



Public Health
England

A survey of dental services in adult prisons in England and Wales

Rakhee Patel, Public Health England

Desmond Wright, Public Health England

Cathie Railton, Public Health England

Alan Canty, National Association of Prison Dentistry UK



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About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

For queries relating to this document, please contact: desmond.wright@phe.gov.uk

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Working group

Éamonn O'Moore - Director of Health and Justice Team, PHE

Mary Piper – Public health consultant, Health and Justice, PHE

Alan Canty – National Association of Prison Dentistry UK

Cathie Railton –Epi-scientist, Health and Justice, PHE

Desmond Wright – Consultant in dental public health, PHE

Rakhee Patel – Specialty trainee in dental public health, PHE

Anup Karki – Consultant in dental public health, Public Health Wales

Sandra White – Regional consultant in dental public health, PHE

Angelique Whitfield – Health and Justice commissioning manager, NHS England

Simon Marshall – Head of Health, Wellbeing and Substance Misuse Co-commissioning National Offender Management Service

Ian Sharpe – Senior Health and Wellbeing Co-commissioning Manager National Offender Management Service

Scope

This document refers to National Offender Management Service (NOMS) commissioned adult places of detention. The working group set the inclusion and exclusion criteria for the survey.

Included:

NOMS commissioned adult places of detention

NOMS commissioned young adult (18-21years) places of detention

Public and Private sector places of detention

Excluded:

Young people's estate

Immigration Removal Centers (IRCs)

Executive summary

This report presents the findings of a national survey of dental services in prisons in England and Wales prompted by the transfer of commissioning responsibility for these services in England to NHS England and the new role of Public Health England in April 2013. The survey explored the variations in commissioning arrangements and has generated a picture of issues in England and Wales for prison dental services. By providing this current picture, the survey will inform future commissioning to ensure consistency, quality and permit appropriate benchmarking of dental services.

All dental services delivered in prisons in England and Wales were invited to participate in the survey. A working group was established for the survey consisting of representatives from Public Health England (PHE), NHS England, Public Health Wales (PHW), the National Offender Management Service (NOMS) and the National Association of Prison Dentistry UK (NAPDUK). A questionnaire was developed, piloted and electronically administered. The main areas it covered were the prison dental workforce, safety and security, infection control, access, communication and IT.

The survey received 105 responses from 118 prison dental services – a response rate of 89%. All five prison dental services in Wales responded. Most dentists in prisons were on a personal dental services contract (30%) or community dental services contract (24%). Cross-infection compliance was variable, with only 61% reporting meeting best practice or compliant standards. In keeping with previous reports, there was wide variation in waiting times for assessing and treating people in prison, and concerns about the large number of failed appointments. Non-availability, refusal to attend and escort problems were thought to be the main reasons for failed appointments. Complaints are also reported to be common, with waiting times and demand for inappropriate treatments the main cause. Almost all respondents felt that the prison is a safe and secure environment. The equipment and facilities in many sites need replacing, in some cases urgently.

Although 98% of sites are computerised many respondents commented on the lack of adaptability of the software for dental care. The prison dental workforce is experienced, with a quarter of respondents having worked in prison dental services longer than ten years. However, respondents raised concerns about lack of mandatory prison training.

In conclusion, the findings of this survey are in line with previous reports, with prison dentistry posing challenges that are unique to this environment. In light of these challenges, the following recommendations have been made to the multi-agency working group:

1. There is a need to develop a standard specification for a high quality dental service in prisons to include definition of kit and dental equipment required in dental surgeries.
2. Key performance indicators for dental services in prisons need to be reviewed and performance regularly monitored by NHS Commissioners (as measured by the HJiPs in England).
3. Contracts for provision of dental services in prisons need to be reviewed and aligned to ensure provision of high quality services.
4. There is a need to ensure that patient experience and safety is at the heart of service provision and that the equipment and environment meet national safety standards.
5. There is a need to define NHS standard requirements for dental services to explore best practice and to explore opportunities for collaborative approaches for purchasing.
6. There is a need to align the system of inspections of prison dental services with other NHS dental services, including the CQC and the three yearly practice inspections in Wales, and ensure regular inspections of all prisons dental practices.
7. There is a need to support the transition to a new reformed dental contract in prisons in England and Wales.
8. There is a need to monitor workforce training and identify opportunities for dental career development in prisons, appreciating the specialist needs of prison dentistry such as substance misuse, learning difficulties and mental health.
9. There is a need to work with Postgraduate Medical and Dental Education to develop adequate training for dentists working within dental services in prisons, and also for general practitioners, to ensure dental competence meets the specific needs of offenders while in the prison and on release.
10. There is a need to ensure that all dentists working within the secure environment receive formal induction and undergo core establishment training.
11. There is a need to ensure that oral health is integrated into other health activities, including health promotion programmes and care pathways of people in prison with complex healthcare needs.
12. There is a need to ensure that NHS commissioners facilitate engagement between dentists in prisons and local dental networks.
13. There is a need to undertake ongoing work to identify prison-specific oral health and healthcare needs that take into account the views of service users. This information should subsequently inform commissioning decisions.
14. There is a need to inform current discussions regarding the next generation of health informatics systems to ensure dental health needs are appropriately met and capable of integration and /or communication with general prison health records.
15. There is a need to undertake further work to understand the reasons for non-completion of treatment plans, and explore methods to enable continuity of care and treatment completion when people in prison are released or transferred.
16. There is a need to engage with the Health and Justice Research Collaboration (HJRC) and other academic institutions to consider a dental research programme for prisons.

1. Background

1.1 Context

Following the reorganisation of the commissioning arrangements and structures for Healthcare services in England in April 2013 this survey was jointly commissioned by Public Health England, Public Health Wales, NHS England and National Offender Management Service (NOMS) to explore variations in commissioning arrangements for dental health services located within prisons in England and Wales. By providing a snapshot of the current state of dental services, this survey will inform future commissioning arrangements to ensure consistency, the development of quality indicators and outcomes, and permit the appropriate benchmarking of dental services.

In commissioning the report it is recognised that making improvements to services will continue to require partnership action. In England the response to the report will fall under the shared governance around the National Partnership Agreement (1) for commissioning and delivering healthcare in prisons. The working group will work together with Public Health England, NOMS and Public Health Wales to review the implication for services in prisons.

1.2 Oral health of people in prison

Surveys conducted in the UK show the general health of people in prison is poorer than the general population, with poorer physical, mental and social health (2). Drug, alcohol and tobacco dependency levels are high (3). There are also high levels of disability. This pattern transfers to oral health, with the oral health of people in prison reported as poorer than their peers in the community (4).

The prison population generally has poor oral health, with reports of periodontal disease and/or decayed, missing or filled teeth (DMFT) scores around four times higher than the general population (5,6). Studies have shown that oral health is poorer in a population of criminally convicted individuals before entering prison (7). People in prisons are more likely to have come from socially excluded or disadvantaged backgrounds and high levels of unemployment (8). So the oral health needs on admission are high, with significant levels of unmet dental treatment need. Research in North West England showed the DMFT scores of people entering prison are around twice as high as those of the general population (9). This has been attributed to detrimental habits such as drinking alcohol, smoking tobacco and using illicit substances (10), as well as decay-inducing diets, chaotic lifestyles, lack of oral health education and a low perception of oral health. Furthermore, there is a higher incidence of learning difficulties and mental health problems in this population, potentially contributing to poorer maintenance of oral hygiene (2).

Despite the increased need for treatment, evidence suggests that people in prison infrequently seek dental care (9). Dental service provision in prisons has been reported to be insufficient for

the needs of detainees (5). Shortcomings in dental care have been attributed to both infrequent clinical sessions and poorly equipped clinical services. This problem is exacerbated by the rising numbers of people in prison, as well as an ageing prison population, which has increased the strain on all healthcare provision in the prison service. It was proposed that one weekly clinical session for every 200 people in prison is an acceptable level of care (11). However, it is unlikely this will still be relevant because of the increase in the prison population. The transient nature of the prison population as a result of people having short sentences or being relocated to other facilities also means courses of treatment are often disrupted or left incomplete (12).

1.3 Commissioning prison dental services

A major reformation of prison healthcare was undertaken in 2003 when the funding for prison healthcare services was transferred from the Home Office (HO) to the Department of Health (DH) (2). At this time, prisons employed dentists locally often via a service level agreement. The prison dental services varied across the country provided by general dental services, community dental services and private contracts. In some areas, there were difficulties in recruiting a dentist to work in the prisons; especially those with high turnover, such as local prisons.

The Department of Health issued a series of publications to support commissioning of dental services in prisons, these include: 'Strategy for modernising dental services for prisons in England' (2), and 'Reforming prison dental services in England: a guide to good practice' (6). As part of this programme, funding was also made available to update dental equipment, and support new initiatives.

In April 2006, Primary Care Trusts and Local Health Boards in Wales were given the responsibility for the commissioning of prison dental services (6). There was vast variation across England and Wales, whereby commissioning teams were under scrutiny to understand the complexities of prison dentistry and its specialist nature. Additionally, in some areas the unit of dental activity (UDA) payment system raised contractual issues, with prisons failing to meet contract targets due to the higher levels of disease in prisons, complex medical and social histories of people in prison and numerous incomplete courses of treatment.

The Health and Social Care Act 2012 resulted in the reorganisation of the NHS in England and changes in the commissioning of prison healthcare, including dental services (13). From April 2013, NHS England took up its full commissioning duties to ensure that the NHS delivers better outcomes for patients within its available resources. One of NHS England's responsibilities is to directly commission health services or facilities for persons who are detained in prison or in other secure accommodation. 'Securing excellence in commissioning for offender health' (14) was developed collaboratively with stakeholders across the NHS and the youth and criminal justice team, with the ambition to support commissioners in a consistent, high quality approach to the delivery of services that secure the best outcomes for people in prisons and other secure settings (14). The core functions that underpin NHS England's responsibility lie with the

planning of services to meet national standards and local needs; securing of services with robust contracts that hold providers to account and monitoring the quality of services with an outcome focus.

The reform of the health system in England presents an opportunity for health and criminal justice partners to work together more effectively. Partner agencies will be able to work with NHS Health and Justice Area teams to develop prison health needs assessments to inform the commissioning of health services for people in prison. However, it is recognised that NHS England has inherited many and varied legacy contractual forms and service level agreements, which will have been locally negotiated by PCTs. It will take some time for all contracts to be brought in line with the standard NHS contract, but NHS England are working towards a standard provision for contracts.

In Wales, Local Health Boards are responsible for provision of prison dental services. These are either provided through Local Health Board's community dental service or commissioned from the general/personal dental service (GDS/PDS) providers. The dental public health team within Public Health Wales has recently carried out an oral health needs assessment of people in prison to inform future commissioning/service provision (15).

1.4 Policy priorities and governance

In England, the NHS outcomes framework (16) acts as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour. It is aligned with the public health outcomes framework (PHOF) (17) to encourage collaboration and integration. It forms part of the way in which the Secretary of State will hold NHS England to account for the commissioning system in the English NHS. Of particular relevance to this survey are domain 4 '*ensuring people have a positive experience of care*' and domain 5 '*treating and caring for people in a safe environment*' and '*protecting them from avoidable harm*'.

The PHOF (17) introduces the overarching vision for public health, the expected outcomes and the indicators to monitor these outcomes. The PHOF has a number of indicators related to the justice system and people in prisons. These indicators can be found in domain 1 '*improving wider determinants of health*' and domain 2 '*health improvement*'.

The DH document 'Public health services for people in prison or other places of detention'(18) sets out the steps to be taken to deliver public health programmes that reduce health inequalities and support people in prison to live healthy lives with continuity of care on return to the community.

'Securing excellence in commissioning NHS dental services' (13) identifies the need to ensure hard to reach and disadvantaged groups are able to access services as a priority. In particular '*the special care dentistry specialty and the development of a pathway in relation to it offers an opportunity to address this systematically across all providers; including dentistry in prisons.*'

Previously, prisons have been performance measured by the prison health performance and quality indicators (PHPQI) framework, which considered healthcare providers performance in delivering healthcare services (19). In 2009, in line with measures being developed in the wider NHS, offender health redeveloped the previous prison health performance indicators to become broader indicators of the quality of healthcare in prisons, as well as the performance of other contributing health and prison services (19). The PHPQIs have now been replaced by the Health and Justice Indicators of Performance (HJIPs) and include a much more comprehensive indicator set for dental services in prisons. The new indicators are being introduced nationally from July 2014.

All healthcare services in England and Wales require registration with the Care Quality Commission (CQC) or Healthcare Inspectorate Wales (HIW) (20). This extends to prisons, immigration removal centres and secure training centres. The CQC and HIW work closely with Her Majesty's Inspectorate of Prisons (HMIP) with whom they have a memorandum of understanding (MOU) that sets out how they ensure checks are not duplicated between the two bodies (21). The CQC has mapped out all of its regulations to HMIP's expectations and inspection methodology, meaning that healthcare providers should be able to demonstrate they comply with regulations through the same information they use to demonstrate they meet HMIP expectations.

In Wales, a framework of standards, 'Doing well, doing better – standards for health services in Wales' sets out the requirements of what is expected of all health services in all settings (22). Dental services' compliance with the standards for health services in Wales is monitored through the three-yearly dental practice inspection programme.

'Together for health: A national oral health plan for Wales 2013-18' provides health boards a strategic direction in oral health and dental services in Wales (23). The national plan requires health boards to develop a local oral health plan. The national plan states that a strategic approach is required to develop effective services for all vulnerable people in Wales and to ensure the current inequalities in access to, and uptake of, services can be addressed and monitored. Health boards' local oral health plans should include plans to address oral health needs of all vulnerable groups including people in prison.

A national partnership agreement between the National Offender Management Service, NHS England and Public Health England for the co-commissioning and delivery of healthcare services in prisons in England was published in 2013 and sets out the shared strategic intent and joint commitment in the commissioning, enabling and delivery of healthcare services in prisons (1).

2. Aim

The aim of this survey is to collect and present data across the prison estate in England and Wales to inform future commissioning of prison dental services by NHS England and Local Health Boards in Wales.

3. Methodology

3.1 Study design and sampling

This survey was a cross sectional study across the prison estate in England and Wales. All 118 adult prisons in England and Wales were contacted and asked to participate.

3.2 Inclusion and exclusion criteria

This document refers to National Offender Management Service (NOMS) commissioned adult places of detention. The working group set the inclusion and exclusion criteria for the survey.

Included:

NOMS commissioned prisons (public and privately managed), in England and Wales holding 18 year olds and over

Excluded:

Young people's estate (including YJB funded places operated by HM Prison Service)
Immigration Removal Centres (IRCs)

3.3 Questionnaire design

A working group was established for the survey consisting of representatives from PHE, NHS England, PHW, NOMS and NAPDUK. The group worked in partnership to identify salient information areas and design the questionnaire.

The questionnaire centered on the following areas of prison dental practice:

- The surgery, including equipment
- The prison dental workforce
- Infection control
- Safety and security
- Information technology
- Appointments
- Training
- Oral health promotion
- Communication.

Following piloting, comments were incorporated into the final version of the questionnaire

(Appendix 1).

To support the distribution process PHE Centre Health and Justice Public Health Specialists and/or health protection leads were asked to liaise with the dental services in the prisons in their area regarding completion of the survey.

3.4 Approval processes

In England, prior to any research being carried out with the NHS by a government organisation a proposal has to be approved via the review of central returns (ROCR) process to ensure that the data being collected is appropriate and necessary. The ROCR process is concerned with supporting the government's policy in 'reducing the burden' of data collections from the NHS. In order to obtain ROCR approval the audit has to be approved by a Minister. ROCR approval was gained to proceed with this survey (reference: ROCR/13/2212VOLU).

3.5 Dissemination

A joint letter from PHE, NOMS, PHW, NHS England and NAPDUK was sent to all prisons in England and Wales to request that the lead dentist for the prison complete the survey (Appendix 2). The letter gave a detailed description of the study and rationale for its completion. Within this letter was the online link for completion of the survey. Dentists were given three weeks to respond.

To raise awareness of the survey and encourage completion of the questionnaire, the survey letter was circulated to:

- Prison healthcare via NHS England area teams
- Lead dentists via NAPDUK
- Consultants in dental public health through regional DPH leads

4. Results

4.1 Response rates and details of responders

Responses were received from 105 out of 118 prisons, a response rate of 89%. All five Welsh prisons responded. The responses were largely representative of the prison estate. The overall categorisation of the estate and the responses for this survey are detailed in Table 1.

Table 1: Response rates by characteristics of prisons

		NUMBER
Prison security categorisation * (Out of 90)	A	7
	B	46
	C	27
	D	10
Gender	Male	95
	Female	9
	Mixed	1

* See Appendix 2

4.2 The dental surgery

The majority of prisons have one surgery (93%). At all sites with two surgeries, both are reported to be in regular use.

The majority of the dental clinics (91%) are based in the healthcare department. The remainder are based in the prison wing, community clinic, mobile site or within a private clinic.

Two thirds (66%) of clinicians were unaware if a Disability Discrimination Audit had been completed, but most considered the surgery to be wheelchair accessible (88%). A small number of dentists in prisons reported the surgery being too small for wheelchair access, with issues around the lay out of the surgeries resulting in restricted space and storage.

Over half (55%) of dentists reported their surgery had been refurbished and redecorated in the last five years. Twenty two percent of respondents commented that the state of decoration of the surgery needed attention. Only a quarter of surgeries were reported as being fit for ambidextrous use.

Infection control

The vast majority of prison dental services are using autoclaves or a mix of autoclaves and

disposable instruments (92%) to sterilise equipment. The remaining 8% are using central sterile and supplies department (CSSD) (4%), or a mix of CSSD and disposables (4%).

Vacuum autoclaves are being used in most cases (61%). Only half of sites have a separate decontamination room (51%). Lack of funding and space limitations were noted as reasons for not having a separate decontamination room.

Only 40 (38%) sites reported having a fully functioning washer disinfector. In a number of cases, it was reported that the washer disinfector was present, but not used, although reasons for this were not explored.

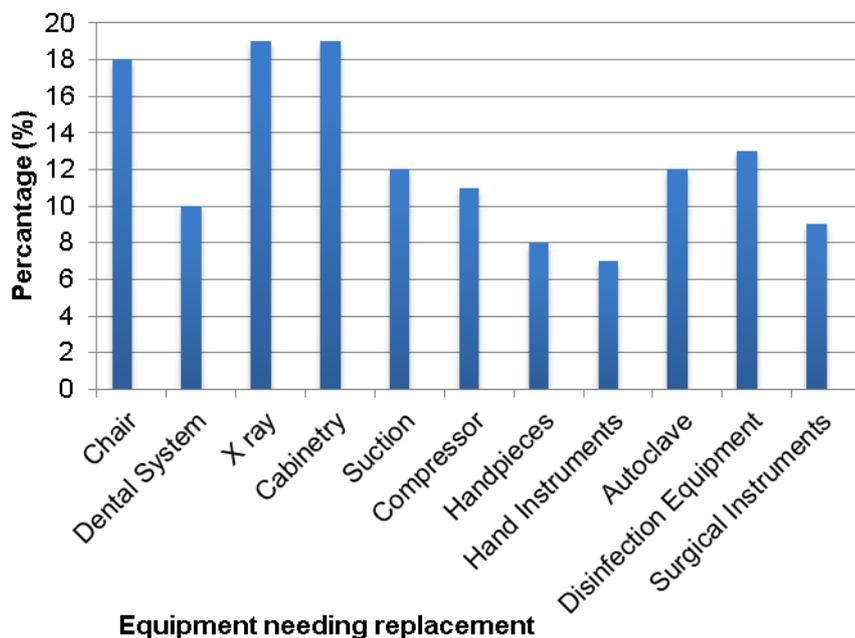
Where CSSD was used for the dental services, this was turned around within 10 days.

Fifty-nine (56%) of dental units had completed an infection control audit in the last year. In terms of cross infection compliance overall, 19 sites reported being 'best practice', 45 reported being 'compliant', six reported non-compliance, and 35 did not respond. Of interest, of the 19 that reported being best practice, only 13 had a fully functioning washer disinfector. Three-quarters (75%) of sites had not had, or were unaware of having, a CQC inspection or Welsh equivalent.

Equipment

Approximately two thirds (69%) of all respondents reported needing at least one item of equipment replacing. This is shown in Figure 1. A third of dentists reported needing an item replaced urgently, most commonly the suction system.

Figure 1: Equipment needing updating or replacement



Maintenance contracts were in place in 58% of the sites, with the primary responsibility for organisation coming mainly from the commissioner (52%), or provider (34%). The majority of payments for maintenance contracts came either from the prison/prison and NHS (54%) or contract holder (27%).

Radiography

Radiographic equipment used was most commonly film-based (75%). All film processing was carried out on site, with the vast majority using automatic film processors (91%). It was noted that in places where dentists worked part-time, the X-rays solutions needed changing more frequently, as the machine was not used for long periods. Only 7% of sites had additional radiographic equipment and in all cases this was an orthopantomogram (OPG). Again, a number of comments were made about the usefulness of an OPG, especially for such high needs patients who require multiple extractions.

Both a radiation protection advisor (RPA) and a radiation protection supervisor (RPS) were in place in 75% of sites, with only 3% of sites having neither.

Technology

Almost all (98%) of sites were computerised. In most cases (94%) the booking system was 'SystemOne', which was used for appointments (91%), waiting list management (83%), prescribing (71%), tasks (57%), messaging (50%) and patient records (75%). A third (33%) of dentists had not received training on 'SystemOne'.

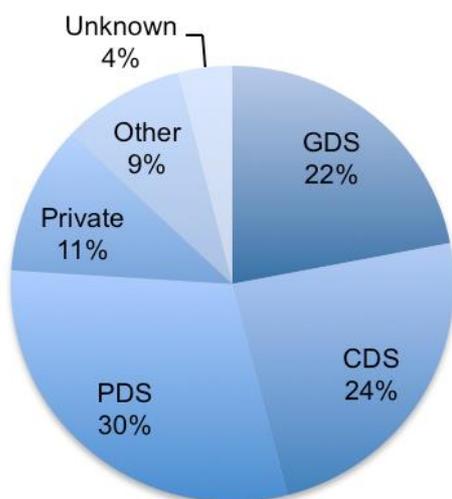
Just under half (45%) of respondents were aware that they were registered with the Information Commissioner's Office. However, 55% were either not registered or did not know.

4.3 The prison dental workforce and training

Dentists commissioned by NHS England and Local Health Boards in Wales were employed under GDS (22%), CDS (24%), PDS (30%) and private (11%) contracts. This is shown in Figure 2. Other contracts reported were dentists paid on sessional basis (9%). A small number of respondents (4%) were unsure of their contract type.

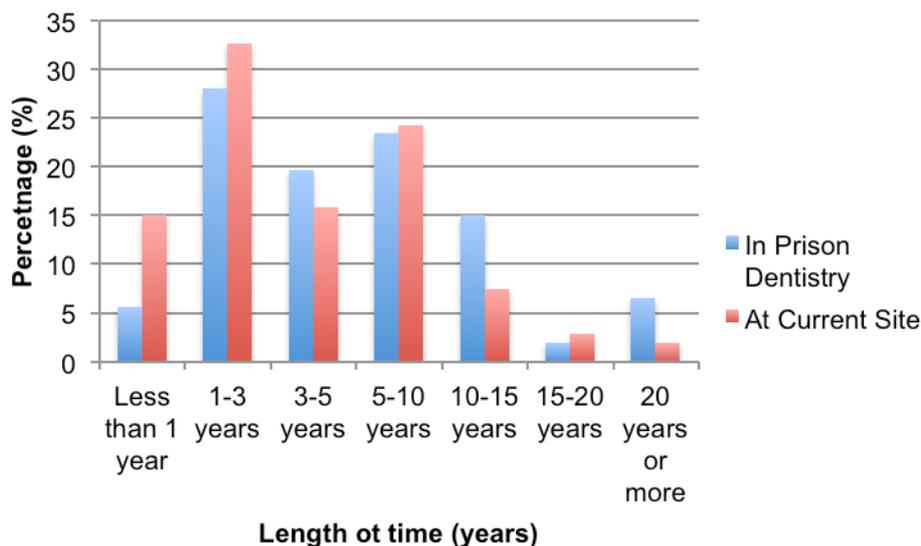
Of the respondents, 60% were not holders of the prison dental contract. Contract holders were primarily trusts or another named dentist. Service level agreements (SLA) were in place in most cases (62%).

Figure 2: Distribution of contract types



The length of time the dentist has worked as part of a prison dental service follows the same distribution pattern as the length of time they have worked at their current site, with the majority having worked in the prison dental services (28%) and at their current site (33%) for one to three years. Almost a quarter (24%) have worked in a prison dental service for ten or more years, and 9% at their current site for this time period. This is shown in Figure 3.

Figure 3: The length of time the dentists have worked within a prison dental service, and at their current site



The average number of sessions worked by a prison dentist is four, with a range between one and ten per week. Two-thirds of the dentists (66%) worked between two to four sessions per week. Two thirds of dentists (66%) booked in between seven to ten patients per session, with half booking 15 minutes for a new patient examination. Five dentists reported being on a General Dental Council specialist list, two in special care dentistry, one in special care/pediatric dentistry, one in special care dentistry/oral surgery and one in oral surgery.

Half (50%) of dentists reported being the sole dentist employed on site, 37% having two dentists, 10% having three dentists. A similar trend is followed with dental nurses, with half of the surgeries (55%) having only one nurse. Most sites (98%) reported having a health care manager, although only half had a healthcare receptionist (50%).

In terms of additional staff within the dental team, dentists reported having support from a therapist (14%), hygienist (5%) and clinical technician (3%). Under 'other', 20% of dentists reported having an oral health promoter working within the team.

Two thirds (65%) of dentists felt the prison, contract holder and local deanery supported their educational needs. The majority of dentists used a combination of training resources to fulfill continuous professional development (CPD) requirements.

In terms of training in operating in the prison environment, 84% of respondents reported having undertaken prison induction and key training. Less than half (46%) reported having received personal protection training. A third (36%) reported receiving fire training and 17% reported Assessment and Care in Custody Training (ACCT). Expectations around the nature of training required will vary by the type of establishment, its regime and the organisation of the dental

services including length of time staff have been in post and frequency of access required.

4.4 The prison environment

Safety and security

Almost all (92%) respondents considered the prison environment to be safe. For the small number of respondents who reported feeling unsafe one issue highlighted was perceived accessibility of panic buttons.

Most dentists in prisons did not have a prison radio (95%) and the majority did not feel they needed one (85%). Three-quarters did have keys issued (78%).

In terms of security, 82% reported regular security audits being carried out by the prison staff and in the majority of cases (91%) sessional tool checks were routinely carried out by staff and submitted to security. In almost all cases (98%) the door did not lock on closure for their safety, and three-quarters of staff felt security staff were readily available during the clinical sessions.

Communication

Communication between the dental and other health care staff was positive with 73% reporting it as good or very good. Approximately a quarter (29%) of dentists were invited to health care governance meetings that report to local prison partnership arrangements. Of the 30 invited, 17 (57%) attended the meetings and the majority (n=15, 88%) found them worthwhile.

4.5 The patient oral care pathway

Appointments and referrals

Diary management was reported to be primarily undertaken by a combination of the dental care professional and dentist (30%) or the receptionist (27%). Managing the waiting list is mostly the role of the healthcare manager, dental nurse and dentist.

At the time of the survey, the average waiting time for an examination was less than six weeks in 55% of cases, with 35% having a wait of six to 12 weeks. Only 3% of dentists reported a waiting time for examinations of longer than 18 weeks. For treatment, over a third of patients (38%) are seen within four weeks, with 44% of people in prison waiting longer than four weeks and 12% waiting in excess of ten weeks. Data on waiting time for examination and treatment are shown in Figures 5 and 6.

People in category B and C prisons were likely to wait six to 12 weeks for an examination, but three to four weeks for a follow up treatment appointment. People in category A and D prisons were more likely have an examination appointment within six weeks, and the follow-up treatment wait was five to six weeks.

Figure 4: Time on waiting list for examination



Figure 5: Waiting time for treatment



Although 51% of people in prison requiring emergency dental care are reported to be seen within the hour, 23% reported waiting longer than 4 hours. Thirty-one per cent in pain will be seen within eight hours; however, 23% will be seen within 24 to 48 hours, and 21% longer than 48 hours.

The majority of dentists (62%) referred between one-three people in prison per month for external specialist treatment and in almost all of these cases (98%) this was for oral surgery services.

Failure to attend appointments was reported as a significant issue. The reasons and frequency of failures were frequently unknown to the prison dentist. Non-availability due to visitation or release, as well as refusal to attend was frequently reported. Occasionally escort problems limited attendance.

Completion of treatment was an issue of concern. Over half (58%) of respondents reported that people in prison were released before dental laboratory work was fitted. Almost a third (35%) of

dentists reported having between 10% and 30% of laboratory work unfitted.

Eight dentists in prisons reported recording and collating oral health data (DMFT scores) separately from the dental records for epidemiology or monitoring purposes. These were all situated in the Midlands and South of England.

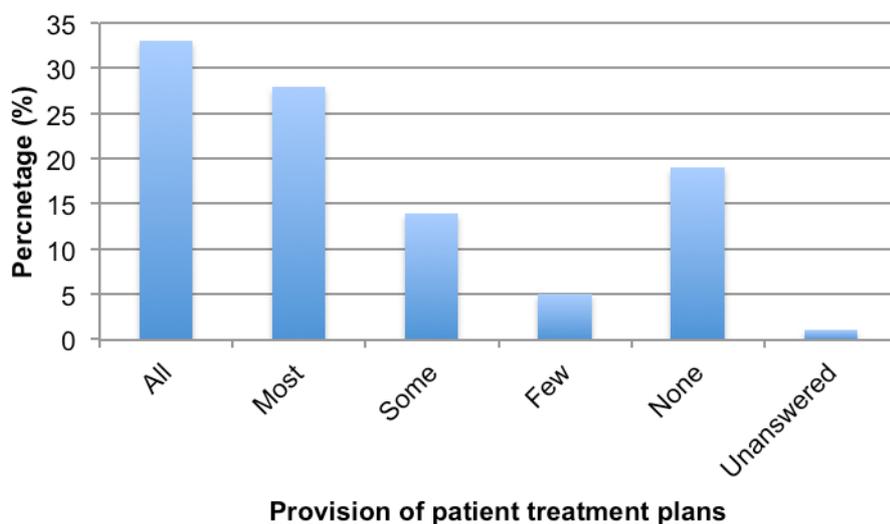
Oral health promotion

Oral health promotion is predominantly carried out one-to-one in surgery (25%) or as a combination of one-to-one and leaflets/posters (31%). Eighty-eight per cent of dentists in prisons were aware of a smoking cessation service in the prison and three quarters of respondents (80%) offered smoking cessation advice to dental patients.

Patient care

Half (52%) of dentists in prisons reported a patient care pathway being in place, with 66% also reporting an effective dental triage pathway. The frequency of provision of patient treatment plans is shown in Figure 7.

Figure 6: Reported provision of patient treatment plans



Language line was available for use in 48% of sites, with 52% not having it available, or did not know.

Complaints

Complaints received in the past 12 months were widely reported. This is shown in Figure 8. 18% of respondents had not had a complaint in the last 12 months, 43% had between 1-5 complaints, 22% 5-20 complaints, and 10% more than 20 complaints. Reasons for complaining were mainly around the waiting time for examination and treatment, requests for inappropriate treatment and dissatisfaction with treatment provided.

Figure 7: Number of complaints

Number of Complaints	Percentage Respondents (%)
0	18
1-2	35
3-5	8
6-10	15
11-20	7
More than 20	10
No response	7

5. Discussion

Previously published literature reported variations in contracting arrangements, delivery of dental services, and barriers to people in prison accessing dental care (6). The findings of this survey of dental services across the estate in England and Wales corroborate previous findings. While it is acknowledged that providing dental services in prison settings present unique challenges, due to complex health needs, lifestyle choices and other risk factors, standardisation across the service is necessary. Despite these challenges, prison dental services should be of the same standard and quality as services offered in general dental services. Accessible quality care should still be strived for, with compliance of legal standards. A standard template service specification with SMART (specific, measurable, achievable, realistic and timely) key performance indicators would provide quality assurance and ensure comparability of service provision across the various estates.

The responses from this survey are representative of the prison estate as a whole across England and Wales. However, there are limitations to the survey. Despite having been clear in the request that the lead dentist of the dental service for the prison complete the survey, in a number of cases it was completed by dental care professionals or healthcare staff. Additionally, in some cases the dentist who holds a cluster of dental contracts replied on behalf of all sites, instead of the lead clinicians at the individual sites. There were also a number of dentists who were unable to answer some of the questions as they had only just commenced the post.

It has been acknowledged in previous literature that many prison dental surgeries are in need of modernisation (6). There is an apparent need for consultation with professionals on surgery design as demonstrated by the fact that only a quarter of surgeries were fit for ambidextrous use. In this survey, the equipment and facilities in many sites were reported as needing replacing, in some cases urgently. It is essential that all equipment and facilities function efficiently and that recommended standards are met. Further work needs to be done with commissioners to understand in more depth what the issues are and what arrangements are in place for the management and replacement of equipment.

Legal requirements such as compliance with infection control, and health and safety, need to be regularly monitored through audits and action plans. It is important to identify areas for improvement to ensure that necessary adjustments are made so that the working environment is suitable and compliant for dental care. In a number of cases, maintenance contracts were not in place for key equipment. This is part of the CQC inspection process in England and three-yearly practice inspections in Wales, and needs to be monitored and addressed. It was also of some concern that a number of prisons reported having washer disinfectors, which were not in use. Steps need to be taken to ensure that all equipment is functioning and used in line with best practice.

Almost all the respondents felt that the prison is a safe and secure environment though a small number were concerned about the accessibility of the panic button. Further work is needed to understand these concerns in greater detail before any necessary corrective actions can be planned.

A large proportion of people in prison waited for over six weeks for an initial examination and treatment. For those requiring urgent or emergency dental care, waiting times are variable across the estate. In a population with identified high needs, timely access to care is paramount, especially for urgent and emergency care, which are the services frequently accessed by people in prison. There is a need to take into consideration the session's available, dental workforce and the prisoners dental needs when considering waiting time standards.

The high number of failed appointments, incomplete courses of treatment and unfitted laboratory work limit the productivity of the prison dental workforce. The significant proportion of unfitted laboratory work is a waste of scarce resources. The challenges presented with people being transferred between prisons are unavoidable, but those released should be planned for in line with continuity of care principles. Consideration should be given to putting systems in place to ensure that when people are transferred laboratory work that has started is also transferred so that the treatment can be completed.

The dental team needs to work in partnership with healthcare providers and prison staff to minimise failed appointments – for example, through better diary management and better communication, as well as keeping up to date with any planned transfers. Efforts should be made to ensure appointments are made available for other people in prison at short notice in a bid to minimise failed appointments. Communication with the healthcare team and prison staff is vital to ensuring an efficient service. Dentists should be actively encouraged to link with other services to promote the integration of oral health into other prison health improvement programmes.

With the high number of complaints in relation to those received by dentists in the community it is important that due process is followed for each complaint and that handling of the issue are in line with the NHS complaints policy and that this is regularly monitored and reported.

In terms of the workforce, many dentists and nurses are sole providers and mainly work on a part-time basis, which in itself may pose an access issue. Many dentists and nurses work in single-handed surgeries, and there is a need to monitor provision and continuity of care in their absence. The contract holder should ensure that care arrangements are in place for continuity. There is also variation in the number of dental sessions across the estate. The dental capacity in prisons suggested by Gerrish and Forsyth in 1995 is (11) unlikely to be relevant today because of the increased prison population. This should be re-visited and a more appropriate dentist/dental session: prison population ratio developed.

All dentists are required to undertake mandatory continuous professional development (CPD)

and audit in core areas. These include medical emergencies, radiography and infection control. A proportion of their CPD should also relate to their work in prisons. While the majority have undertaken key and induction training, few had done personal protection, ACCT and fire training.

Integral to running an efficient service is information technology. The IT system also provides a means to collate data and review service output as well as carrying out audits of dental practice. In this survey, many respondents commented on the lack of adaptability of current systems for dental care. In addition, a number of sites did not have IT access and a large proportion of dentists had not been trained in the use of these systems. The IT system should enable the transfer of dental data to the NHS Business Services Authority so that comparisons on dental prescribing can be made with other prisons.

6. Conclusions

The findings of this survey are in line with previous reports, with prison dentistry posing challenges unique to this environment.

The survey identified a number of key areas that need to be addressed. These are set out as recommendations in the next section.

7. Recommendations

The recommendations set out in this report will require multiagency partnership working in both England and Wales to take forward. This could potentially form a discrete work plan for which the further engagement of the working group would be required.

1. There is a need to develop a standard specification for a high quality dental service in prisons to include definition of kit and dental equipment required in dental surgeries.
2. Key performance indicators for dental services in prisons need to be reviewed and performance regularly monitored by NHS Commissioners (as measured by the HJiPs in England)
3. Contracts for provision of dental services in prisons need to be reviewed and aligned to ensure provision of high quality services.
4. There is a need to ensure that patient experience and safety is at the heart of service provision and that the equipment and environment meet national safety standards.
5. There is a need to define NHS standard requirements for dental services to explore best practice and to explore opportunities for collaborative approaches for purchasing.
6. There is a need to align the system of inspections of prison dental services with other NHS dental services, including the CQC and the three yearly practice inspections in Wales, and ensure regular inspections of all prisons dental practices.
7. There is a need to support the transition to a new reformed dental contract in prisons in England and Wales.
8. There is a need to monitor workforce training and identify opportunities for dental career development in prisons, appreciating the specialist needs of prison dentistry such as substance misuse, learning difficulties and mental health.
9. There is a need to work with postgraduate medical and dental educational organisations in England and Wales to develop adequate training for dentists working within dental services in prisons, and also for general practitioners, to ensure dental competence meets the specific needs of offenders while in the prison and on release.
10. There is a need to ensure that all dentists working within the secure environment receive formal induction and undergo core establishment training.
11. There is a need to ensure that oral health is integrated into other health activities, including health promotion programmes and care pathways of people in prison with complex healthcare needs.
12. There is a need to ensure that NHS commissioners facilitate engagement between dentists in prisons and local dental networks.
13. There is a need to undertake ongoing work to identify prison-specific oral health and healthcare needs that take into account the views of service users. This information should subsequently inform commissioning decisions.
14. There is a need to inform current discussions regarding the next generation of health informatics systems to ensure dental health needs are appropriately met and capable of integration and /or communication with general prison health records.

15. There is a need to undertake further work to understand the reasons for non-completion of treatment plans, and explore methods to enable continuity of care and treatment completion when people in prison are released or transferred.
16. There is a need to engage with the Health and Justice Research Collaboration (HJRC) and other academic institutions to consider a dental research programme for prisons.

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Appendix 1

Overview of the prison population

Since the 1940s the prison population in England and Wales has risen steadily. There has been an annual average increase of 3.6% in the prison population since 1993 and at the end of December 2013 in England and Wales it stood at 84,163 of which 3807 were females.

Between 2002 and 2012, the prison population in England and Wales grew by 14,830 or 21%. The number on remand fell by 13%, while those sentenced to immediate custody rose by 28%.

The proportion of the prison population comprising sentenced adult males (aged 21 and over) increased from 60% in June 1993 to 75% in June 2013. While the number of males in prison increased by 24% between 2002 and 2012, the average number of females decreased by around 3%. At the end of June 2013, there were approximately 3,853 females in prison.

Almost half of all people in prison are aged 25 to 39. The overall prison population in March 2013 was 3% lower than it had been the year earlier. The number of people in prison in most age groups fell, with the exception of those aged over 50, which increased by 5.2%. The 60 and over age group has grown at the fastest rate during the past decade: 3,741 are now in prison, representing 4% of the total prison population and the group's highest recorded proportion.

At 30 June 2013, 10,786 foreign nationals from 160 different countries were in prisons in England and Wales. Poland, Jamaica and the Irish Republic have the most nationals in prisons. The proportion of foreign nationals in prison increased steadily over the decade from 1997. In the early to mid 1990s they accounted for 8% of the total prison population, but increased to around 14% by June 2006. At the end of July 2013, the proportion of foreign nationals remained fairly level at 13%.

Source:

<https://www.gov.uk/government/collections/prison-population-statistics>

<https://www.gov.uk/government/collections/offender-management-statistics-quarterly>

Appendix 2

Prison Categories

Category A	People in prison whose escape would be highly dangerous to the public or the police or the security of the state and for whom the aim must be to make escape impossible
Category B	People in prison for whom the very highest conditions of security are not necessary, but for who escape must be made very difficult
Category C	People in prison who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt
Category D	People in prison who present a low risk; can be reasonably trusted in open conditions and for whom open conditions are appropriate

Appendix 3

Prison dentistry survey questions

Your Name

Your e-mail address

Name of Prison or Facility

Type of establishment (please tick all that apply)

(Male/Female/HMP/YOI/IRC/FNP/Male/Juvenile)

If HMP and Male:

What category is the prison? (A / B / C / D)

1. THE SURGERY

- 1.1 How many dental surgeries are there in the prison? (1 / 2 / 3 / 4 or more)
If 2 or more:
 - 1.1.1 How many dental surgeries are in use? (2 / 3 / 4 or more)
- 1.2 Where is the dental surgery located? (Healthcare department/Prison wing/Other _____)
- 1.3 Is the surgery designed for ambidextrous use? (Y/N)
- 1.4 Has a Disability Access Audit been carried out on the dental surgery? (Y/N/Unknown)
- 1.5 Is the dental surgery wheelchair accessible? (Y/N)
- 1.6 When was the surgery last refurbished?
(In the last 12 months/1-5 years ago/5-10years ago/More than 10 years ago/Unknown)
- 1.7 When was the surgery last redecorated?
(In the last 12 months/1-5years ago/5-10years ago/More than 10 years ago/Unknown)
- 1.8 Any additional comments on The Surgery (Free text)

2. ABOUT YOU AND THE PEOPLE WHO WORK WITH YOU

About You

- 2.1 How long have you worked in this prison? (Less than 1 year/1-3 years/3-5 years/
5-10 years/10-15 years/15-20 years/20 years or more)
- 2.2 What is the total number of clinical sessions worked by all dentists at this prison per
week? (1/2/3/4/5/6/7/8/9/10)
- 2.3 How long have you worked in prison dentistry? (Less than 1 year/1-3 years/3-5 years/5-
10 years/10-15 years/15-20 years/20 years or more)

2.4 Are you on a GDC specialist list? (Y/N)

If Yes:

2.4.1 Which of the following specialist lists are you on? Please tick all that apply.
(Special Care Dentistry/Dental Public Health/Oral Surgery/Restorative Dentistry/
Prosthodontics/Endodontics/Other _____)

2.5 Under what type of contract are you employed? (GDS/PDS/CDS/Private/Other _____)

2.6 Are you both the performer and the contract holder? (Y/N/Not Applicable)

If No:

2.6.1 Who is the contract holder? (Free text)

2.7 Is there a signed Service Level Agreement (SLA) in place? (Y/N/Don't Know)

2.8 To your knowledge, has an oral health needs assessment been carried out at this prison? (Y/N/Unknown)

Dental Staff

2.9 How many dentists are employed in the prison? (1/2/3/more than 3)

2.10 How many dental nurses are employed in the prison? (1/2/3/more than 3)

2.11 Do any of the following work at the prison? Please tick all that apply.
(Hygienist/Dental Therapist/Clinical Technician/Oral Health Promoter/Other _____)

Healthcare Staff

2.12 Is a healthcare manager employed in the prison? (Y/N)

2.13 Is there a healthcare receptionist? (Y/N)

2.14 Any additional comments on About You and the People Who Work With You (Free text)

3. THE EQUIPMENT

3.1 Does any of the following equipment need to be updated or replaced?

(Dental chair/Delivery system/X-ray Unit/Cabinetry/Suction/Compressor/
Handpieces/Hand Instruments/Autoclave/Disinfection eqpt/Floor covering/
Decoration/Surgical Instruments/Other _____)

3.2 Who is responsible for organising the maintenance of equipment? Please tick all that apply. (Contract holder/Prison/NHS/Performer/Unknown)

3.3 Who is responsible for payment of the maintenance contracts? Please tick all that apply. (Contract holder/Prison/NHS/Performer/Unknown)

3.4 Are maintenance contracts in place for equipment that needs regular certification?
(Y/ N/ Some but not all/Unknown)

If No or Some but not all:

3.4.1 What items are currently without a maintenance contract? (Autoclave/Washer-disinfector/X-ray equipment/Compressor/Suction/Other _____)

3.5 Are there any items of equipment that urgently need replacing or updating? (Y/N)

If Yes:

3.5.1 What equipment urgently needs replacing or updating? (Autoclave/Washer-disinfector/X-ray equipment/Compressor/Suction/Other _____)

Radiographic Facilities

- 3.6 What type of radiographs are used? (Film/Digital)
If Film:
3.6.1 What method do you use for X-ray processing? Please tick all that apply.
(Dark room hand processed/Automated film processor/Self-processing film packets)
3.6.2 Are radiographs processed at the prison? (Y/N)
If Digital:
3.6.3 What make of digital sensor is being used? (Free text)
3.6.4 What software package is being used? (Free text)
3.7 Which of the following have been appointed?
[Radiation Protection Advisor (RPA)/Radiation Protection Supervisor (RPS)/Neither]
3.8 What is the make and model of the X-ray unit? (Free text)
3.9 Apart from intraoral radiographic equipment, is any other radiographic equipment used
(e.g. OPG)? (Y/N)
If Yes:
3.9.1 What other radiographic equipment is used? (OPG/Lat Ceph/Other _____)
3.10 Any additional comments on The Equipment? (Free text)

4. CROSS INFECTION CONTROL

- 4.1 Which of the following are used by the surgery? Please tick all that apply.
(CSSD/Autoclave/Disposable instruments)
If CSSD:
4.1.1 How quickly are instruments generally returned from CSSD? (Less than 3 days/
3-7 days/7-10 days/10-14 days/14 days or more)
4.1.2 Have any security issues arisen over the use of CSSD? (Y/N)
If Autoclave:
4.1.3 What type of autoclave is used? (Vacuum/Non-Vacuum)
4.1.4 Is there a dedicated, separate decontamination room? (Y/N)
If Yes:
4.1.5 Is the decontamination room adjacent to the surgery? (Y/N)
4.1.6 Is there a fully functioning clinical washer/disinfector? (Y/N)
4.2 When was the most recent HTM 01-05 audit carried out? (An HTM 01-05 audit has
never been carried out/Less than 3 months ago/3-6 months ago/6-12 months ago/12-24
months ago/More than 24 months ago/Unknown)
If NOT "An HTM 01-05 audit has never been carried out" OR "Unknown"
4.2.1 What was the result of the HTM 01-05 audit? (Best Practice/Compliant/Non-
Compliant)
4.3 Has a full CQC inspection (England) or an equivalent inspection (Wales) been carried
out? (Y/N/Unknown)
If "Yes"
4.3.1 When was the CQC inspection carried out? (Less than 6 months ago/6-12
months ago/12-24 months ago/Unknown)
4.4 Any additional comments on Cross Infection Control (Free text)

5. THE TECHNOLOGY

- 5.1 How many computers are in the dental surgery? (1/2/3 or more)
- 5.2 Is SystemOne used in the dental surgery? (Y/N)
If Yes:
5.2.1 For which of the following do you use SystemOne? Please tick all that apply.
(Appointments/Waiting lists/Prescribing/Tasks/Dental Notes/Messaging/Other _____)
- 5.2.2 How many SystemOne training sessions did you attend? (No training was offered/0/1/2/3/4 or more)
- 5.3 Is there a bespoke dental software solution in place? (Y/N)
If Yes:
5.3.1 Which software solution is in place? (Dentsys "Paragon"/EMIS/Software of Excellence "EXact"/Kodak R4/Other _____)
- 5.4 Is the dental surgery registered with the Information Commissioner's Office (ICO)? (Y/N)
- 5.5 Any additional comments on The Technology (Free text)

6. THE DIARY

- 6.1 Who manages the dental appointment diary? Please tick all that apply.
(DCP/Receptionist/Dentist/Healthcare manager/Nursing Staff)
- 6.2 Who manages the dental waiting list? Please tick all that apply.
(DCP/Receptionist/Dentist/Healthcare manager/Nursing Staff)
- 6.3 How long is the waiting list for routine examinations?
(Less than 6 weeks/6-12 weeks/12-18weeks/18-26 weeks/26 weeks or more)
- 6.4 After the initial examination, how soon is a follow-up appointment for treatment available? (1-2 weeks/3-4 weeks/5-6 weeks/7-10 weeks/More than 10 weeks)
- 6.5 How many patients, on average, are booked into a clinical session?
(6 or less/7-8/9-10/11-12/13-18/18-24/24+)
- 6.6 How long do you book for an average new patient exam?
(5 mins/10mins/15 mins/20mins/25 mins/30 mins/more than 30 mins)
- 6.7 How quickly are patients requiring emergency dental treatment (trauma, hemorrhage, etc) seen by the dentist or other appropriately trained staff?
(Immediately/less than 1 hour/1-2 hours/2-4 hours/More than 4 hours)
- 6.8 How quickly are patients with dental pain normally seen by the dentist or other appropriately trained staff?(Less than 4 hours/4-8 hours/8-16 hours/16-24 hours/24-48 hours/more than 48 hours)
- 6.9 On average, how many external dental referrals are arranged each month for specialist dental care outside the prison? (0/1/2-3/4-5/6-7/8-10/More than 10)
If not "0":
6.9.1 For which of the following are referrals made? Please tick all that apply. (Oral Surgery/Oral Medicine/Restorative/Periodontic/Prosthodontic/Orthodontic/Other)
- 6.10 Are there any problems with making referrals for specialist dental care in your area or for patients attending these appointments? (Y/N)
If Yes:
6.10.1 What are the problems with making referrals for specialist care in your area or for

patients attending these appointments? Please tick all that apply:
(No centres with specialist facilities nearby/Local centres reluctant to accept referrals from the prison/Shortage of escorts on day of appointment/Waiting lists for referral services exceed patients' expected stay in the prison/Difficulties in coordinating between all parties (hospital, prison security, healthcare, etc.)/Other)

- 6.11 Are there administrative problems in providing escorts for external referrals?
(Never/Sometimes/Frequently/Always)

Failures

How frequently do the following cause DNAs? (Very Rarely/Rarely/Occasionally/Frequently/
Very Frequently)

- 6.12 Escort problems
6.13 Prison security (lock downs, counts, bad behaviour, etc.)
6.14 Patients being released or transferred without notice
6.15 Patients unavailable due to court appearances or video links, etc.
6.16 Patient out of prison due to medical appointments
6.17 Patient has visitors
6.18 Patient refuses to attend
6.19 Unknown
6.20 Other
If 6.20 = "Frequently" or "Very Frequently"
6.20.1 Please give details of 'Other' reasons that result in DNAs. (Free text)
6.21 Do you have an issue with patients being transferred or released before laboratory work is fitted? (Y/N)
If Yes:
6.21.1 What percentage of lab work is unfitted? (<10%/10-20%/20-30%/30-40%/>40%)
6.22 Are DMFTs recorded and collated separately from the dental records for epidemiological or monitoring purposes? (Y/N)
6.23 Any additional comments on The Diary (Free text)

7. SAFETY AND SECURITY

Dental Surgery Safety

- 7.1 Do you consider the dental surgery to be a safe and secure environment? (Y/N)
7.2 Is there an appropriately positioned panic button in the surgery? (Y/N)
7.3 Are the dental staff issued with a prison radio? (Y/N)
If No:
7.3.1 Is there a need for the issue of a prison radio to the dental staff? (Y/N)
7.4 Are all dental staff issued with keys? (Y/N)
If No:
7.4.1 Who is not issued with keys? (Dentist / DCP)
7.5 Are regular security audits carried out for the dental surgery by prison staff? (Y/N)
7.6 Are sessional tool checks carried out and submitted to security? (Y/N)
7.7 Does your surgery door automatically lock to those outside the surgery when the door closes? (Y/N)

7.8 Are security staff readily available during your clinical sessions? (Y/N)

7.9 Any additional comments on Safety and Security (Free text)

8. TRAINING

8.1 Which of the following prison training have you received? Please tick all that apply. (Prison Induction and Key Training/Personal Protection Training/Fire Training/ACCT Training/Any other training)

8.2 Do you receive regular updates for your prison training? (Y/N)

8.3 Does your healthcare department provide any additional training (e.g. Risk Management, CPR, etc.)? (Y/N)

8.4 How do you ensure that your educational needs are met with respect to your role in prison dentistry? Please tick all that apply. (NAPDUK events/Deanery events/Other verifiable CPD courses)

8.5 Are the prison, the provider, and your local deanery supportive of your need to participate in prison dental education? (Y/N)

8.6 Any additional comments on Training (Free text)

9. ORAL HEALTH PROMOTION

9.1 In what ways is OHP delivered? Please tick all that apply. (One-to-one in the surgery/Participation in events such as "Smile Week," etc./Prison health fayres and other educational events/Oral health educators providing group work/Posters and OHP information leaflets/Other)

9.2 Is there a specialist smoking cessation team in the prison? (Y/N)

9.3 Do you offer smoking cessation advice in the surgery? (Y/N)

9.4 Any additional comments on Oral Health Promotion? (Free text)

10. COMMUNICATION

10.1 How would you rate cooperation and liaison between the dental staff and other healthcare staff? (Very Good/Good/Neutral/Bad/Very Bad)

10.2 Does the dental team meet regularly with doctors and nursing staff to discuss healthcare issues? (Y/N)

10.3 Are you invited to attend healthcare governance meetings that report to the Partnership Board? (Y/N)

If Yes:

10.3.1 Have you ever attended any of these meetings? (Y/N)

If Yes:

10.3.2 Do you attend them regularly? (Y/N)

10.3.3 Do you find these meetings worthwhile? (Y/N)

Complaints

10.4 How many patient complaints have been received in the last 12 months concerning the dental service? (0/1-2/3-5/6-10/10-20/more than 20)

If not 0:

10.4.1 Which of the following have been the subject of complaints? Tick all that apply.

A survey of prison dental services in England and Wales

Patient waiting too long due to length of waiting list
Escort issue (patient not brought over or brought over too late, etc.)
Patient kept too long in waiting area
Patient wanting treatment that is clinically inappropriate
Patient dissatisfied with the care and treatment provided
Other

The Patient Journey

- 10.5 Is there a patient care pathway in place? (Y/N)
- 10.6 Is there an effective dental triage pathway in place? (Y/N)
- 10.7 For how many of your patients do you provide patient treatment plans?
(All Patients/Most Patients/Some Patients/A Few Patients/None)
- 10.8 Is Language Line translation service or an equivalent service available for your use in the surgery? (Y/N/Don't know)
- 10.9 Any additional comments on Communication (Free text)

Appendix 4

Letter to prisons

To:

Lead prison dentists
Prison Governors & Directors

Cc:

Healthcare Managers
NHS England Area Teams
PHE Health & Justice Public Health Specialists

26th September 2013

Re: National survey of prison dentistry

The National Association of Prison Dentistry UK (NAPDUK), Public Health England, Public Health Wales, NHS England and the National Offender Management Service are working in partnership to undertake a national survey of prison dentistry throughout England and Wales. The aim of this survey is to gain an accurate understanding of service provision across the estate and use this information as a driver to make improvements in the commissioning and delivery of dentistry services for prisoners and detainees.

We are writing to all establishments across England and Wales to ask that **the lead dentist** at your prison completes a short survey which is available online at:
<https://adobeformscentral.com/?f=fzBcAp99Ydgw651yh0K3DQ>

Please note that only one survey should be completed per prison/detention centre.

Your input will be most valuable and will serve to drive forward improvements nationally to dentistry provision for prisoners and other detainees.

We are asking for the survey to be completed by the lead dentist for each prison/detention centre by **Friday 18 October 2013**.

The results of the survey will be published in early 2014 and a report will be disseminated to stakeholders throughout England and Wales.

If you have any queries please contact survey@napduk.org

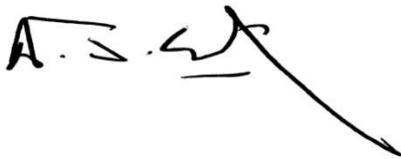
Yours sincerely,



Dr Éamonn O'Moore
Director for Health & Justice
PHE



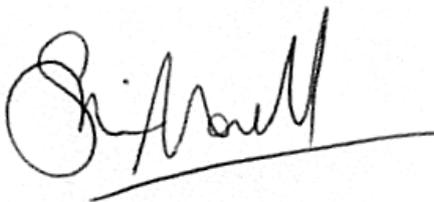
Kate Davies OBE
Head of Public Health, Armed Forces
and their Families & Health and
Health and Justice
NHS England



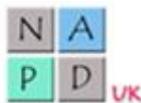
Alan Canty
NAPDUK Executive Committee



Anup Karki
Consultant in Dental Public Health
Public Health Wales



Simon Marshall
Head of Health, Wellbeing and Substance Misuse Co-commissioning
National Offender Management Service



PHE Health & Justice Team, Public Health England, 133-155 Waterloo Road, London, SE 1 8UG

NAPDUK, PO Box 32, Stroud, Gloucestershire, GL6 1DL

NHS England, Public Health, Armed Forces and their Families and Health & Justice Commissioning

Birch House, Southwell Road West, Rainworth, Nottinghamshire, NG21 0HJ

NOMS, Health and Well Being Co-commissioning, Clive House Post point 3.09, London, SW1H 9EX

Public Health Wales, Dental Public Health, Temple of Peace, Cathays Park, Cardiff, CF10 3NW