Evaluation for the Impact of the National Strategy for Improving Prison Dental Services in England

Prison Health Research Network

2006

Executive Summary

Background

In April 2003 the Department of Health in conjunction with Her Majesty's Prison Service published the document 'Strategy for Modernising Dental Services for Prisoners in England'. This document sets out standards which prison dental services in England are expected to meet. Accompanying the publication of this document, £4.75M of new monies were injected into the prison dental service over a three-year period to help prisons achieve the standards set in the strategy.

The Prison Health Research Network is a Department of Health funded initiative that aims to identify research and development priorities in prison health care, and coordinate a programme of research to address these identified gaps. In 2005 the then Chief Dental Officer asked the PHRN to evaluate the impact of the national prison's modernisation strategy on prison dental services.

A postal questionnaire was used to gather the relevant data on prison dental services between 2003 and 2006. The questionnaire was sent to all 134 prisons in England during the months of January, February, March and April 2006.

Main findings

Prisons reported that there had been a marked improvement in dental services in the 3-year period since publication of the national strategy. Improvements were identified in 4 areas:

Service Specification & Access

The number of prisons that could provide emergency dental care within 24 hours had increased from 71% in 2003 to 76% in 2006 and the proportion of prisons able to offer routine dental care within 6 weeks had increased from 48% in 2003 to 65% in 2006.

There had been an increase in the number of prisons that had an agreed service specification in place with the dentist / organisation providing the service.

The number of prisons that were providing toothbrushes and fluoride toothpaste to prisoners and had an oral health promotion programme in place had increased markedly.

Clinical Governance

The number of prisons that had a clinical governance programme in place including policies for identifying and managing potential security and cross infection risks had increased significantly over the last three years.

Dental Equipment

The number of inspections of dental surgeries and equipment by PCT General Dental Practice Advisors had doubled.

Workforce

Nearly half of prisons reported that the morale of their prison dental staff had improved.

Additional Questions

Over half of the prisons that responded to this questionnaire reported that the quality of the prison dental service had improved.

The number of prisons that included a dental assessment with the general healthcare assessment on admittance had doubled.

The evaluation was hampered by a lack of standardised, routinely collected data on the performance of prison dental services.

Recommendations

There are significant challenges for PCTs as commissioners of prison services to improve the dental health of prisoners and the quality of dental services provided to them. Standardised data sets need to be devised and agreed, and information systems to collect these data are required to support strategic development and to enable efficient performance management of prison dental services.

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1. Background

In April 2003 the Department of Health together with Her Majesty's Prison Service published a document entitled 'Strategy for Modernising Dental Services in England'. The aims of this strategy were to help prisons, working with their NHS partners, to:

- Improve the quality of dental care in prisons by ensuring high quality standards are in place, based on the principles of clinical governance and robust audit trails.
- Raise the awareness of good oral health throughout the prison, amongst prisoners, prison staff and voluntary agencies working in prisons.
- Identify resources and operational issues specific to prisons that are required for each prison to meet the dental needs of prisoners.
- Ensure that cost effective dental services are commissioned to meet the oral health needs of prisoners including appropriate performance measures.
- Develop a model service specification for the provision of dental services in prisons that will enable prisoners to have access to dental care appropriate to their needs.

To accompany the strategy £4.75M of funding was provided to prison healthcare services to support the implementation of the strategy. However, this money was not ring-fenced for dentistry and at the time there were concerns within the dental profession that not all of this new funding would be spent on improving dental services.

The Prison Health Research Network is a Department of Health initiative that aims to develop the infrastructure needed to establish and sustain a strong programme of research and development in prison health care. In 2005 the dental team of the PHRN was asked by the Office of the Chief Dental Officer to evaluate the impact on prison dental services of the national strategy and the additional funding that had been provided by the Department of Health.

2. Aim of the Evaluation

The aim of the evaluation was to measure the reported changes in prison services between 2003 and 2006 in each of the key areas identified in the Strategy for Modernising Dental Services in England (April 2003). In addition the evaluation would seek to gauge the morale of prison health care staff and record the views of health care staff on specific problems with the service.

3. Key Recommendations within the Strategy

The national strategy concentrated on six key areas for the modernising of prison dental services in England. They were:

3.1 Service Specification & Access

The key recommendations under this theme were concerned with waiting times for access to dental services. Specifically the strategy recommended that prisoners with an urgent need should be able to access dental care within 24 hours and prisoners requiring routine dental care should be able to access the service within 6 weeks. Prison dental services would also be expected to have an oral health promotion programme in place and have an agreed service specification in place with the dentist or organisation providing the service.

3.2 Contracts Standards & Commissioning

Recommendations in this area suggested that a service specification should be a key component of the overall contract between PCTs and prisons and between prisons and service providers. The strategy recommended that the length of each dental session should be 3 hours and it set a standard for the amount of care that should be provided for prison populations, stating that as a minimum, one dental session should be provided per week for every 250 prisoners.

3.3 Commissioning

The strategy lays out the four main ways of commissioning dental services within prisons:

- commissioning services from independent contractors working on either GDS or PDS contracts
- from salaried dental services
- from prison dental services
- through a private dental contract at a fixed price per session

The potential influence of the Health and Social Care (Community Health and Standards) Bill and local commissioning of all NHS dental services on prison dental services was also recognised.

3.4 Clinical Governance

The strategy recognised that clinical governance is an essential part of all clinical services and is particularly important in prison dental services that provide care for high-risk populations. The strategy recommended clear lines of responsibility for the quality of clinical care should be established. Services should have regular quality assurance checks and all prisons should have a daybook to record activity and have an effective complaints procedure. The importance of continuing professional development of prison dentists was stressed and the strategy recommended that this should be monitored and supported. The risks of inadequate cross infection control were also recognised and the strategy recommended that PCT General Dental Practice Advisors (GDPAs) should undertake inspections of the dental surgery and equipment at least once every 3 years.

3.5 Dental Equipment

The strategy concentrates on the general standards for the safe and effective running of the prison dental service and summarised the standards and regulations that all dental equipment must comply with. The GDPA visits should include an inspection of the dental surgery and all equipment. This is to ensure that standards within the prison dental service are equal to those in the General Dental Practice.

3.6 Workforce

The strategy stressed that it is essential that all dentists working within the dental service should undertake continuing professional development and hold appropriate qualifications. In addition the strategy recognised that skill mix could play an important part in delivery of prison dental services. The strategy recommended also that prisons should keep abreast of developments concerning the extension of skills and roles for dental care professionals.

4. Methodology

The report focuses principally on access and quality of services measured by reference to the specific recommendations set out in the strategy. A postal survey was used to gather the relevant data to measure change between 2003 and 2006. A questionnaire was developed to measure compliance of prisons against the standards set out in the strategy. The questionnaire focused on four of the six categories in the strategy with clearly identifiable recommendations, which could be measured over time. They were:

- Service Specification & Access
- Contracts, Standards & Commissioning
- Clinical Governance & Dental Equipment
- Workforce

Ideally, baseline data should have been collected prior to the implementation of the new strategy. This was not possible, as the evaluation was commissioned after the process of implementation of the strategy had started. Therefore the questionnaire asked healthcare managers working in each prison to provide retrospective information on the situation as it stood in January to March 2003 prior to the publication of the strategy, and to provide information on service delivery for the same period in 2006. The questionnaire was piloted with healthcare staff in two prisons in the Northwest of England and minor changes were made to the wording and presentation of the questionnaire.

The survey included all 134 prisons in England. A covering letter was addressed to the prison governors, which requested that the questionnaire be passed onto the prison healthcare manager for completion.

The questionnaire was posted in three waves during the months of January, February, March and April 2006. The prisons were given five weeks between each wave to complete and return the questionnaire. After the five-week period had lapsed the non-responders were sent another questionnaire with a copy of the previous covering letter. This process was repeated until the three waves had been completed over a 15-week period.

A prepaid, addressed envelope was supplied for the return of completed questionnaires. Replies were sent to the Prison Health Department, in the Department of Health and civil servants in the department collected and forwarded the completed questionnaires onto the University of Manchester for processing.

Once the questionnaires were received by the research team, data from the questionnaires were loaded into a computer for analysis. Every 5 entries were double-checked for accuracy. Analysis consisted of calculating simple counts and percentages to describe the situation in 2003 and 2006 for the key issues identified in the strategy.
The responders were given the opportunity to add additional comments on issues that they perceived to be important in the questionnaire. These data were collected as free text responses to the statement *'If you wish to provide additional comments please do so here. This might include, for instance, your views about significant challenges faced in providing health care in your prison.'* Responses to this statement were thematically analysed.

5. Findings

All 134 prisons in England were included in the survey and 109 responded giving a response rate of 81.3%. However, several prisons felt that they could not complete the questions related to 2003 as the health care manager completing the survey was either not in post at that time or there were no historical records available for that period to refer to. This led to varying levels of item non-response for different questions; the denominator used in each analysis was the population providing a response to each question for the situation in 2003 and 2006. Item non-response for each question was reported.

The analysis of the survey is based on the key areas identified in the recommendations of the strategy. The majority of prisons had difficulty in providing accurate data on the mean number of dental sessions provided and the mean number or prisoners seen each week for the 2003 reference period. Likewise, historical information on ratios of prison dental sessions to prison population was not available. Therefore comparisons could not be made between the capacity of dental services and activity levels before and after the implementation of the national strategy. The survey asked additional questions on morale of the workforce. A single item subjective question was introduced asking if, in the opinion of the health care manager, the prison dental service had improved in quality. The findings of the study are laid out under the following headings:

- Service Specification & Access
- Clinical Governance
- Dental Equipment
- Workforce
- Additional questions
- Free text comments by responders

5.1 Service Specification & Access

The strategy states that all prison dental services should have completed a robust costed action plan by the end of November 2003. Table 1 sets out the compliance with this recommendation as reported in 2006. Prison healthcare managers reported that approximately three quarters of prisons had a plan in place in 2003. This finding provides some concerns that even though this was a requirement of the strategy published in 2003 a quarter of prisons still didn't have an action plan in place at that time. Sub analyses demonstrated that those prisons without an action plan consistently under performed in other areas set out in the strategy when compared with those prisons with an agreed action plan.

Specific issues raised in the questionnaire	Compliance by the end Nov 2003 N & (%)
To enable modernisation of prison dental services each prison will be expected to have completed a robust costed action plan by the end of November 2003.	75 (72.8)

Table 1: Responses to questions: Service Specifications & Access

Under the theme of Service Specifications & Access, the strategy was particularly concerned with the length of waiting lists for prisoners who wish to access both urgent and routine dental care. The findings in Table 2 demonstrated an increase in the number of prisons that can now offer urgent dental care within 24 hours and routine dental care within 6 weeks. However, for both of these key indicators, over 30 percent of prisons in 2006 were still unable to meet the standard set by the strategy. There had also been an increase in the number of prisons that had produced an oral health promotion programme. The majority of prisons now had an agreed service specification in place with the individual dentist or organisation providing the dental service in their institution.

Specific issues raised in the questionnaire	Compliance in 2003 N & (%)	Compliance in 2006 N & (%)
All Health Care Managers should ensure that they have an agreed service specification with the dentist providing the service.	52 (55.3)	85 (82.5)
All prisoners will be given information during reception about how to access health care, including dental services.	72 (80.9)	98 (97)
Urgent care for dental pain and minor trauma will require access to a dentist within 24 hours.	51 (54.3)	76 (71)
Appointments for routine care will not normally exceed 6 weeks from time of asking.	31 (47.7)	62 (65.3)
All prisons must develop an oral health promotion programme in conjunction with their health care.	11 (10.8)	44 (41.1)
Prisoners should have ready access to fluoride toothpaste and toothbrushes and other oral health materials.	75 (79.8)	101 (97.1)

Table 2: Responses to questions: Service Specifications & Access

5.2 Clinical governance

The strategy recognised the importance of clinical governance, particularly in this high-risk population. Table 3 demonstrates a dramatic increase in the number of prisons that had a clinical governance programme in place. Additionally, improvements had occurred in all other areas identified in the national strategy, such as having effective complaints procedures in place for both the prisoners and professional staff.

Specific issues raised in the questionnaire	Compliance in 2003 N & (%)	Compliance in 2006 N & (%)
All prisons should have a Clinical Governance programme.	30 (31.3)	91 (90.1)
All prisons should have a clinical governance programme that should include the following: Clear policies for identifying and managing potential security risks.	81 (89)	97 (97)
All prisons should have a clinical governance programme that should include the following: Clear policies for identifying and managing potential cross infection risks.	56 (62.9)	101 (97.1)
Effective complaints procedure for patients to be in place that reflects best practice in the NHS.	50 (53.2)	94 (90.4)
Process must be in place for any member of the professional team to raise concerns in a confidential and structured way.	60 (55)	96 (93.2)
All prisons should have a daybook to record activity legibly.	63 (70)	83 (82.2)

Table 3: Responses to questions: Clinical Governance

Table 4 reports the number and proportion of prisons that received a visit from a Dental Reference Officer each year from 2003 to 2006 (inclusive). The proportion of prisons being inspected each year was fairly constant at 30 percent.

Specific issues raised in the questionnaire	Compliance in 2003 N & (%)	Compliance in 2004 N & (%)	Compliance in 2005 N & (%)	Compliance in 2006 N & (%)
Dental Officers from the Reference Service must be invited from the Dental Practice Board (DPB) to undertake quality assurance.	24 (32.4)	30 (39)	31 (36.5)	30 (37.5)

Table 4: Responses to questions: Clinical Governance

5.3 Dental Equipment

The strategy recommends that the PCT's GDPA should undertake visits at least every 3 years to monitor clinical governance arrangements and inspect the dental surgery(s) and equipment. Table 5 shows that prison health care managers reported that the number of inspections by GDPAs undertaken each year since 2003 had increased markedly.

A PCT General Practice Advisor (GDPA) should undertake an inspection of the dental surgery and equipment every three years.	
	Compliance N & (%)
Compliance in 2003	30 (38.5)
Compliance in 2004	37 (45.7)
Compliance in 2005	69 (70.4)
Compliance in 2006	61 (67.8)

Table 5: Responses to questions: Dental Equipment

5.4 Workforce

The strategy recognised the importance of job satisfaction for those working in the prison dental service. From the reported data, Table 6 shows that 40.9 percent (N=38) of prisons reported an increase in job satisfaction in their dentists between 2003 and 2006.

Specific issues raised in the questionnaire	**YES N & (%)**	**NO N & (%)**	**NO CHANGE N & (%)**
Do you think that the morale of prison dental service staff has improved from January 2003 to January 2006	38 (40.9)	15 (16.1)	40 (43)

Table 6: Responses to questions: Workforce

Table 7 summarises the results concerning support for, and monitoring of, continuing professional development of prison dentists. It appears from the reported data that there had been an increase in the number of prisons ensuring that dentists were undertaking continuing professional development. The data also demonstrated a rise in the number of prisons ensuring that the dentist had the appropriate qualifications to practice.

Specific issues raised in the questionnaire	**Compliance in 2003 N & (%)**	**Compliance in 2006 N & (%)**
All prisons will ensure that the dentist has appropriate qualifications.	86 (90.5)	98 (93.3)
All prisons will ensure that the dentist undertakes appropriate Continuing Professional Development.	39 (42.4)	74 (72.5)

Table 7: Responses to questions: Workforce

5.5 Additional Questions

A series of questions was asked about how the service was provided in each prison. The questions identified the subjective views of prison health care managers on the general quality of the dental services and the morale of the dental providers.

Table 8 summarises the number and percentage of prisons contracting with different providers. The largest proportion of prisons reported contracting with private providers for their prison dental services, paying a fixed session price for a service.

The survey asked:	GDS N & (%)	PDS N & (%)	CDS N & (%)	Private provider N & (%)
Who provides the dental service in your prison?	20 (18.7)	8 (7.5)	29 (27.1)	50 (46.7)

Table 8: Responses to additional questions

Table 9 reports the subjective opinion of prison health care managers on whether or not there had been an improvement in the overall quality of the their dental service between 2003 and 2006. A large majority (67.6%, N=71) of prison health care managers thought that the quality of services had improved during this period.

The survey asked:	YES N & (%)	NO N & (%)	NO CHANGE N & (%)
Do you think the quality of the service has improved from January 2003 to January 2006?	71 (67.6)	12 (11.4)	22 (21)

Table 9: Responses to additional questions

Table 10 summarises the responses to a question concerning whether a routine dental assessment was provided for each prisoner on entry to the prison. Although the number of prisons offering a dental assessment to all new prisoners on admittance has doubled between 2003 and 2006, only about a fifth of prisons offer this service.

The survey asked:	Compliance in 2003 N & (%)	Compliance in 2006 N & (%)
Was a dental assessment provided for all new prisoners on admittance in 2003 / 2006?	10 (9.7)	22 (20.8)

Table 10: Responses to additional questions

There have been concerns about inefficient use of dental session in prisons. Table 11 provides information on the main reasons why dental sessions are lost. It can be seen that annual leave (45.3%) was reported to be the main reason for loss of the clinical service. This could be due to difficulties in finding locum dentists to cover holidays.

The survey asked:	Annual Leave N & (%)	Sick Leave N & (%)	Annual & Sick Leave N & (%)	Other N & (%)	No sessions lost N & (%)
What was the main reason for dental sessions being lost?	43 (45.3)	6 (6.3)	11 (11.6)	7 (7.4)	28 (29.5)

Table 11: Responses to questions: Additional Questions

Table 12 reports items of major equipment procured by prisons in the three-year period under investigation. Of the 106 prisons that responded to this question over half (N=60) reported that they had a total surgery refurbishment. Each of the items is not mutually exclusive as the prisons could procure more than one item on the list.

The survey asked: Have any of the following major items of capital equipment been procured since April 2003?	
Equipment	**N (%) of prisons that had procured items**
Refurbishment of dental surgery	60 / 106 (56.6%)
Radiograph equipment	38 / 105 (36.2%)
Autoclaves	60 / 105 (57.1%)
New clinical instruments (over £1000)	37 / 105 (35.2%)
Compressor	46 / 105 (43.8%)
IT Hardware	32 / 105 (30.5%)
Other (over £1000)	13 / 103 (12.6%)

Table 12: Responses to questions: Additional Questions

5.6 General comments (qualitative data)

The survey provided an opportunity for respondents to make additional comments on the provision of dental health care in their prison. Health care managers were encouraged to provide their views on how the service had developed over the last three years and highlight any current problems within the service. Many responders reported that a key problem was dental appointment slots being wasted. This is an important issue as the national strategy recommends that *'The prison must ensure a commitment is made to utilise the dental time to its maximum capacity'.* The reasons for wasted appointment slots included appointment slips not being given, or given late to the prisoners and therefore prisoners were unaware that they had a dental appointment and failed to attend. Prisons also reported that court attendances and social visits resulted in significant numbers of appointment slots being wasted.

Several respondents reported that in many instances prisoners simply refused or forgot to attend appointments. There were other multiple reported reasons for appointment slots being wasted, although these reasons were infrequent. They included:

- prisoners being discharged but the appointment book had not been altered
- the prison roll being incorrect.
- general prison security issues.
- not enough staff to man the healthcare department, for example, no one to escort the prisoners to and from the healthcare department.

- prison officers not bringing prisoners to the healthcare department for their appointments.
- poor dental equipment which broke down regularly leading to dental sessions being cancelled.
- prisoners not accepting responsibility for their own healthcare.

A small number of prison reported implementation of systems which had dramatically reduced wasted appointment slots. These included a 'replacement' system if a prisoner refused or failed to attend an appointment. In these cases another prisoner is seen in their place immediately. The problem of missed appointments was more acute in category A and B prisons and those with a large proportion of remand and short stay prisoners. Those prisons in lower security categories and with a more static population had fewer appointments missed.

Respondents reported additional comments for the reasons why whole or part of dental sessions were lost. These included sessions on bank holiday Mondays, surgeries not available, surgery closed for refurbishment, security concerns, general prison procedure and dentists arriving late at the prison. Several prison managers were concerned about the number of Monday sessions they were losing due to bank holidays and some reported that they had moved the dental sessions to another day to address this issue.

A number of prisons reported that their main concern was the length of the waiting lists. It appears that in prisons where escorts were not needed the waiting lists were shorter as prisoners could make their own way to the healthcare department. A further concern with regard to waiting lists was the fact that it was difficult to replace lost sessions. Additionally, many healthcare managers reported that the number of sessions available was inadequate for the high need population they were responsible for. A few respondents reported that the service was under resourced and stretched to its limit with no 'real' investment, and dental equipment was not robust enough to deal with the amount of work that needed to be carried out. Many who provided qualitative information felt that the equipment in their prison was too old to provide a reliable service.

A number of respondents thought that hygienists and therapists could do the majority of the work and dental nurses could be used to assess the needs of the individual prisoners when they request an appointment. One prison reported that they were currently thinking about employing a dental nurse to ensure continuity of service.

A recurrent theme highlighted by many healthcare managers was the problem of recruiting dentists. Many felt that prison dentists were an isolated group with no national structure to provide peer support and to share information about good practice.

6. Commentary on the findings

This evaluation provides useful information on how prison dental services have changed since the publication of the Strategy for Modernising Dental Services for Prisoners in England. It is important to recognise that the evaluation was hampered by a number of factors.

The findings are based on reported data from prison healthcare mangers; there were no high quality independently validated data from other sources to compare with the responses obtained from healthcare managers.

The Business Services Authority Dental Practice Division could only provide data for those prisons that had a contract with GDS and PDS providers. Robust activity data was not available for the period prior to publication of the strategy. The lack of a single data set providing information on how the service was organized and delivered posed serious problems as this shortage of relevant data prevented effective analysis of performance associated with the key issues identified in the strategy.

More fundamentally, the evaluation was compromised as it was commissioned after the strategy had begun to be implemented and therefore high quality baseline data could not be collected. A detailed baseline audit of healthcare processes and procedures in prisons could have provided richer information, however such an approach would also have come up against the obstacle of no, or poor data. Additionally resources to pursue this methodology were not available.

Acknowledging the caveats about data quality large improvements were reported in each of the key areas examined.

6.1 Service Specification & Access

Although there have been dramatic improvements reported, some problems remain. More than 25% of prisons reported that they still did not have an action plan in place in 2006 even though there had been a requirement to have one in place by November 2003. Those prisons without a plan under performed in almost every area when compared to those with an agreed action plan. It is difficult to see how a methodical approach to improving services can be delivered without a clear plan stating the agreed aims and objectives for the service.

The key recommendations under this theme are:

- To reduce waiting times for prisoners accessing urgent and routine dental care
- To produce oral health promotion programmes in prisons
- To agree service specification with the dentist / organisation providing the service.

The strategy states that prisoners must have access to urgent dental care within 24 hours of asking and access to routine dental care within 6 weeks of asking. The reported data demonstrated that there had been an increase in the number of prisons that could provide urgent care and routine care within the given time limits. Reported access had improved dramatically over the three years for patients with urgent treatment needs, with 70 percent of prisons meeting the target in 2006 compared to 54 percent in 2003. However, over 30 percent of prisons were still failing to meet these essential targets for access to urgent and elective

care.

All prison dental services were expected to have an oral health promotion programme in place. The data provided shows the number of prisons with a programme in place had increased from 10.8 percent in 2003 to 41.1 percent in 2006. It was reassuring that there was a significant increase in the proportion of prisoners who had daily access to fluoride toothpaste.

Prison dental services were also expected to have an agreed service specification in place with the dentist or organisation providing the service to the prison. From the data provided the number of prisons with a service specification in place had increased from 55.3 percent in 2003 to 82.5 percent in 2006.

6.2 Clinical Governance

Clinical governance is an essential part of any clinical service especially for services that provide care for high-risk populations such as prisoners.

The strategy recommends that all prison dental services have regular quality assurance checks, a day book to record activity daily, an effective complaints procedure so that prisoners can make a complaint, and a process for any member of the professional team to raise concerns in a confidential and structured way. The reported data demonstrate an improvement in all of these areas.

Additionally, the strategy recognises that visits from General Dental Practice Advisors (GDPA) every three years were essential. The number of visits to prisons by GDPAs had dramatically increased since 2003 and these visits were being supplemented by visits from Dental Reference Officers from the Dental Practice Division of the NHS Business Services Agency.

6.3 Equipment

The questionnaire data showed that there had been considerable capital investment with over half of prisons having a complete surgery refurbishment. This information should allay fears that the additional investment, which accompanied the strategy, did not go into dental services.

6.4 Workforce

It is essential that all dentists working within the prison dental service should be undertaking CPD and have checks to ensure that they have the appropriate qualifications to practice. The reported data showed that there had been an increase in the number of prisons with a procedure in place to monitor CPD activity and all dentists working within the prison environment have the appropriate qualifications to practice.

It was not possible to gather accurate data on the number of sessions that dentists worked in prison in 2003 or 2006 due to the lack of data. Equivalent information on Dental Care Professional activity was also unavailable. A reported increase in morale of the prison staff after publication of the strategy was good news and should have beneficial effects on retention and recruitment of staff.

The reasons for inefficiency of prison services were articulated in the text responses to open ended questions. In a service that always had to take into account security issues there would always be difficulties in minimising disruption and running a service at a high level of efficiency. From April 2006 responsibility for commissioning prison dental services passed to PCTs. This report highlights some of the challenges PCTs will have to tackle to ensure value for money in commissioning dental services in this unique environment. Some sensible solutions have been suggested to deal with some of the inherent problems of running a dental service in prisons, other examples of good practice have been described in a recent report by the Office of Public Management entitled Reforming Prison Dental Services in England – A Guide to Good Practice (July 2005). PCTs face a new set of problems if they are to effectively commission and performance manage prison dental services. This evaluation identified a lack of standardised robust information, which was a significant hindrance to PCTs if they are going to commission prison dental services effectively.

7. Recommendations

Although this evaluation reported an improvement in virtually all areas of prison dental services over the last three years, probably the most important finding was the lack of high quality standardised information. It is clear that PCTs cannot effectively commission prison dental services without robust service information. This information needs to be standardised across the whole system to enable PCTs and prisons to make comparisons between services and to benchmark performance.

7.1 National minimum data sets are needed to support a number of PCT requirements, these include:

Health Needs Assessment – agreement is needed on a group of key health indicators to assess the healthcare needs of prisoners.

Service Delivery - agreement is needed on a group of key measures to assess service delivery against a contract. These must relate to the standards set out in the national strategy, which can act as a basis of a commissioning framework for prisons. These data must be able to be externally audited to ensure that reporting is valid.

Quality audit tool - a standardised dental service inspection proforma is needed for GDPAs to ensure quality standards are being met.

7.2 A national working group should be charged with the task of defining the content of these minimum data sets

7.3 PCTs and prisons should set up the necessary information systems to provide the data identified by the working group.

8. References

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9. Acknowledgments

The authors of this report are:

Prof. Martin Tickle
Prof. of Dental Public Health & Primary Care
The University of Manchester

Miss Katie Buchanan
Prison Dental Research Co-ordinator
The University of Manchester

Dr Keith Milsom
Consultant in Dental Public Health & Primary Care
Halton & St Helens PCT

Dr Liana Zoitopoulos
Consultant / Honorary Senior Lecturer
Head of Community Special Care Dentistry
Kings College London Dental Institute

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School of Dentistry
The University of Manchester
Higher Cambridge Street
Manchester
M15 6FH