists queried the rational for taking emergency drugs and equipment when only denture work was being undertaken.

Appendix 12

Questionnaire for Community Clinical Directors
Domiciliary Dental Care

1 Do you have a dedicated team(s) specifically for domiciliary care?

☐ Yes ☐ No

If yes, please indicate the sessional time for each staff group within the domiciliary team:

CDO ____ SDO ____ Salaried GDP ____

Therapists ____ Hygienists ____ Nurses ____

2 Do you supply your dental staff with portable equipment? (Please tick all relevant boxes)

☐ Handpieces ☐ Suction ☐ Light

Other (please specify) _____

3 Do your dental staff carry an emergency drug kit?

☐ Yes ☐ No

If yes, please detail what is carried:

_____

_____

4 Do you provide training specifically for those going on domiciliary visits?

☐ Yes ☐ No

If yes, please give details _____

_____

5 Please indicate the approximate number, per month, of:

domiciliary visits undertaken _____

patients seen (*may be the same as above, or different*) ____

6 Do you receive referrals for domiciliary care from any of the groups below? If so, please give approximate numbers per month.

Local GDPs	☐ Yes (approx. no. per month: ____)	☐ No
GMPs	☐ Yes (approx. no. per month: ____)	☐ No
District nurses	☐ Yes (approx. no. per month: ____)	☐ No
Nursing homes	☐ Yes (approx. no. per month: ____)	☐ No

7a Do you keep a database of referrals?

☐ Yes ☐ No

7b Do you use a proforma for recording referral information?

☐ Yes ☐ No

8a Do you have a protocol or guidance for those going on domiciliary visits?

☐ Yes ☐ No

8b Do you have a lone working protocol?

☐ Yes ☐ No

If you are willing to share any of your paperwork relating to questions 7 & 8 we would be very grateful to receive it.

9 Do you have logistical problems to deal with regarding domiciliary visits? E.g. travelling time, city parking permits

☐ Yes ☐ No

10 Do you have any other comments to add concerning the provision of domiciliary care?

_____

_____

_____

Appendix 13

Results of CDS Questionnaire

Out of 15 replies received, 10 said they had no dedicated team for domiciliary care. When asked about portable equipment, 13 replies stated that they took equipment on visits, the majority taking handpieces and lights. Six took portable suction, and others denture equipment.

Twelve took emergency drug kits, but two only took these into the house if they were undertaking restorative treatment. Little staff training was given in relation to domiciliary care, with only a few areas offering this.

The number of visits per month was variable, with four areas doing less than 10 and another four areas more than 100. The numbers of patients seen per month was equally wide-ranging, from under 10 to more than 200. The numbers are not completely related to the presence of a dedicated team, as one area with less that 10 visits per month reported having a team, while two out of the three areas with more than 200 visits per month did not have a team. It was also suggested that the numbers may be influenced by dental hygienist visits which increase the overall number of visits. It was noted that some dental practices had contracts to visit nursing homes which would decrease the demand for CDS input.

Most areas reported that referrals for domiciliary care came from GDPs, GMPs, district nurses, and care homes. A smaller number of referrals came from social work and health visitors. It was pointed out that some areas may also receive referrals from hospices or the patients' families. Some CDS will take referrals from other sources if they think that they are appropriate.

Regarding the use of databases for domiciliary care referrals, most respondents did not keep a database on domiciliary visits. SMR13 forms record this information, but these are not always accurately filled in, and so could not be relied upon. There is also the issue of the break in continuity of SMR13 data. When questioned about the use of a proforma, the responses were related to the previous question on databases, as those who kept a database tended also to use a proforma. (See Appendix 12).

Six areas had protocols or guidance for those going in domiciliary care. (See Appendix 11 for guidance and risk assessment forms). A 'lone working' protocol was in place in 10 areas, and it was suggested that, due to the cross infection risk, dentists should always have assistance. However, some dentists go to a care homes alone if staff nurses were there to assist.

Logistical problems included the transport of bulky equipment, parking, distance to travel, and time out of the surgery. There are major parking problems in Edinburgh city centre, where permits are not available.

It is often better if the patient can be transported to the surgery, rather than carrying out treatment in a home setting without the proper equipment. However, care homes sometimes charge nursing time and transport costs to take a patient to the dental surgery. This cost may then have to be covered by the patient's family, although in some areas the local authority may pay. Ambulance transport will take patients to appointments in hospitals, but not clinics, where the CDS often operate.

Other points were raised, including the issue of the long-term health of a dentist who has to carry very bulky and heavy equipment. Domiciliary visits are likely to be increasingly in demand in the future, because of the ageing population.

Abbreviations

ADL	Activities of Daily Living
BDA	British Dental Association
BPS	Best Practice Statement
BSDH	British Society of Disability and Oral Health
CDS	Community Dental Services
COSLA	Convention of Scottish Local Authority
CPR	Cardio-pulmonary resuscitation
DCPs	Dental Care Professionals
EMI	Elderly Mentally Incapacitated
GDPs	General Dental Practitioners
GDS	General Dental Services
GMPs	General Medical Practitioners
GRO	General Registrar's Office (Scotland)
HNA	Health Needs Assessment
ISD	Information and Statistics Division
NDAC	National Dental Advisory Committee
NHS QIS	NHS Quality Improvement Scotland
NICE	National Institute for Clinical Excellence (Now - National Institute for Health & Clinical Excellence)
ppm	parts per million
SCRUGS	Scottish Care Resource Utilisation Group
SDCEP	Scottish Dental Clinical Effectiveness Programme
SDNAP	Scottish Dental Needs Assessment Programme
SDPB	Scottish Dental Practice Board
SDR	Statement of Dental Remuneration
SDS	Salaried Dental Services
SNAP	Scottish Needs Assessment Programme
SSA	Single Shared Assessment
SSSC	Scottish Social Services Council
YPD	Young Physically Disabled

Glossary of Terms

Dentate	Describing someone who has their own natural teeth
Edentulousness	Describing someone with no natural teeth
Xerostomia	Dry mouth
Periodontal disease	Gum disease