Reforming prison dental services in England

A guide to good practice

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Foreword by Professor Raman Bedi, Chief Dental Officer, England

Any healthcare system that aspires to improve the health of the population it serves and to reduce the inequalities between those with the best and those with the poorest levels of health must pay close attention to the most deprived and excluded sections of the community. Those in prison, either on remand awaiting trial or in receipt of a custodial sentence, have been shown to have poorer health, including oral health, than the general population.

The prison dental service, therefore, has two challenges. First, there is the need to provide high quality services to treat the dental disease with which prisoners present. Those needing urgent treatment on admission to prison should be seen as soon as possible. All prisoners need to be able to access dental care appropriate to their dental needs and length of time in prison. Second, there is a responsibility to try to reduce the amount of dental disease that the prisoners will have in the future. This will entail, for example, providing advice on healthy lifestyles such as regular and effective tooth brushing with a fluoride toothpaste and linking with others giving advice on the cessation of tobacco use and on making healthy choices in relation to diet and nutrition.

In the past, the provision of dental services in prisons has been of variable quality. For this reason, the *Strategy for Modernising Dental Services for Prisoners in England* was published in 2003. Every prison was required, in consultation with the local primary care trust, to develop a Dental Action Plan for improving their dental service. £4.75 million over three years was allocated towards the implementation of these plans.

I am most grateful to the Office for Public Management for undertaking this review which has assessed what progress has been achieved so far and identified a number of examples of ways in which prisons have improved their dental services. This report enables a sharing of these examples of good practice so that other prisons can consider whether what has worked well elsewhere might also be appropriate for them.

There are recommendations for primary care trusts, strategic health authorities and prison health services. It is important that the start that has already been made in improving prison dental care can be maintained and developed so that standards are comparable to those in the wider community and the dental health of prisoners, whilst they are in prison and after release, is improved.

I commend this report to the NHS and prison authorities.

Professor Raman Bedi

Chief Dental Officer, England

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Introduction

In April 2006, primary care trusts (PCTs) will take full responsibility for commissioning prison dental health services in their area. Prison health care and the commissioning of primary dental care are both new responsibilities for PCTs; for some organisations, putting the two together will prove to be a significant expansion of their roles and responsibilities.

The 'good news' is that there is now a clear vision about what modern prison dental care should look like. Consequently, there have been some real improvements in the level and quality of prison dentistry in the 135 prisons in England in the last few years (See Appendix 1 for a full list of prisons). The majority of prisons are well aware of what they need to do to improve these services and equally aware of the challenges they need to address in meeting them. There are also early signs of very positive relationships between prisons and their local primary care trust that illustrate the benefits of linking prison healthcare to mainstream services.

The Chief Dental Officer's commitment to modernise prison dental health led the Department of Health to commission the Office for Public Management (OPM) to review current practice in prison dental health and produce this good practice guide.

Our review draws on several sources of information: a qualitative and quantitative analysis of 120 Prison Dental Health Action Plans; a survey and telephone interviews with prison health care managers; analysis of the Department of Health prison waiting lists data; and some case study visits to exemplar prisons, selected because they provided insights into particular aspects of good practice. You can find further details about these sources in Appendix 2, together with information about the approach we took to developing this guide.

Overview of the guide

The guide has been written for prison dental health leads in strategic health authorities (SHAs) and primary care trusts (PCTs) and for prison health care managers. The guide falls into four parts.

Part one sets the policy context and summarises the key elements of the Department of Health's (DH) strategy for modernising prison dental care

Part two outlines the main challenges of providing dental care in prisons: the factors that make it more difficult to provide dental services to prisoners than to the general population.

Part three looks at how these challenges are being addressed in prisons across the country and highlights examples of existing good practice and other ideas about how the challenges can be addressed.

Part four recommends some actions for prisons, PCTs and SHAs to consider

Part one:
What are modernised prison dental services?

In April 2003 the Department of Health took over responsibility for prison health services from the Home Office. In the same month, the Chief Dental Officer launched his 'Strategy for Modernising Dental Services for Prisoners in England'. The strategy recognised that there was an urgent need to improve dental care within prisons. Demands on prison dental services had increased, not least because of the growth in the prisoner population. Waiting times, particularly for routine treatments, had been growing and were in excess of NHS waiting times. In addition, there was considerable variation between prisons in the quality, type and availability of dental services.

The strategy set out recommendations about the standards of dentistry in prisons and this was backed by a three-year investment programme in England amounting to £4.75m over three years. A top priority for this funding was the reduction of long waiting lists. In the light of the strategy, each prison was asked to prepare an action plan for modernising its dental services and the majority of risons completed these in Autumn 2003.

A further recommendation in the strategy was that prisons should aim to provide at least 1 dental session per week for every 250 prisoners. This was intended as a guide that would need to be interpreted flexibly depending on the needs of the inmates and the characteristics of the prison – for example, high security prisons where fewer patients tend to be treated per session due to security issues may need to provide a larger number of sessions than this indicative level.

A modernised prison dental service will:

- Offer a universal service based on clinical need
- Provide an appropriate range of dental services
- Shape services around the needs of patients
- Be responsive to the needs of different prison populations
- Continually improve its services
- Support staff
- Co-operate with others
- Work to reduce health inequalities
- Offer open access to information about services and treatments.

From the Strategy for Modernising Dental Services for Prisoners in England (D0H) April 2003

The target waiting times for emergency, urgent and routine dental care reflect the general guidance from the NHS on dental access:

- Emergency care, for example severe facial trauma and severe bleeding, may require access to an accident and emergency department, in line with local health care provision and subject to local prison security policies.
- Urgent care for dental pain and minor trauma will require access to a dentist within 24 hours. Where this cannot be achieved, an appropriate practitioner will see the patient within 24 hours to make an assessment as to the appropriate course of action.
- Appointments for routine care will not normally exceed six weeks from time of asking.

From the Strategy for Modernising Dental Services for Prisoners in England (D0H) April 2003

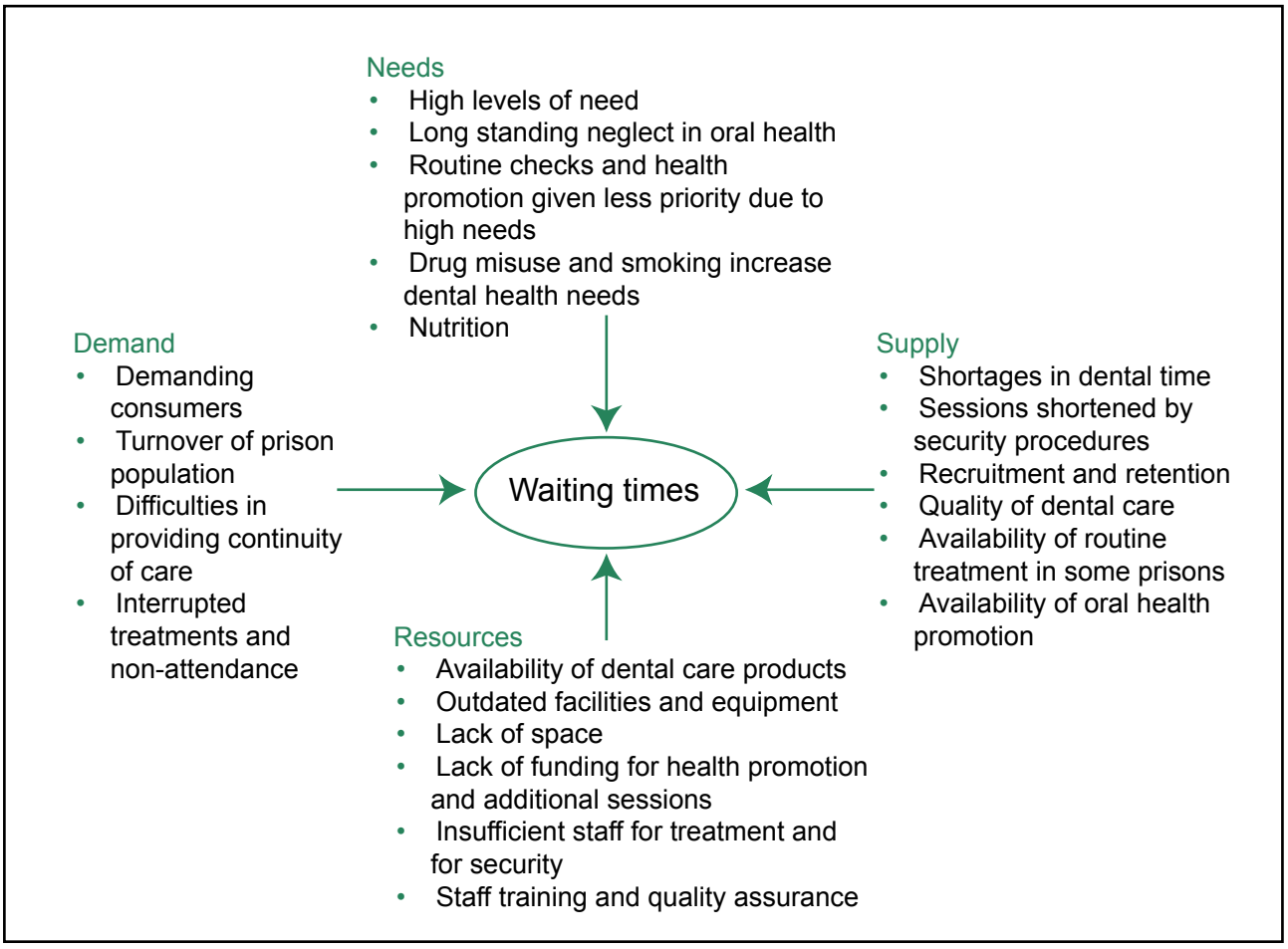
Part two:
The challenges in providing dental care to prisoners

'The amount of untreated dental disease amongst all prisoners is approximately four times greater than the level found in the general population coming from similar social backgrounds.'
– Strategy for Modernising Dental Services for Prisoners in England 2003

In this part of the guide we explain some of the challenges that prison health departments have to cope with in organising and providing dental care.

Prisoners' dental health needs are comparatively high. There are several factors that contribute to those needs both prior to prison admission and during the sentence itself. These needs and the nature of prison stays lead to high levels of demand for emergency, urgent and routine care. The resources available to meet those needs are currently stretched and the ways in which the services are provided sometimes mean those resources are not always used as efficiently as they might be. Figure 1 summarises the most significant challenges facing PCTs and prison health care providers. These are outlined more fully in the rest of this section.

FIGURE 1: THE CHALLENGES IN PROVIDING EFFECTIVE DENTAL CARE TO PRISONERS



a) The dental health needs of prisoners

- **High number of emergency and urgent cases.** There are a high number of emergency and urgent cases that must be prioritised over routine care. If routine care is neglected there is the risk that emergency needs will continue to spiral.
- **Neglect of oral care amongst prisoners.** Many prisoners enter prison with extensive and long-standing oral neglect. This may be due to lack of knowledge about good oral health practices. A number of prisons cited 'poor inmate knowledge of causes of dental disease' as being a key challenge for the improvement of prison dental health. This in turn may be linked to previous difficulties in accessing dental care in England or in the country of origin.
- **Substance misuse and smoking.** Substance misuse and smoking also pose a particular challenge to dental health. Methadone contributes to higher levels of tooth decay and gum disease and smoking is a risk factor in mouth cancer. Prisoners with substance misuse problems are likely to report toothache very soon after entering prison, as the pain is no longer inhibited by the analgesic properties of the drugs they had previously been taking: '*… only when detoxed do prisoners know the full extent of their pain*.' There are also cross-contamination issues related to drug misuse, as a number of prisons have populations with a high level of blood-borne disease infection. For example, in HMP Ranby, the prevalence of Hepatitis C and Hepatitis B is 20% and 11% respectively.
- **Nutrition**. The dietary regime in prison can also have an effect on oral health needs. Access to fresh fruit and vegetables and health eating options is a challenge in some prison environments.

b) Demand for dental care in prisons

- **Growth in the prison population**. The prison population in England and Wales has grown by over 11% since 1998 (Home Office Research). This in itself has increased demand for dental care. In some prisons where there has been significant increase in the number of inmates there has not been a corresponding increase in the level of dental care. '*We are already struggling to cope with the demand for a dentist… soon there will be another 300 prisoners… with no further dentist cover arranged seemingly.*'
- **The demanding nature of prison populations.** Prisoners can be surprisingly demanding clients. They tend to be more likely to know their rights than the general population and more likely to take legal action if they feel that are not being provided with the services to which they are entitled. Not all urgent demands are truly 'urgent' and some prisoners will exaggerate their symptoms either as a way of getting treatment quickly or as a way of 'testing' the system.
- **Demands presented by foreign nationals**. In some institutions, there is a high percentage of detainees who are foreign nationals. On release, many will be returning to their home countries where dental provision may be difficult to access so their demands for treatment whilst in prison will be informed by that knowledge. '*The population is very demanding of dental services. 70% of our ladies are foreign nationals who wish to access services before they return to their home countries.*'
- **Chaotic lifestyles and ability to self care**. Prisoners vary in their ability and motivation to take care of their own oral health. Those that enter prison with a previously chaotic lifestyle may be more disposed to expect treatment than take responsibility for preventive approaches that they can carry out themselves.
- **High turnover of prisoners** can fuel additional demands. The high turnover of prisoners in some institutions, particularly in remand or short-stay institutions, can act as a barrier to effective dental care. In some cases, waiting lists are so long that prisoners do not reach the top of the list before they are transferred elsewhere, only to be put to the bottom of another waiting list. In the event that treatment is commenced, the work may not be completed before the prisoner moves on. This has the effect of inflating waiting lists. '*As a large, local prison with a significant number of remand,*

and short-stay prisoners, combined with necessary measures to control overcrowding, there is a considerable throughput of prisoners which makes it difficult to give continued treatment.'

- **Demand for cosmetic treatment**. In some prisons there are difficulties in addressing what some prison health care managers perceive to be 'unrealistic' or 'inappropriate demands' particularly for cosmetic treatments. '*Many of the boys have no idea of the care they should be giving their teeth and only attend the dentist if they are in pain or if they wish to have fashion work carried out.*' '*Cosmetic treatment requests are too high.*' '*There are problems around unrealistic demands such as cosmetic treatment…*'

c) Supply of dental care

- **Shortages in dental time**. Not all prisons currently provide the recommended level of 1 dental session per week per 250 prisoners and as we mentioned earlier this may not be an appropriate standard for all institutions. Many prisons experience difficulties in attracting dentists, hygienists and support staff to work there. Shortages of security staff to supervise clinics can also have an impact on the level of care available (see section on Security).
- **Recruitment and retention of dentists**. Against a background of a national shortage of dentists in England it is not surprising that there are real difficulties in attracting dentists to work in prison dentistry. Some prisons have, or have had, difficulty in securing the services of a dentist who is reliable, provides a high standard of care and is willing to work within the service specification set out in the national strategy. '*I know the PCT has the same problems and I have discussed the problem with them but staff are very difficult to recruit in this part of the country.*'
- **Quality of dental practitioners**. Given the difficulties that exist in attracting dentists, prison health care managers can be reluctant to tackle instances of poor performance due to the risk of this leading to no service at all. '*The dentist refuses to attend clinical governance meetings.*' '*The dentist does treat patients but does not spend time in health promotion. The prison has tried to address some of these issues but the particular practitioner is reluctant to change.*' In a further example, the prison dentist was only prepared to provide one session every six weeks but the prison was reluctant to tackle the problem head on.
- **Availability of nurses, therapists and hygienists**. For a variety of reasons – space, funding, and recruitment difficulties – many prisons have found it difficult to expand the dental workforce beyond dentists. Of the prisons surveyed, just under one-fifth reported a need for a dental hygienist who could help in providing provide targeted oral health advice and preventive care. Similar shortages were reported in dental nurses who can help in undertaking x-ray and triage.
- **Security** is one of the key areas of performance for prisons. Not surprisingly there are various ways in which security and the regulation of prisoner movement can affect the provision of dental care. The net effect of factors such as prisoner supervision, security checks on dentists and checks on instruments before and after sessions is that the actual clinical time available for dentists to actually treat patients is shortened. '*Counting all the instruments at the end of the day takes time.*' '*Sometimes we have dentists there and nurses but no patients. It's dependent on the Governor releasing prisoners to come. The Governor has targets to meet on education and work, but not health'*
- **Movement of prisoners to the dental surgery.** The logistics of transporting prisoners around the prison to their dental appointments can be complicated. Even if prisoners are on 'free flow' and able to go to their appointments unescorted, this can result in problems at the surgery in terms of managing the influx of patients. If security requirements stipulate that prisoners must be escorted to and from their appointments, this may have implications for staffing. It is not always clear who should be responsible for providing escorts – whether it should be prison health care staff or discipline officers but in both cases staff shortages can lead to cancelled sessions or non-attendance.

- **Categories of prisoners**. The need to maintain some separation between 'vulnerable' and non-vulnerable prisoners makes the booking of appointments complex particularly if there is limited space for segregating prisoners in the waiting or holding area.
- **Treatment outside prisons.** In circumstances where prisoners have complicated health care needs or where the service or equipment in the prison dental surgery is limited referrals may need to be made to dental services outside the prison. Even if these services can be easily accessed prisoners may have to wait because of the need to provide an escort. '*… if someone wants referral to another/ outside service, it's not simple because there are security implications, escorting needs, etc..'*
- **Out of hours cover.** Many prisons find it difficult to provide dental care on demand, i.e. at times when the dentist is not in attendance in the prison. There are several difficulties here. There may be a lack of clarity about who is responsible for arranging cover – the prison, the dentist or the PCT – and how this can be assured. The willingness of other general dental practitioners (GDPs) to take responsibility for prisoners' treatment is a further issue. Some prisons acknowledge that they do not have a clearly defined procedure for facilitating emergency dental treatment. Those that have discussed the matter with their PCT have found that they can often offer helpful solutions to the problem.
- **Range of care.** Some prison dentists feel restricted by the range of care that they are able to provide. Even if the full range of services is available to prisoners in principle, prisons may set regulations or work within norms and rules that lead dentists to provide high levels of palliative care in preference to an extended course of treatment. There are also some constraints about what type of pain relief can be provided safely. In some cases, the range of care may be limited by the level of funding that prison authorities (and now PCTs) make available. *'…prison authorities limit levels of NHS charges that the prison will meet and the dentist is sometimes asked by patients to provide private treatment.'*
- **Service availability**. Longer stay prisoners, as well as pregnant and nursing mothers are entitled to receive a full range of treatment in accordance with the General Dental Service regulations. Although the majority of prisons comply there are still around 10% of institutions where this is not the case. Prisoners on remand, awaiting release or sentenced to six months or less are entitled to receive care as detailed in the NHS 'occasional treatment' guidelines. Again around 90% of prisons surveyed comply with this requirement.
- **Provision of oral health promotion**. Most prisons recognise the importance of oral health promotion, although not all of them have the resources or capacity to do so. While 40% of prisons '*always*' have oral health advice available to prisoners, in over one quarter of institutions prisoners have access only '*sometimes*' and in a further 10% of prisons, oral health advice is accessible to prisoners '*rarely*' or '*never*'. Part of the difficulty is the competing demands on dentists' time. '*You need time for the dentist to advise patients about dental hygiene. There are always too many people needing treatment who naturally take up his time.'*
- **Effective health promotion**. Evidence about the effectiveness of health education in changing behaviour and improving dental health status is relatively weak. From our analysis of prison dental health plans and survey data it would appear that prisons are placing greater emphasis on health education than on health promotion interventions that are known to be more effective such as those which increase fluoride intake.
- **Prison culture**. Underpinning some of the factors listed above is the priority that prisons place on dental care and how it fits within their overall culture. '*It's not easy. There are problems with the numbers of staff, the distance patients have to be transported within the prison. You cannot at very short notice say I have a vacancy. It can only happen if it is a real emergency and that depends on there being lot of good will from many people. It's to do with the regime, the structure of the prison and apathy amongst prison officers. Some are co-operative, others are not. Sometimes they will say 'I can't get a dentist, so why should they?"*

d) Resourcing issues

Lack of resources is a frequently cited but clearly not the only difficulty that prisons face in providing adequate dental services.

- **Quality of facilities**. The standard of the dental surgeries varies widely across prisons. In general, dental surgeries in prison are of a lower standard than those in the community. The surgery itself may not be purpose-built and may compromise clinical practice. '*Outdated equipment, outdated practices.' 'Our main problem is out-of-date facilities: the dental suite is 17 years old. We need refurbishment of the surgery*.' Where prisons have had investment in refurbishing dental facilities they have had to find temporary arrangements outside the prison whilst the work is carried out. '*At present the health care centre is being refurbished and we are unable to access the dental room. Pro tem we are looking at providing emergency only cover from NHS Emergency Dental Clinic.*' Sub-standard facilities are not only a problem in their own right they can also contribute to difficulties in recruitment and retention as dentists may be reluctant to undertake prison work if the standards fall far short of the facilities in which they work ordinarily.
- **Infection control**. Recent changes to regulations on infection control have increased the need for refurbishment of surgeries and investment in equipment. Given that there is higher proportion of patients with blood-borne infections than in the general population, there are particular requirements to avoid cross-contamination. '*[We need] more support with stock control, latest sterilisation guidance and security of equipment. PCT have said we will be unable to use desktop sterilisers within a year which will pose real problems for us.*'
- **Lack of space**. In some prisons, though the equipment meets specification, the space in which the dentist must practise is extremely limited. This is particularly relevant in prisons where there is no dedicated dental facility, rather a shared space with other health care surgeries. '*Due to the space limitation it is difficult to alter scheduled sessions as every day a clinic is running.*' Space available for oral health education as well as dental treatment was identified as a further barrier to improving the dental health of prisoners.
- **Staff training**. Fifteen of the prisons surveyed highlighted the need to invest in more training of staff. The two main areas were for nurses to improve dental health needs assessment and triage and for health promotion. '*We are still waiting for some training in dental health promotion/ oral hygiene which has been promised for some time.*'
- **Funding for additional sessions and health promotion**. Although resources are a big barrier to reducing long waiting times it is unclear whether the need is for short term funding to remove the backlog or a longer term systemic problem that needs recurrent funding. '*Allocation of funding for extra sessions to reduce waiting list.' Increasing the number of sessions to clear the backlog would be the most practical means of help.' 'We are unable to offer dental 'check ups' due to financial constraints.' 'We were promised more capital to run more sessions and run oral hygiene sessions and dental hygiene sessions*.'
- **IT facilities**. the prison service has lagged behind the NHS in its investment in information technology. Information systems could help to promote greater continuity of care, to aid appointments and track treatment programmes between prisons when prisoners move. '*Although treatment has been undertaken in other prisons, dental records fail to accompany patients. Dental records need to be merged with medical records*.'
- **Equipment**. The lack of equipment, or inadequate equipment is often a problem. X-ray facilities were identified as a particular challenge. '*We need an X-ray machine so patients don't have to go outside of the prison for X-ray*.' Prisons highlighted as a further difficulty the lack of access to equipment servicing and repair.
- **Availability of dental care materials**. Most prisoners have access to basic dental health products such as fluoride toothpaste and toothbrushes but access to other products – a better range of toothbrushes and toothpaste, electric toothbrushes, safe dental floss, fluoride products and oral

health aids is more limited. Even where these are available they may be prohibitively expensive to prisoners whose average wage may be just a few pounds per week.

- **Commissioning prison dental services**. Commissioning is a relatively new concept for prison health departments and not all have been able to write service specifications for dentistry. '*We have no dental care experience and I, for one, struggle with some of the guidelines.*' Most PCTs are not actually commissioning dental services at present and have most of their work cut out in introducing new dental contracts.

Capacity and waiting times

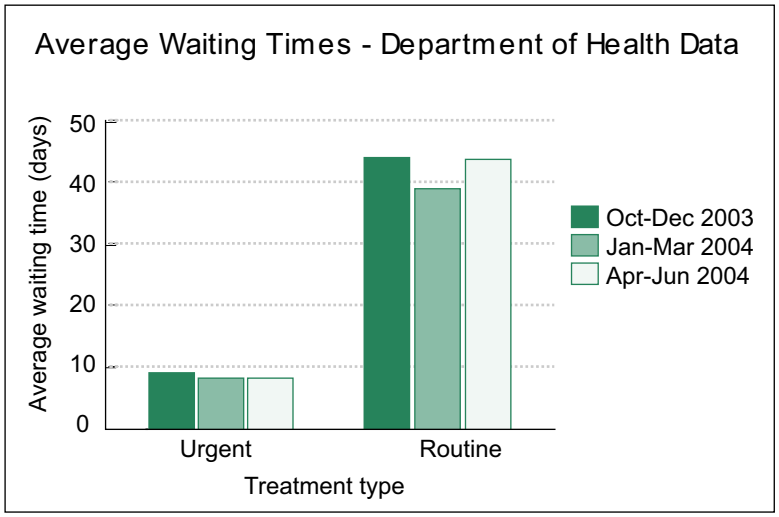
All of the factors above have a combined impact on the length of time that prisoners may have to wait for dental treatment. '*We have 104 on the waiting list, all of whom need a considerable amount of treatment … more sessions per week are needed.*'

In this section we explore what progress has been made in addressing long waiting times for dental care for prisoners drawing on the prison dental health action plans, survey findings and Department of Health data for the past last three years. A 'health warning' needs to be given about the use and interpretation of this data. There are however, some real difficulties in getting an accurate picture as none of these data sources – including the DH data – provide comprehensive coverage across all prisons or time periods. Not all prisons completed baseline action plans or replied to the survey and trend data was inconsistently reported.

Waiting time figures

The waiting time figures shown in the chart below show average waiting times in days for urgent and routine treatments. In the vast majority of cases emergencies are seen immediately so waiting times do not really apply.

FIGURE 2(A) WAITING TIMES FROM DH RETURNS

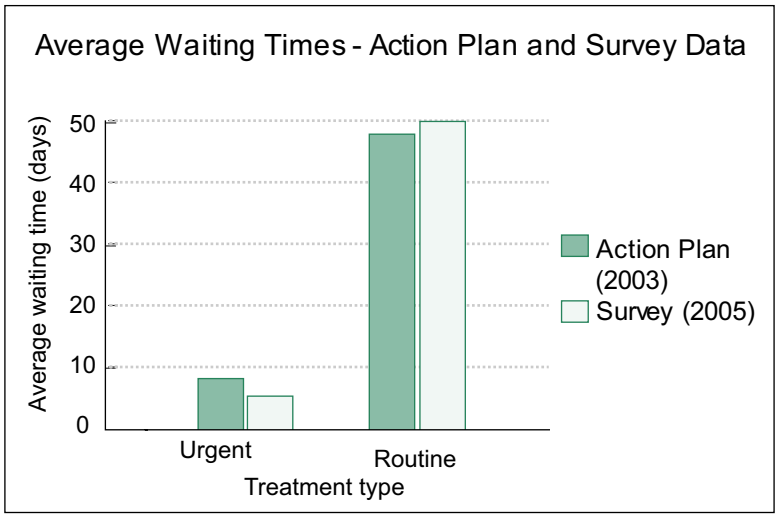


		Nos. of Prisons	Nos. of Prisons
DH data	Oct-Dec 2003	Urgent: 137	Routine: 135
DH data	Jan-Mar 2004	Urgent: 132	Routine: 132
DH data	Apr-Jun 2004	Urgent: 134	Routine: 133

The lack of progress in reduction of waits for routine treatment is disappointing but it would appear that there are different interpretations about categories such as 'urgent' and 'emergencies'. It would appear that the same rigour that has been applied to routine data collection of waiting times in

mainstream NHS services needs to be applied to prison health care. In this way there will be a way for PCTs and prison health departments to compare like with like.

FIGURE 2(B) WAITING TIMES BASED ON ACTION PLANS AND SURVEY DATA



The key points to note are:

- In 2003 the prison dental health action plans identified that the mean wait for routine treatment was 47.7 days and for urgent treatment 7.7 days.[1]
- In the 2005 follow up survey we found that the mean waiting time for routine treatment appeared higher than previously, at 50.4 days although the reported average waiting time for urgent care, had fallen. While these figures are slightly different to the figures collected by the DH, the general trend is the same – waiting times for urgent care have improved but there is far less improvement in waiting times for routine dental care.

The table below shows the 2003 action plan and 2005 survey findings in more detail. Where the waiting time is reported as 0, this indicates immediate treatment. Non-responses indicate either no information was provided or the respondents stated 'next session' and the timescale could not be determined.

WAITING TIMES FOR TREATMENT – ACTION PLAN (2003) AND SURVEY (2005)

Type of treatment	Lowest waiting time (days)	Highest waiting time (days)	Mean waiting time (days)	Number of responses	Non-responses
2003 (action plan data)					
Emergency	0	42	2.24	109	11
Urgent	0	70	7.66	115	5
Routine	7	196	47.65	118	2
2005 (survey data)					
Urgent	0	112	5.95	83	4
Routine	3	185	50.35	84	3

1. Base: Action Plan Urgent: 115 Routine: 118
   Base: Survey Urgent: 83 Routine: 84

The main points to note are:

- In 2003 there was a significant range in waiting times for urgent treatment from 0 (immediate treatment) to 112 days. Around one-third of prisoners had to wait between 29 and 42 days for urgent treatment but a quarter waited less than one month for routine care.
- Just under two-thirds (63.6%) of the prisons who provided details of their routine waiting times, met the guideline target of less than 6 weeks. In 2005 this was slightly lower at 61.9%.
- By 2005 the average waiting time for routine care had increased slightly but the range had decreased which suggests that those prisons with the worst waiting times are beginning to tackle the backlog.

Why do waiting times vary?

Dental clinic availability

There is a huge variation in the number of dental sessions that prisons offer but this figure on its own is meaningless unless the length of sessions and the size of the prisoner population is taken into account. Although most prisons run sessions of approximately three hours (the rule of thumb for NHS sessions) – around one-third offer sessions of different lengths from one to six hours. Variations in session length have increased over the past three years – this may be an indication of efforts to increase capacity by simply extending existing clinic sessions. In looking at whether waiting times can be fully explained by available dentist time there are three questions to be addressed:

Does capacity match likely demand?

In 2003, the number of sessions per month in each prison, as detailed in their Action Plans, ranged from one to 28, with the mean number being 8.42. By 2005, the number of sessions per month ranged from 0 to 40, with the average number of sessions provided being 10.3. Therefore, the number of clinic sessions per prison has gone up. Prisons do vary in size and security so it is not simply a matter of extra sessions but the extent to which these match expected demand.

To enable us to make comparisons between prisons of different size and session length we developed a capacity indicator (CI) based on the recommended minimum of one three-hour session per week for every 250 prisoners. The closer to a score of 1, the nearer the compliance with the recommended standard and the higher the score the greater the capacity of dental services for the prison size.

$$CI = \frac{(\text{Average no. of dental sessions} \times \text{Average length of sessions}) \times 250}{\text{Size of prison} \times 3}$$

Capacity scores in 2003 calculated from information in the dental health action plans ranged from 0.5 to 11.4, with a mean score of 3.6 (base: 77). This means that some prisons have far fewer clinic sessions than we would expect for the size of the prison population whilst other prisons may have more sessions (in one case over three times as many sessions as we might expect).

What improvement has been achieved in the last two years?

In 2005 both the average and the maximum capacity indicator scores were higher than they were in 2003. Capacity scores in 2005 calculated from the survey data ranged from 0.4 to 14.6, with a mean score of 4.7 (base: 81). This suggests that there has been a real expansion in prison dental care capacity in the last two years.

We can also conclude that prisons with the highest waiting times have attempted to expand their capacity to reduce waits. In 2003, the action plans showed that 11% of the prisons with waits of more

than 6 weeks for routine care (base: 44) had a capacity indicator of less than or equal to 1. In 2005, the equivalent figure was only 4% (base: 28).

What do these trends tell us?

Putting data on waiting times and capacity together it is clear that whilst the majority of prisons with long waiting times have low capacity scores there are also a few where the converse is true suggesting that increasing capacity in itself is no guarantee to reducing waiting times. It is also likely to be the case that where waiting lists are very long and capacity is low that efficiency improvements or increasing health promotion efforts are unlikely to make a significant contribution to lowering waits for dental care.

Where additional capacity has been made available, it seems to have benefited patients needing urgent treatment and there remains a need to improve waiting times for routine dental care. It may be that some of the successes in reducing waiting times in mainstream NHS services through a better balance between demand and capacity could be adapted to achieve similar improvements in dental care in prisons

Category of prison

Security issues within a prison can reduce the actual time that dentists have to spend in treating prisoners so it is conceivable that prisons catering for higher security prisoners may have higher waiting times. The prison health action plans (2003) indicate that the average wait for routine treatment in Category A prisons was 62 days whereas it was 43 days for Category D prisons. Prisons with a high turnover – large local prisons for example – report difficulty in reducing waiting times and fully addressing dental care needs because of the practice of adding new prisoners to the bottom of the waiting lists. It means that prisoners who are moved frequently can wait far longer than those who serve long sentences in the same institution.

Efficient use of dental clinic time and skills

A further explanation for variations in waiting times is the degree to which prisons are able to make efficient use of the time available. The 2005 survey explored differences between the actual numbers of prisoners seen in each session and the numbers expected to be seen. Of the prisons that replied just under half saw fewer patients than they expected to due to:

- The number of DNAs (did not attends);
- Patient sessions over-running due to treatment or advice needs being more complex than anticipated.
- Security factors

There has been no change in the last two years in the average number of patients expected to be seen per session. It has stayed constant as 12 per session. With an average session length of three hours this suggests that each prisoner has around 16 minutes for treatment. There is some evidence to suggest that the prison type may be associated with throughput ratio and that higher security prisons may find it more difficult to make efficient use of clinic time due to security procedures.

Part three: Good practice in modernising prison dental health

Two-thirds of prison health care managers rate the quality of dental care services in their prisons as either *Good* or *Excellent* (4 non-responses). Just over one-fifth regarded their services as Average with just under 10% rating their prisons as *Below Average* or *Poor* overall.

There are many different factors that underpin these perceptions for example, the efficiency of the service, how well it is supported by the PCT and SHA, waiting times and the resources available. In looking for case studies of prisons that could demonstrate excellent or even good practice across a range of service areas, we found far greater reluctance to describe the overall quality of care as excellent. It is likely that all prisons have room for improvement in some aspect of their dental care.

In this section, what we have aimed to do is to describe some of the approaches that are already being put into practice and further ideas that have been put forward for improving prison dental care. The term 'good practice' needs some qualification here. All prisons are different and what works well in one location may not be appropriate in another. Moreover, the examples are not meant to indicate that these are the only prisons adopting such practices. A key point to note is that there is no shortage of creative thinking about how the significant challenges in providing prison dentistry highlighted earlier can be tackled.

To help structure this section we have broadly followed the headings in the modernising prison dental health strategy:

- Health needs assessment
- Oral health promotion and health improvement
- Increasing access to treatment
- Continuity and follow up care
- Using contracts and service specifications to improve service quality

In each section, we summarise current initiatives and identify some areas that have been highlighted by prisons as ideas for further investment.

Health needs assessment

An increasing number of prisons undertake a needs assessment of new prisoners at the point of admission and use this to prioritise dental treatment and access.

- At HMP Hollesley dental problems are identified at the point of reception and appointments booked with a dentist within three weeks.
- A well man clinic incorporating different aspects of health promotion sees all prisoners within three weeks of admission at HMYOI Aylesbury.
- A number of prisons provide basic information on how to access dental services and application forms during induction (e.g. HMP Stafford, HMP Everthorpe and HMP Wellingborough)

- A self completion questionnaire can assist in assessing prisoner dental health needs for triage purposes
- Dental sessions are split to allocate time for new patients to get an initial assessment and any emergency treatment HMP Morton Hall

Oral health promotion and health improvement

A priority for many prisons in improving their dental services is establishing or extending oral health promotion services. Only 22% of prisons in the 2005 survey report having an oral health programme that is run in conjunction with their prison health department. Some examples of efforts that are already being made in this field are set out below.

Oral health needs assessment

- HMP Lindholme staff are currently working with the PCT to assess the extent of need in this area.'*… a pilot oral health needs assessment took place in December 04. A bigger research study is to take place this year… [we are] just awaiting ethics committee approval. The results of this will enable future planning to improve oral health in prisons.*'

On arrival, new prisoners are provided with an induction pack, which details the dental services provided at the prison and its aims. A general health assessment is carried out on all new entrants by the medical staff and if any urgent need for treatment is spotted then the dentist is informed – *HMP Holloway*

Dedicated time for oral health promotion purposes

- A designated planned oral hygiene clinic – led by dental nurses has been found to be an effective way of providing time and space for oral health and hygiene.' – HMP Randby
- An alternative approach to the clinic is to offer one-to-one oral health promotion at the time of the appointment. – HMP Morton Hall.
- An oral health promotion programme for one session per week has been developed with the PCT – HMP Garth

Integrating oral health promotion into mainstream prison activities

- Dental education provided on a one-to-one basis, such as wing visits during association for direct access to prisoners. – HMP Hull

Oral health campaigns

- HMP Shrewsbury includes oral health promotion in its annual health fair.
- HMP Shepton Mallett holds an 'open day' where '*dental health advisors are available for drop-in sessions*.' Activities such as this were also suggested by other survey respondents as being a useful way to raise awareness.
- Oral health 'fun days' with oral health specialists invited into the prison to deliver health promotion has worked well at HMP Eastwood Park
- Free dental products are issued at prison health events as a health promotion exercise e.g. 'attend our stall and get a free toothbrush'. – HMP Blundeston

Linking prison dental staff with PCT health promotion experts

- Prison health care staff at HMP Eastwood Park have developed close links with oral health specialists in the community to develop their approach to health promotion. A folder on oral health has been developed which includes a CD-ROM and leaflets to share with prisoners.
- A similar approach to using PCT oral hygiene specialists has been developed at HMYOI Thorn Cross. This has enabled the prison to access dental care tools free of charge.'

Training prison dental staff in health promotion

- The dental nurse at HMP Haverigg has been supported to undertake an oral health promotion course at Leeds University and is using care of prisoners as evidence for her course work. (HMP Haverigg)
- At HMP Hindley the local PCT provides oral health advice/ training for nursing team within the prison and they are now developing an oral triage package.

Recruitment of specialist health educators

- HMP Coldingley has appointed a health promotion development worker whose brief includes oral health promotion.
- At HMYOI Swinfen Hall the PCT has provided support for a dietician to join the prison health team.

Tackling problems of drugs misuse

- Trained dental nurses who specialise in drugs misuse have proved a great asset to oral health promotion for prisoners with these risk factors – HMP Bullingdon

Ideas for further investment

In the action plans and surveys we asked about what further funding was needed to improve oral health promotion. Some of the ideas for further investment that might be of interest in other places included the following:

- Using external health promotion experts to train prison health staff
- Using visual aids such as videos that are purposely designed for prisoners
- Improving the quality of free toothbrushes provided to prisoners
- Ensure artificial sweeteners are available in the canteen
- Linking oral health promotion to smoking cessation advice
- Regular provision of fresh fruit and vegetables
- Ensuring health promotion information is available in an appropriate range of languages.
- Paying prisoners to attend oral health promotion sessions or ensuring these do not clash with paid work. '*Currently, the prisoners face a dilemma: on the one hand they can get paid for working or on the other they can spend their time learning about the merits of oral care. I know which one I would choose if I was in their boots.*'
- Providing free fluoride supplements

Estimates of how much such measures would cost vary between prisons. A number of respondents commented that, in their view, these measures would be more effective if they are integrated into a wider health promotion strategy for the prison.

Increasing access to treatment

As we noted earlier in this report that a significant challenge facing prisons is the complexity of factors affecting the level dental care actually available to prisoners. We also noted that waiting times are strongly linked to available capacity. However, short of increasing sessions and ensuring these are expanded to match any increases in the prison population, what else can prisons do to improve the accessibility of dental care? Several approaches have been taken:

Reducing the level of non-attendances

- HMP Pentonville has piloted an 'escort system' where a designated team of health care escorts assist with prisoner movement. HMP Wandsworth is looking to establish a similar project.
- Reminders to prisoners about their appointments and notification of non-attendance is used at HMP Wellingborough. Their view is that well-informed prisoners tend to be happier to apply for, attend and cooperate with dental treatment (HMP Wellingborough)
- Sanctions for prisoners who miss appointments could be used to discourage prisoners from not attending a booked session, and improving internal communication between prisoners and the dental team, although it was suggested that this would be fairer if it related to a non-financial penalty, given the limited amount of money available to the prisoner, with which they must purchase everything they need.
- Ensuring there are effective communication routes for prisoners to notify the dental team if they no longer wish to attend, or are unable to attend can help make best use of available time. Providing prisoners with access to a health care phone line/ message service are ways in which this could be achieved.
- Patient satisfaction questionnaires (e.g. HMP Durham) can help in understanding why prisoners do not attend appointments and their attitudes to the service.
- Non-attendance of appointments has a knock-on effect for other prisoners' ability to access services. Better communication between medical staff and the houseblock can help to reduce failed attendance rates.

Since his arrival 18 months ago, the dentist has successfully reduced the waiting lists for initial appointments and has cleared the backlog of patients waiting for treatment. Despite the prison having sufficient facilities to treat them in-house, the previous dentist referred a high proportion of these patients to an outside hospital.

The prison used to have only one dentist to undertake treatment, but now, with the Bedford Dental Access Centre providing a service under a contractual agreement, the prison has a guaranteed level of service and cover arrangements. The Dental Access Centre provides salaried dentists, replacing the previous fees for item of service system. The dentist says: *'Paying dentists by item of service is flawed because dentists would be deterred from practising in the prison as it will not be worth their while in remuneration terms'.*

This approach enables the primary care trust to manage and coordinate prison dentistry more effectively since the arrangements for prison dentistry mirror those in the community.
– *HMP Bedford*

- Improving the flow of prisoners to clinics. '*Improvements could be made just by re-organising the way patients come to and from the dental facility … we could get about 20% increase in dental time for almost no extra cost. It's not a panacea, but is certainly a significant step forward.*'

The prison undertook a successful 6 month pilot of a new escort service designed to improve the transfer of prisoners from their cells to the dental surgery. The decision to try out such an initiative was taken collectively by a number of other prison governors from the Greater London area.

A number of specialist clinic officers were recruited from the existing pool of security personnel to accompany and assist inmates to the health care facilities. The training they received was focused on ensuring that prisoners are searched appropriately before and after the appointment and at improving the safety of all prisoners whilst in the health facilities. Previously, several cases of bullying, intimidation, assault and criminal damage to equipment/facilities in the waiting room had nurtured a culture of fear amongst some inmates who had begun to miss appointments in favour of personal safety. Since the permanent adoption of the scheme, this behaviour has been stopped, there are few complaints about dental services and attendance levels have improved. As one person said: '*Actually, sometimes the dentist feels that the prisoners arrive too early!*'

Recently, the clinic officers provided patients with reminder slips 24 hours before their appointments. There are now plans to involve the clinic officers in encouraging patients to fill in and return self-assessment health questionnaires while they wait in the waiting rooms. The prison feels that: '*This pilot helped us to identify a common sense system that is aiding us to negate anti social behaviour by a minority and the resulting unsafe environment for staff and prisoner alike which it led to. For other prisons this would be a good approach to implement as long as their re venue and manpower constraints allow them.*'
– HMP Holloway

Prioritising patients using triage systems

- Efficient and reliable appointment systems can help ensure that prison dental sessions are used to best effect. Management of appointments appears to vary greatly from prison to prison, but HMP Blundeston, HMP Stanford Hill, HMP Wellingborough and HMP Durham have all have developed effective services in this area
- Triage has been established successfully in many prisons. At HMP Askham Grange, the dentist will triage the patients when '*the waiting time for appointments is nearing the acceptable limit.*' In other cases, such as HMP Doncaster and HMP Whatton, dental nurses are responsible for triage duties and hold regular clinics to '*set the criteria for access to the service*'. HMP Lowdham Grange and HMP Stafford also cited their triage clinics as examples of good practice in facilitating patient access to oral health services.
- In HMP Hull, the whole dental team takes part in triage clinics. Individual professionals take responsibility for their own administration and waiting lists and the system is reported to be working well.
- HMP Acklington uses triage with structured the dental appointment lists so that there is provision for emergency patients in each session, working on the basis that a body of emergency work will be predictable.
- Clarity about the roles and skills of each health professional and extending the roles of nurses and therapists can help to release dentist time for the most specialist work.
- HMP Send is planning to introduce a six monthly recall system for routine appointments with the expectation that regular check-ups will help bring waiting lists down. In addition, if prisoners

know with a fair degree of certainty that they will be seen as a matter of course, this could limit demands for urgent treatment and help prison staff manage needs and appointments more easily.

On arrival, all prisoners undergo a clinical interview with a health care officer. If a dental problem is identified then the details of the prisoner and the nature of their problem are passed to the dentist the next morning for follow up.
– *HMP Bedford*

The dentist providing the service has had previous experience of domiciliary visits. Assessment clinics have been held on the prison wings to assess the needs of patients and prioritise their dental care. This helps her manage her patients more effectively and deters those patients with minor complaints from taking up valuable appointment time in the healthcare department clinical sessions.

'*The fact that the dentist knows the problems of her client community enables her to have a holistic picture and act accordingly.*'
– *HMP Whitemoor*

The dentist runs triage (clinical prioritisation) sessions around the prison on Monday and Tuesday evenings. Prisoners self-select if they come to these and then she prioritises them according to need. Between 20 and 30 prisoners are seen every evening.
– *HMP New Winson Green*

Culture and relationships

- Effective joint working between health care specialists in the prison also helps in improving access to dental care. At HMP Brixton liaison between the dental team and other specialists e.g. diabetes nurse and HIV coordinator has helped to improve access to dental care for the more vulnerable prisoners. (HMP Brixton.)
- Non attendance due to security checks and shutdowns have been reduced in HMP Swaleside through an agreement between the dental team and the Governor to ensure that clinical time is not disrupted by impromptu security checks. A similar agreement was reached within the Isle of Wight Prisons. '*Staff were instructed not to cancel dental sessions due to being unable to escort and supervise the dentist. Sessions were supported by a manager or agency staff if no regular staff were available. Where prisons were unable to host sessions due to security reasons, they were rescheduled at another prison.*' (Isle of Wight prisons – HMP Albany, HMP Parkhurst, HMP Camp Hill).

'I try to view all the people in I treat in prison as just any other patients of mine rather than 'inmates'. This perspective has, I think, helped me build strong relationships with the patients and the prison authorities.'
– *HMP Bedford*

The movement of prisoners to the health centre used to be at the bottom of the movement schedule in this prison. Often this meant that we were unable to get our patients into the clinics as they could not be escorted until after other movements around the establishment. In early 2004, the Health Care Manager successfully negotiated a revised prisoner movement schedule which means prisoners requiring a visit to the healthcare department are now escorted earlier in the process. Now, if there is a standstill roll check, the prisoners are in the department and can continues to be treated, This positive initiative has allowed the dentist more time to continue with here sessions and has kept the effect of disruptions and rescheduling of appointment times to a minimum.
– *HMP Whitemoor*

Tackling backlog waiting lists

- One way of reducing backlog waiting lists is for a group of prisons to invest in mobile dental facilities and dentists who would rotate between the sites.
- Financial incentives to dentists to reduce waiting times or payment related to the number of patients treatment may also help. The current arrangements reward complex treatments for a relatively small number of patients. This means that whilst some prisoners may receive an excellent service a greater number of prisoners receive none.
- '*Oral in-reach surgery has reduced waiting times at NHS hospitals close to HMP Coldingley. The two additional sessions each month has cut waiting times for routine appointments.*' (HMP Coldingley)

An emergency treatment session is held at the prison every Saturday morning. This means that waiting times for urgent and emergency treatments are kept down to a maximum wait of two days
– *HMP New Winson Green*

Reducing the number of sessions cancelled by dentists

A significant proportion of respondents to the survey highlighted the difficulties caused by clinics cancelled by dentists. This issue has already been addressed in a number of prisons where an established procedure for cases of dentist absence was cited as being useful for avoiding cancelled appointments.

- *'If the dentist is unavailable, additional sessions are normally arranged or the dentist will arrange for another dentist to cover in his absence.'* (HMP Leeds)
- Contract clauses that penalise dentists for cancelled clinics which are not covered by back up arrangements were a further suggestion although it is unclear how widespread this practice is.
- Providing dentists with keys and security clearance. In HMP Elmley dentists are given keys which has helped to improve the flow of patients and access to services *'If I have medical specialists coming in, I don't want them sitting there twiddling their thumbs – it's my responsibility to make sure they get the prisoners in front of them. Dentists say the keys make so much difference'*

Improving recruitment and retention

There are low and high risk approaches to improving the quality and availability of the prison dental care workforce.

- The PCT responsible for HMP Bullingdon plans to put the whole dental care service out to tender in order to lever in improved services.

- HMP Wandsworth and HMP Wayland are looking to develop closer links with the community dental services. They are exploring the option of including prison dental care obligations in the contracts of community dentists.
- At HMP Swifen Hall the dentist is now on a PDS contract, which enables them to focus more on the quality of care than the volume.
- Salaried or fixed price sessional contracts have been tried in some places experiencing recruitment difficulties. Some prisons, however, have said that the cost of salaried dental services in terms of 'the patient charge element of General Dental Service fees, dental consumables and laboratory equipment' is prohibitive because of limited health care resources and inaccessibility of the Dental Practice Board income stream.
- Across SHAs there may be scope for appointing agency dentists to provide cover to prison dentists during times of leave or sickness or a regional on-call dental service.
- HMP Brinsford has employed a dental nurse, which has released the dentist from some tasks and provided additional hours of direct clinical time with patients.

Continuity and follow up care

- Ensuring personal safety training sessions and/or 'security talks' specifically for people working in prison dentistry – e.g. 'breakaway training', 'personal protection techniques' or 'prison awareness' sessions – can be included in the induction programme for dentists working within prisons. A quarter of prisons surveyed do not yet have an induction process in place.
- Personal alarms and radio links for those working with prisoners have been a valuable way of improving personal safety.
- Providing procedures for dental staff to raise concerns is important. The vast majority of prisons have a complaints procedure but only 1% of prisons surveyed reported having a process in place for any member of the professional team to raise concerns in a structured and confidential way.
- Ensuring that there are links between prison dentists and wider NHS dental provision is a way of safeguarding against professional isolation. This could be through involvement in clinical governance or education and training events.
- Continuity of care can be improved by having electronic records for patients
- Continuity of care can likewise be improved by building links with local dental clinics

The regular updating of a patient's medical records on the IMR system has enabled Bedford prison to be well placed to transfer all such data onto the local PCT's electronic storage system. '*The fact that the PCT will be able to electronically pull up records on a patient in the prison will allow it to monitor my service but also to be in a position to provide continuity of care, if that prisoner is released.*'
– *HMP Bedford*

When a prisoner mentions that he is going to be discharged, the dentist offers to make an appointment for them at a local dental clinic. When possible this is done whilst the patient is in the dental chair! Her experience is, however, that many prisoners fail to turn up for these appointments.
– *HMP New Winson Green*

Using contracts and service specifications to improve the quality of care

The Modernising Prison Dentistry Strategy recommends that prison health care managers agree a service specification for the prison dental service. The contract with the dentist should form part of this. Around one half of the prisons surveyed have not reviewed their service specification since 2003. A further quarter stated that it has been reviewed 'once' but nine prisons claim to have reviewed the specification 'more than once'. More frequent reviews of service specifications could help in levering quality improvements.

Over two-thirds of prisons have an agreed protocol with the dentist providing the service, in line with the DH recommendations but a quarter still do not. A number of prisons are taking the opportunity of reviewing their service specification to tackle the issue of contracts with dental providers.

There are differences in the way that contracts are drawn up. HMP Rochester, for example, appoints its dental service provider by means of a 'formal letter of engagement' rather than a contract. A significant number of prisons referred to the need for formalised contracts in their Action Plans and some were more specific about the need to improve their skills and capacity for writing service specifications and negotiating contracts. This may be an area where PCT support would be valuable.

Ways of using contracts and specifications include the following:

- Prison-specific dental guidelines. The service specification in the national strategy provides a good starting point but it needs to be adapted to local circumstances. 'More information about what work can be carried out and by whom (NHS or private)'.
- GDPA inspections. A PCT GDPA representative has inspected the majority (81% according to the 2005 survey) of prison dental surgeries and equipment since 2003. This suggests that the regulatory aspects of prison dental health services are now in place. These inspections however, need to be undertaken regularly if they are to be effective in securing the quality of services. HMP Leyhill reported benefiting from '*… having the PCT carry out an inspection and advise the health care manager on NHS equivalence.*'

Being part of the Personal Dental Services arrangements run by the local PCT is very important to the dentist: 'It would be really easy to feel isolated in this role but through being part of the PDS I can get regular support and even advice on difficult clinical issues. It is far better than working on my own.'
– *HMP New Winson Green*

- Effective performance management. Ensuring there is clarity about who is accountable for the quality of the prison dental services, what performance information they should report and to whom is an obvious point but not always demonstrated in practice.
- Analysis of Dental Practice Board reports. Nearly half of all survey respondents stated that Dental Practice Board reports were not made available on a quarterly basis. Only 30% reported that they were. Ensuring that these are regularly analysed could be a helpful aspect of the commissioning and monitoring of prison dental services.

Part four: Recommendations for PCTs, SHAs and prison health leads

In this best practice guide we have highlighted both the challenges for providing modern dental services in prisons and some of the good practice being demonstrated around the country to stimulate ideas and possibly networking between prison health departments. Although each prison is different and at a different stage in improving its dental services there are some actions that would appear to apply to most prison health care departments, to the PCTs that are responsible for the development and performance of prison dental health services and to the SHAs that have an overall leadership and performance management role.

Whilst we have set out below some suggestions for PCTs, prison health departments and SHAs to consider individually it is important to stress that there are real gains to be made where these parties work together and where having prison health services are closely connected to general NHS provision. There are opportunities to bring some good practice from outside prisons into the prison environment – in health promotion, in the management of waiting lists and in recruitment and retention for instance. There are also opportunities for the different strands of health care within prisons to be better linked and for the NHS to help raise the profile of health and health care provision in prisons alongside traditional performance measures for prisons of security and offender rehabilitation.

Ten positive actions for primary care trusts

PCTs are already making a difference to the delivery of prison dental health services but there is still considerable variation in the way that they have interpreted this role. Those that have taken an active role in the development of prison dental health have been highly valued by their prison health care colleagues and some have made a real difference to the quality of services and health improvement activities in a very short space of time. Others have taken a more hands off role but with an overview of quality being taken by the GDP advisor. The message for PCTs is to get involved in the delivery of prison dental health care. This might include:

1. Reviewing the current capacity available in the prison to identify whether it is sufficient to meet recommended waiting time standards and any gaps in resourcing that need to be filled.
2. Ensuring that PCT staff who are involved in developing prison dental health services understand the contextual and cultural differences of delivering health care in a prison environment.
3. Taking your performance management role seriously. This includes:
    - Reviewing activity and performance data on a regular basis and providing feedback to the prison dental service
    - Regular (at least three-yearly) inspections of prison dental services by the GDPA. This should be more frequent in services that have given cause for concern or which are undergoing rapid development.
    - Agreeing clear improvement milestones for waiting times would be a sensible approach for those prisons that are significantly above recommended standards.
    - Ensuring there is clarity of responsibility for the provision and development of prison dental health in each prison.

4. Ensuring that prison dental health services are included within the overall governance framework for the PCT ensuring both clinical and corporate risks are identified and managed. Efforts should be made to involve prison dentists in the PCT's wider clinical governance and professional development activities and dental health networks to avoid isolation and encourage the spread of learning between different elements of dental services.
5. Applying some of the lessons that have been learned from the modernisation of mainstream NHS services to the planning and delivery of prison dental care. Some examples here include establishing greater rigour in the way that dental health waiting times are recorded, looking at ways in which demand and capacity planning can be improved and waiting list backlogs eradicated.
6. Identifying existing PCT resources that can be linked with prison health care to support service development. Examples here include using health promotion expertise to support the development of oral health promotion packages and campaigns, linking prison dentists to community dentists for professional development purposes, enabling prison health and dental health staff to take part in education and training opportunities made available to PCT staff and contractors.
7. Ensuring that there are effective cover arrangements in place for providing dental care throughout the year. Services that are entirely dependent on one contractor are unlikely to be robust.
8. Using the PCTs expertise in commissioning and contracting where necessary to lever changes to current contracts with prison dentists.
9. Involve prison dentists in developing the PCT's overall strategy for dentistry.
10. Work with prisons to ensure that good procedures are in place for continuity of dental care for prisoners when they leave.

Ten positive actions for SHAs

1. For many prisons the role of SHAs is currently unclear so a first but basic recommendation for SHAs is to define their role in the management and development of prison dental health services.
2. Support PCTs in developing their expertise in managing prison dental health services through networking and benchmarking within the SHA and with other SHAs. The distribution of prisons between PCTs and SHAs is very variable and PCTs with only one prison in their patch will have few points of comparisons for their services.
3. Explore ways of developing networking and learning exchange between prison dental health professionals who are a scarce but valuable resource. Some prison dental health leads are highly committed and innovative practitioners who may need supporting to continue in their current roles and to share their good practice with others. Such an approach could help in the recruitment and retention of prison dental health staff.
4. Discuss options for providing pan SHA cover arrangements with PCTs. Some options may be best organised across a larger geographical area/range of prisons.
5. Work with the workforce development confederation and higher education providers to raise the profile of prison dental health as a career option for nurses, hygienists and therapists. There are increasing demands for these skills in prisons as well as in mainstream NHS and private dentistry. Prisons may need additional help to be seen as an attractive career option, although as an area which is suitable for part-time work it could be promoted as an opportunity for people wanting to fit their professional work around family commitments.
6. The Prison Health Research Unit at the University of Manchester is currently evaluating the effectiveness of modernising prison dentistry. Ensuring that the lessons from this research are duly disseminated and applied across the SHA would be helpful.

7. Ensure that the concerns of and issues faced by prison dental health departments and their PCTs that are difficult to resolve locally are communicated to the DH and the wider government.
8. Increase the profile of prison dentistry nationally in order to highlight the challenges around this population's specific needs, and how these relate to all citizens' rights to access care services.
9. Ensure that PCTs provide sufficient resources for prison health generally and for prison dental health in particular.
10. Use the expertise of prison dental health leads within the SHA to keep a watching brief of the dental health of prisoners and the extent to which it is being improved.

Ten positive actions for prison dental health services

There are many examples in this good practice guide that are worth following up to check how well they might be applied to other circumstances. Beyond this some actions for prison dental health services to consider are:

1. Exploit all opportunities to draw on resources and expertise within the PCT
2. Make sure that the prison dental health department service makes and sustains networks between prison dentists and the dental community outside the prison to avoid professional isolation.
3. Work with the PCT to ensure there are adequate levels of resource and cover in order to meet national waiting time standards
4. Develop effective internal relationships with the Governor and Prison Officers to ensure they understand the importance of good oral health and dental care and its links to prisoner satisfaction and security
5. Explore ways in which you can improve the effective use of existing resources in order to increase activity and reduce waiting times.
6. Work with your PCT to ensure that your future plans for the service include improved oral health and hygiene. Particular attention should be paid to interventions where there is evidence of proven effectiveness.
7. Check that the definitions that you are using to record waiting times for routine appointments are consistent and in line with those recommended.
8. Use the FP17 data to check what activity is being undertaken in your prison and that this aligns with what you know about prisoner needs and priorities.
9. Develop your networks and links with other prison dental health services so you can learn from their experience
10. Take a holistic view of dental health and at the contribution of diet and nutrition – particularly the consumption of sugar – can make to improving prisoner's dental health needs.

Other bodies

If prison dental services are to be seen as an interesting career option there is a case for postgraduate deans to ensure that these placements are included in vocational training schemes. There may be scope for including prisons within undergraduate outreach training but the impact and ease of organisation are likely to be greater for postgraduates.

A final point is aimed at the DH. The prison population has been growing and resources for prison health care are already stretched. Providing appropriate uplifts in PCT baselines to take account of any further changes to the prison population may be the key to ongoing investment in these services.

Appendix 1 – List of prisons

The prison details that follow were provided by the Department of Health.

Prison List 1

Strategic Health Authority	*Primary Care Trust*	*Establishment*
Avon, Gloucestershire and Wiltshire	Bristol North	Bristol
Avon, Gloucestershire and Wiltshire	West Gloucestershire	Gloucester
Avon, Gloucestershire and Wiltshire	Kennet & North Wiltshire	Erlestoke
Avon, Gloucestershire and Wiltshire	South Gloucestershire	Eastwood Park
Avon, Gloucestershire and Wiltshire	South Gloucestershire	Leyhill
Bedfordshire and Hertfordshire	Bedford	Bedford
Bedfordshire and Hertfordshire	Dacorum	The Mount
Birmingham and The Black Country	Heart of Birmingham	Birmingham
Cheshire and Merseyside	North Liverpool	Liverpool
Cheshire and Merseyside	Eastern Cheshire	Styal
Cheshire and Merseyside	Warrington	Risley
Cheshire and Merseyside	Warrington	Thorn Cross
County Durham and Tees Valley	Durham & Chester-le-Street	Low Newton
County Durham and Tees Valley	Durham & Chester-le-Street	Durham
County Durham and Tees Valley	Durham & Chester-le-Street	Frankland
County Durham and Tees Valley	Durham Dales	Deerbolt
County Durham and Tees Valley	North Tees Teaching	Holme House
County Durham and Tees Valley	North Tees Teaching	Kirklevington Grange
Cumbria and Lancashire	Preston	Preston
Cumbria and Lancashire	West Cumbria	Haverigg
Cumbria and Lancashire	Fylde	Kirkham
Cumbria and Lancashire	Morecambe Bay	Lancaster Farms
Cumbria and Lancashire	Chorley & South Ribble	Garth
Cumbria and Lancashire	Chorley & South Ribble	Wymott
Dorset and Somerset	Mendip	Shepton Mallet
Dorset and Somerset	North Dorset	Guys Marsh
Dorset and Somerset	South West Dorset	Portland
Dorset and Somerset	South West Dorset	Dorchester
Dorset and Somerset	South West Dorset	Verne, The
Dorset and Somerset	South West Dorset	Weare

Strategic Health Authority	*Primary Care Trust*	*Establishment*
Essex	Castle Point & Rochford	Bullwood Hall
Essex	Chelmsford	Chelmsford
Greater Manchester	Rochdale	Buckley Hall
Greater Manchester	Ashton, Leigh & Wigan	Hindley
Greater Manchester	North Manchester	Manchester
Hampshire and Isle Of Wight	Portsmouth City	Kingston
Hampshire and Isle Of Wight	Isle of Wight	Camp Hill
Hampshire and Isle Of Wight	Isle of Wight	Albany
Hampshire and Isle Of Wight	Isle of Wight	Parkhurst
Hampshire and Isle Of Wight	Mid-Hampshire	Winchester
Kent and Medway	Canterbury & Coastal	Canterbury
Kent and Medway	Maidstone Weald	Maidstone
Kent and Medway	Maidstone Weald	East Sutton Park
Kent and Medway	Maidstone Weald	Blantyre House
Kent and Medway	Medway	Cookham Wood
Kent and Medway	Medway	Rochester
Kent and Medway	Swale	Elmley
Kent and Medway	Swale	Stanford Hill
Kent and Medway	Swale	Swaleside
Leicestershire, Northamptonshire and Rutland	South Leicestershire	Glen Parva
Leicestershire, Northamptonshire and Rutland	Eastern Leicester	Leicester
Leicestershire, Northamptonshire and Rutland	Daventry & South Northamptonshire	Onley
Leicestershire, Northamptonshire and Rutland	Melton, Rutland & Harborough	Ashwell
Leicestershire, Northamptonshire and Rutland	Melton, Rutland & Harborough	Gartree
Leicestershire, Northamptonshire and Rutland	Melton, Rutland & Harborough	Stocken
Leicestershire, Northamptonshire and Rutland	Northamptonshire Heartlands	Wellingborough
Norfolk, Suffolk and Cambridgeshire	Waveney	Blundeston
Norfolk, Suffolk and Cambridgeshire	Suffolk West	Highpoint North
Norfolk, Suffolk and Cambridgeshire	Suffolk West	Highpoint South
Norfolk, Suffolk and Cambridgeshire	Suffolk Coastal	Hollesley Bay
Norfolk, Suffolk and Cambridgeshire	Huntingdonshire	Littlehey
Norfolk, Suffolk and Cambridgeshire	Norwich City	Norwich
Norfolk, Suffolk and Cambridgeshire	Southern Norfolk	Wayland

Strategic Health Authority	*Primary Care Trust*	*Establishment*
Norfolk, Suffolk and Cambridgeshire	East Cambridgeshire & Fenland	Whitemoor
North and East Yorkshire & N. Lincs	Yorkshire, Wolds & Coast	Full Sutton
North and East Yorkshire and Northern Lincolnshire	Selby & York	Askham Grange
North and East Yorkshire and Northern Lincolnshire	East Yorkshire	Everthorpe
North and East Yorkshire and Northern Lincolnshire	Eastern Hull	Hull
North and East Yorkshire and Northern Lincolnshire	Hambleton & Richmondshire	North Sea Camp
North and East Yorkshire and Northern Lincolnshire	Hambleton & Richmondshire	Northallerton
North Central London	Islington	Holloway
North Central London	Islington	Pentonville
North West London	Hounslow	Feltham
North West London	Hammersmith & Fulham	Wormwood Scrubs
Northumberland, Tyne and Wear	Northumberland Care Trust	Acklington
Northumberland, Tyne and Wear	Northumberland Care Trust	Castington
Shropshire and Staffordshire	South Western Staffordshire	Brinsford
Shropshire and Staffordshire	South Western Staffordshire	Drake Hall
Shropshire and Staffordshire	South Western Staffordshire	Drake Hall
Shropshire and Staffordshire	South Western Staffordshire	Featherstone
Shropshire and Staffordshire	South Western Staffordshire	Stafford
Shropshire and Staffordshire	Shropshire County	Shrewsbury
Shropshire and Staffordshire	Shropshire County	Stoke Heath
Shropshire and Staffordshire	Burntwood, Litchfield & Tamworth	Swinfen Hall
Shropshire and Staffordshire	Staffordshire Moorlands	Werrington
South East London	Greenwich	Belmarsh
South East London	Lambeth	Brixton
South West London	Richmond & Twickenham	Latchmere House
South West London	Wandsworth	Wandsworth
South West Peninsula	Teignbridge	Channings Wood
South West Peninsula	South Hams & West Devon	Dartmoor
South West Peninsula	Exeter	Exeter
South Yorkshire	Doncaster East	Lindholme
South Yorkshire	Doncaster East	Moorland
Surrey and Sussex	Woking	Coldingley
Surrey and Sussex	East Elmbridge & Mid Surrey	High Down
Surrey and Sussex	East Elmbridge & Mid Surrey	Downview
Surrey and Sussex	Western Sussex	Ford
Surrey and Sussex	Sussex, Downs & Weald	Lewes
Surrey and Sussex	Guildford & Waverley	Send
Thames Valley	Vale of Aylesbury	Aylesbury
Thames Valley	Vale of Aylesbury	Grendon/Spring Hill

Strategic Health Authority	*Primary Care Trust*	*Establishment*
Thames Valley	North East Oxfordshire	Bullingdon
Thames Valley	South East Oxfordshire	Huntercombe
Thames Valley	Reading	Reading
Thames Valley	Milton Keynes	Woodhill
Trent	Derbyshire Dales & South Derbyshire	Foston Hall
Trent	Derbyshire Dales & South Derbyshire	Sudbury
Trent	West Lincolnshire	Lincoln
Trent	West Lincolnshire	Morton Hall
Trent	Nottingham City	Nottingham
Trent	Bassetlaw	Ranby
Trent	Rushcliffe	Whatton
West Midlands South	Redditch & Bromsgrove	Blakenhurst
West Midlands South	Redditch & Bromsgrove	Brockhill
West Midlands South	Redditch & Bromsgrove	Hewell Grange
West Midlands South	South Worcestershire	Long Lartin
West Yorkshire	Leeds West	Leeds
West Yorkshire	Wakefield West	New Hall
West Yorkshire	Wakefield West	Wakefield
West Yorkshire	Leeds North East	Wealstun
West Yorkshire	Leeds North East	Wetherby

Prison list 2

The prison list that follows has been taken from the HM Prisons website[2]. This is the list we used to provide prison category information.

Prison	*Category*
HMP Acklington	M CL C
HMP Albany	M CL B C
HMP Altcourse *	M L
HMP/YOI Ashfield*	CL YOI RC J
HMP Ashwell	M CL C
HMP/YOI Askham Grange	F O
HMYOI Aylesbury	YOI(M) CL A RES
HMP Bedford	M L
HMP Belmarsh	M CL A
HMP Birmingham	M L

2. HM Prisons (2004) List of Prisons. Compiled by Prison Service Library. Available on the web at http://www.hmprisonservice.gov.uk/assets/documents/1000071DPrisonswithcategories.doc

Prison	*Category*
HMP Blakenhurst	M L B
HMP Blantyre House	M S-O C
HMP Blundeston	M CL C
HMP/YOI Brinsford	YOI CL RC J
HMP Bristol	M L
HMP Brixton	M L
HMP Brockhill	F CL
HMP Bronzefield *	F
HMP Buckley Hall	F CL
HMP Bullingdon	M CL C L
HMP/YOI Bullwood Hall	F CL
HMP Camp Hill	M CL C
HMP Canterbury	M L
HMP/RC Cardiff	M L RC
HMP/YOI Castington	YOI CL J
HMP Channings Wood	M CL C
HMP/YOI Chelmsford	M L RC
HMP Coldingley	M CL C
HMP Cookham Wood	F CL
HMP Dartmoor	M CL C
HMYOI Deerbolt	CL YOI
HMP/YOI Doncaster *	M L
HMP Dorchester	M L RC
HMP Dovegate*	M CL B
IRC Dover	CL IRC
HMP Downview	F CL C
HMP/YOI Drake Hall	F S-O YOI
HMP Durham	M CL A
HMP/YOI East Sutton Park	F O
HMP/YOI Eastwood Park	F L
HMP Edmunds Hill	
(previously HMP Highpoint North and HMP North Ridge)	F CL RC
HMP Elmley	M CL B L
HMP Erlestoke	M CL C
HMP Everthorpe	M CL C
HMP/YOI Exeter	M L RC
HMP Featherstone	M CL C
HMP/YOI Feltham	RC CL M YOI J
HMP Ford	M O D
HMP/YOI Forest Bank*	M L YOI
HMP Foston Hall	F CL
HMP Frankland	M CL A
HMP Full Sutton	M CL A

Prison	*Category*
HMP Garth	M CL B
HMP Gartree	M CL B
HMYOI/RC Glen Parva	RC CL YOI
HMP/YOI Gloucester	M L RC
HMP Grendon	M CL B
HMP/YOI Guys Marsh	M CL C YOI
IRC Haslar	
(Immigration Removal Centre)	HC
HMYOI Hatfield	
(now HMP/YOI Moorland)	
HMP Haverigg	M CL C
HMP Hewell Grange	M O D
HMP High Down	M L
HMP Highpoint	
(previously HMP Highpoint South)	M CL C
HMYOI HINDLEY	RC CL YOI
HMP Hollesley Bay	M O D YOI(CL)
HMP/YOI Holloway	F L
HMP Holme House	M CL L B
HMP Hull	M L YOI(CL)
HMYOI Huntercombe	CL YOI J
HMP Kingston	M CL B
HMP Kirkham	M O D
HMP Kirklevington Grange	M RES C D
HMP Lancaster	M CL C
HMP/YOI Lancaster Farms	RC CL J YOI
HMP Latchmere House	M RES D
HMP Leeds	M L
HMP Leicester	M L
HMP/YOI lewes	M L YOI(CL)
HMP Leyhill	M O D
HMP Lincoln	M L
IRC Lindholme	M CL C O IRC
HMP Littlehey	M CL C
HMP Liverpool	M L
HMP Long Lartin	M CL A
HMP Lowdham Grange*	M CL B
HMYOI Low Newton	F L CL
HMP Maidstone	M CL C
HMP Manchester	M CL A
HMP/YOI Moorland Open	
(formerly HMP/YOI Hatfield)	M O D YOI
HMP/YOI Moorland Closed	M CL C YOI
HMP Morton Hall	F O

Prison	*Category*
HMP The Mount	M CL C
HMP/YOI New Hall	F CL YOI(CL)
HMYOI Northallerton	YOI CL
HMP North Sea Camp	M O D
HMP/YOI Norwich	M L YOI(CL)
HMP Nottingham	M L
HMYOI Onley	YOI CL J
HMP/YOI Parc *	M L B YOI(CL,RC)
HMP Parkhurst	M CL B
HMP Pentonville	M L
HMP Peterborough (newly opened)	
HMYOI Portland	YOI CL
HMP/YOI Prescoed	M CL C O D YOI(O)
HMP Preston	M L
HMP Ranby	M CL C
HMP/YOI Reading	YOI RC
HMP Risley	M CL C
HMP Rochester	YOI
HMP Rye Hill*	M
HMP Send	F CL
HMP Shepton Mallet	M CL C
HMP Shrewsbury	M L B
HMP Spring Hill,	M O D
HMP Stafford	M CL C
HMP Standford Hill	M O D
HMP Stocken	M CL C
HMYOI Stoke Heath	YOI CL J
HMP/YOI Styal	F CL L
HMP Sudbury	M O D
HMP Swaleside	M CL B
HMP Swansea	M L RC(YOI)
HMYOI Swinfen Hall	YOI CL
HMYOI Thorn Cross	YOI O J
HMP Usk	M C CL
HMP The Verne	M CL C
HMP Wakefield	M A
HMP Wandsworth	M L
HMYOI Warren Hill	YOI CL
HMP Wayland	M CL C
HMP Wealstun	M CL C O D
HMP The Weare	M CL C
HMP Wellingborough	M CL C
HMYOI Werrington	J
HMYOI Wetherby	CL J

Prison	*Category*
HMP Whatton	M CL C
HMP Whitemoor	M A
HMP Winchester	M L B
HMP Wolds *	M L
HMP Woodhill	M L A
HMP Wormwood Scrubs	M L
HMP Wymott	M CL C

KEY

YOI – young offenders institution

J – juveniles

RC – remand centre

RES – resettlement

L – local

HC – holding centre

IRC – immigration removal centre

CL – closed

O – open

S-O – semi-open

M – males

F – females

A B C D – Prisoner categories

* – privately run prison

Appendix 2 – Developing the guide: sources

This guide has been informed by wide range of source material:

1. *The Strategy for Modernising Dental Services for Prisoners in England*

This strategy, published in 2003, set clear expectations and standards for a modern prison dental service.

2. A review of prison dental services action plans

In early 2003, all prisons in England were asked to complete an Action Plan to demonstrate how they planned to make progressing in modernising dental services. 120 out of 135 prisons submitted plans by the autumn of 2003. These helped form a 'baseline' upon which to make some assessment of progress.

3. A survey of all prisons conducted in early 2005

All prisons in England were given an opportunity to complete a survey form which aimed to provide a current snapshot of progress in modernising prison dental services. The response rate of completed surveys was 64%. We obtained both quantitative and qualitative information.

4. Follow up telephone interviews with prison health care managers

Forty telephone interviews were undertaken. The information obtained supplemented the material gathered through the initial survey.

5. Prison site visits

Following a review of the surveys, six site visits were made. The purpose of these visits was to meet with those responsible for managing and providing prison dental service and obtain examples of best practice that could be incorporated in this guide for the benefit of others.

6. Department of Health waiting time data

General comment

Given the wide range, quality and completeness of the information sources, this guide does not report in detail on all the best practice in modernising prison dental services across England. Inevitably, some examples may have been missed. For the same reasons this guide does not offer a detailed statistical analysis of prison dental service performance. However, it does pick out both recurring themes of best practice and identifies some of the key issues that, according to those working in the field, need to be given attention in order to make further progress.