The decline of domiciliary dentistry

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Domiciliary oral healthcare (DOHC) has been the usual method of care in enabling dental practitioners to access patients who are unable to reach a dental surgery or service themselves; including patients in temporary and permanent residences, such as nursing homes and residential units.¹

The new dental contract in 2006 introduced fundamental changes to state funded NHS dental care in England and Wales. Fee-per-item remuneration was

replaced by Units of Dental Activity (UDAs), with a now capped budget delegated to primary care trusts with a statutory responsibility to commission dental services based on the historical requirements of the local population.² The 2006 contract had radical implications for domiciliary care. Pre-2006, dentists were able to claim a 'call-out' fee for providing home visits, but the introduction of the new contract meant that post 2006, General Dental Practitioners (GDPs) had to have a special contract if they wanted to be paid for

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domiciliary care. Consequentially, access to NHS domiciliary care has been limited to a few General Dental Service providers and the salaried dental services. This has resulted in increasingly fewer domiciliary visits being carried out, but is this a trend that is continuing?

In 2008, 99,200 domiciliary visits were completed in England and Wales, whilst 2019 saw only 62,634 visits delivered.^{3,4} This further declined during the COVID-19 affected period of 2020 where figures show that just 24,943 forms were received for the whole year by the BSA, with 16,237 of these being submitted in the first quarter of the year, from January to March.⁵ These figures would tend to suggest that there are probably many housebound older patients, or shielding and housebound during the pandemic, who are or were unable to access any form of NHS dental care. Unfortunately, figures were not available from the Business Service Authority at the time of enquiry for prior to 2006 and the introduction of the new contract, but one would imagine the decline started prior to 2008.

The 2006 contract has been heavily criticised; with widespread belief that the changes were underpinned by politico-economic drivers, and not for the benefit of dentists or their patients.^{6,7} The Department of Health stated that the aims behind the new contract were to 'build an NHS dental service that offers access to high quality treatment for patients when they need to see a dentist, focuses on preventing disease... gives a fair deal to dentists and their teams and improves their working lives.'⁸ The House of Commons Health Select Committee criticised the contract for failing to address any of these areas.⁸ This is reflected in Chestnutt *et al.* research, which revealed that out of nearly 500 dentists, only 11% liked the new system, 83.4% disagreed that it allowed more time for prevention, and 85.3% felt they had less opportunity to spend time with patients.⁶

Demand for DOHC is likely to continue increasing as a result of a growing population of older people who are more likely to become functionally dependent and who are increasingly dentate, as well as through legislative pressure. The increase in the number of people requiring DOHC services is partly attributable to advances in medical science, enabling people

to survive more illness and disability. Although longevity is increasing, physical or mental disability and other chronic diseases often reduce mobility and the ability for self-care, making it difficult for many disabled or older people to access mainstream dental services for treatment. People who have mental illness or dementia frequently become disorientated and confused when in an unfamiliar environment and may benefit from dental care in a familiar environment, such as their place of residence.

Currently there are limitations in meeting these needs due to both workforce and skills shortages within domiciliary dentistry.

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Solutions?

Currently a lot of the DOHC need is met by the salaried dental services. However, the number of patients who will require a 'dom' both now and in the future is unlikely to be met entirely by already stretched salaried services. Without a plan of action to involve interested GDPs then the supply is always going to be outstripped by the demand.

However, many GDPs may be interested in offering domiciliary care if they are both properly trained and remunerated. There may be opportunities in developing programmes for delivering care via Transformational Commissioning to improve local services to meet local needs, which in this case would be NHS domiciliary dental services.⁹

Projects have already started to be rolled out in Sheffield, Scotland and Wales (amongst others), where the DOHC of patients is dealt with on a shared care basis between the GDS and Special Care Dentistry.⁵

Specialists working in Special Care Dentistry could act as mentors for other primary care dental practitioners. Local postgraduate deaneries could support appropriate training programs for both new dentist (FDs) as well as more established practitioners.

And what would be the potential benefits to the clinicians from engaging in this branch of care? As practitioners we all look for variety in our work to ensure we stay motivated, and many dentists working in the salaried services will often quote that the best aspect of carrying out DOHC is that time from the four surgery walls can be both interesting and enjoyable. But perhaps the greatest benefit of all is being able to help and improve the lives of some of society's most vulnerable patients with simple but effective treatment, and for the General Dental Practitioner to truly be able to offer individual care from the cradle to the grave. ♦

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<https://doi.org/10.1038/s41404-021-0838-9>