



Public Health  
England

Protecting and improving the nation's health

# Survey of prison dental services England, Wales and Northern Ireland 2017 to 2018

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Published March 2019

PHE publications

gateway number: GW-210

PHE supports the UN

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## Forward

The prison population has long been recognised as a vulnerable group with complex health and social care needs including higher rates of mental and physical health problems and drug or alcohol misuse, frequently with a background of poor educational attainment, childhood experience of abuse, social marginalisation, unemployment and homelessness.

People in prisons are less likely to be motivated to maintain their oral health. They often enter prison with higher rates of dental decay and oral disease than their peers in the community but with lower levels of treatment. Those with substance misuse problems are likely to report toothache very soon after entry to prison once the effects of opiates have worn off. Time in prison can be the first opportunity for many to address oral health needs that were previously hidden or neglected.

This document presents the findings of the most recent national survey of prison dentists. Thank you to the many people who have been involved in making the improvements identified in this survey. It is good to see an increase in the number of patients who are having their urgent care needs met immediately, particularly as this appears to be accompanied by increased provision of oral health promotion, and thereby the aim of preventing further disease.

The survey also importantly finds a significant increase in infection control compliance, improved induction training for teams and evidence of successful partnership working, with improvements in surgery facilities and locally developed protocols to improve attendance at appointments. We must continue to build on this progress and bring those involved together to share their innovations.

I am happy to report that we are already making progress on this recommendation and others. Work is underway with colleagues in Public Health England, the British Dental Association and National Association of Prison Dentistry United Kingdom, to produce a standard service specification for dental care in secure settings. This will include clearly defined service outcomes, with as many of these as possible collected electronically using FP17 data. We are also committed to sustaining our dental workforce through work with the British Dental Association and NHS Pensions to ensure that all those eligible for NHS Pension Scheme membership are offered the opportunity.

But we recognise there is more to be done. We will work with Her Majesty's Prison and Probations Service to raise the safety concerns, challenges with escorts and the need to clarify responsibility for equipment and facilities, all highlighted in this report. It is essential that we strengthen our partnerships to improve the enabling environment for

the important work of dental teams. Continued improvement will rely on greater integration at all levels - between healthcare and security to improve access to routine care, between dental and other healthcare services to improve training and opportunities to Make Every Contact Count, and between dentistry in prisons and the community to help improve continuity of care.

The challenges in prison dentistry are well documented, but, as the commissioner for healthcare in secure settings, NHS England is required to offer people in prison an equivalent level of service to the general population. Moreover, it is our ambition to narrow the health gap between those in prisons and the community by improving health outcomes for members of this vulnerable, high needs group. We welcome this report and encourage all those involved in prison dentistry to familiarise themselves with its recommendations. To meet the challenges in this complex field, we all need to work together towards the shared goal that people in prisons have improved oral health.

A handwritten signature in black ink, appearing to read 'Kate Davies', with a horizontal line underneath.

Kate Davies OBE CBE  
Director of Health & Justice, Armed Forces and Sexual Assault Services  
NHS England

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## Executive summary

This report presents the findings of a national survey in 2017 to 2018 of prison dental services located in adult prisons across England, Wales and Northern Ireland. This is a follow-up survey to one carried out in 2014 in England and Wales. Understanding the challenges that prison dental services are currently facing is key to making improvements, and this report will help the system work collaboratively to improve oral health and reduce health inequalities.

This survey explored the variations in commissioning arrangements and provides an updated picture of issues facing dental services in prisons across England, Wales and Northern Ireland. The findings of this survey will permit appropriate benchmarking and inform commissioning decisions to improve consistency and quality of dental services.

All dental service providers in adult prisons in England, Wales and Northern Ireland 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 including the Office of the Chief Dental Officer, Public Health Wales (PHW), Public Health Agency Northern Ireland, Her Majesty's Prison and Probation Service (HMPPS) previously the National Offender Management Service, and the National Association of Prison Dentistry United Kingdom (NAPDUK). A questionnaire was developed, piloted and electronically administered. The main areas covered were the prison dental workforce, safety and security, infection control, access, communication and information technology (IT). The lead dentist at each prison was asked to complete the survey, and this report is based on the findings from the survey.

The survey received 102 responses from 119 adult prison dental services. The response rate was 86%, made up of 110 prisons in England, 6 prisons (including a satellite site) in Wales and all 3 prisons in Northern Ireland.

There have been changes in the commissioning of prison dental services by NHS England, local health boards in Wales and the Health and Social Care Board in Northern Ireland. The survey captured changes made to the employment of prison dentists. The percentage of dentists employed under Community Dental Service (CDS) and Personal Dental Service (PDS) contracts was lower than those found in the 2014 survey. For the CDS, the reduction was from 24% to 20% and for PDS the reduction was from 30% to 17%. Around a quarter (27%) of dentists reported employment under a private contract, an increase from 11% in 2014. Recent changes to contracting and subcontracting of dental services has resulted in the loss of an NHS pension for some clinicians. However, at the time of writing the report, it appears that these issues have now been resolved.

Encouragingly, infection control compliance was reported to be higher in the recent survey: 81 out of the 102 prison dental sites (77%) had an infection control (HTM01-05) audit that had been carried out. The results were:

- 20 sites were awarded 'best practice'
- 47 sites reported being awarded 'compliant'
- 6 sites reported to be 'non-compliant'
- 8 sites were unsure of the result

As per the 2014 report, there was wide variation in waiting times for assessing and treating people in prison, and concerns about the large number of failed appointments. Many of the reasons for failed appointments were like the previous survey and included being released from prison or transferred without notice, having visitors or refusing to attend appointments. Reasons also included the prison regime and enablement, such as lockdown, escort problems, not being released in time and lack of communication of appointment times. Likewise, there were clashes with prison commitments, such as court appearances both in person and by video link, medical appointments or other prison commitments.

Complaints were reported to be common, relating mainly to length of waiting times, escort issues and how demands for inappropriate treatments were managed.

Almost all respondents felt that the prison is a safe and secure environment, but equipment and facilities in many sites need replacing or upgrading and in some cases urgently. Although 96% of sites are computerised, only 45% reported to have specific dental software for dental care.

The length of time dentists had been employed as a prison dentist varied, with over a third (35%) working between 1 to 3 years, and 16% working over 10 years. Almost half (43%) of prison dentists have been working at their current site for 1 to 3 years. Respondents raised concerns about lack of mandatory training for prison dental staff.

This survey reflects some challenges that are unique to this healthcare environment. To ensure that users of prison dental services receive high quality equitable care, key partners should consider taking forward the following recommendations and agree actions and responsibilities.

## Recommendations

1. Develop a standard specification for dental services in prisons, including definition of the specific equipment required and consideration of recommendations on waiting times to ensure consistent delivery of a high-quality service.

2. Agree on indicators for assessing the quality of service provision to ensure that what is measured will inform and lead to remedial actions and improvements for patients.
3. Safeguard patient experience and safety by ensuring that the equipment and environment meet national safety standards.
4. Explore opportunities to improve transfer communication and/or systems so that patients can be assessed, triaged and have access to care according to their need.
5. All members of the dental team working within the secure environment should receive formal induction and undergo core establishment training, with regular updated training, to ensure safety of staff and smooth integration within the prison.
6. All members of the dental team should have access to and complete training and development which reflects the needs of working in a prison environment, such as an appreciation of mental health, substance misuse, learning disability etc. This will create a better understanding of the patient group and prepare staff for opportunities for dental career development in prisons.
7. Ensure that oral health is integrated into other health activities in prison, including health promotion programmes and care pathways to make every contact matter.
8. Facilitate engagement between dentists in prisons and local dental networks to inform the local system and encourage co-operation between community and prison dental services.
9. Explore the possibility of setting up regional resourced Managed Clinical Networks for prison dentistry to share best practice and offer peer support.
10. Explore the integration of healthcare software informatics to support dental and healthcare staff with accessing contemporaneous notes for patients in prisons.
11. Information Technology infrastructure and systems should be in place so that all dental service providers submit FP17 data to NHS Business Services Authority (and 'risk-need' data in Wales) electronically so that activity can be monitored and reported on a regular basis.
12. Engage with dentists working within prisons to encourage participation in research, engaging with the Health and Justice Research Collaboration (HJRC),



Offender Health Research Network, National Association of Prison Dentistry (NAPDUK) and academic institutions to consider wider dental research programmes for prisons. Alongside this, collaborate with the worldwide prison health research and engagement network (WEPHREN).

13. Ensure contribution of dental teams within the prison infrastructure, including attendance at healthcare governance meetings where necessary, so that they can raise issues and support any remedial actions to improve the smooth running of the service.

# 1. Background

## 1.1 Context

Reorganisation of commissioning arrangements and structures for healthcare services in England took place in April 2013. Following this, a national survey of prison dental services (1) was jointly commissioned by Public Health England, Public Health Wales, NHS England and National Offender Management Service (NOMS) to explore variations in commissioning arrangements and service delivery for dental health services located within prisons in England and Wales. This survey provided a snapshot of the state of dental services at the time, informing future commissioning arrangements to ensure consistency, the development of quality indicators and outcomes, and permit appropriate benchmarking of dental services.

The survey was repeated in 2017-18 across England, Wales and for the first time Northern Ireland to understand the current provision of dental services and assess any changes since the last report. Understanding the challenges which prison dental services are currently facing is key to making improvements, and this report will help the system work collaboratively to improve oral health and reduce health inequalities.

Effective improvements to services will require partnership action. In England the response to the report will fall under the shared governance around the existing National Partnership Agreement (2) for commissioning and delivering healthcare in prisons. There are responsibilities for commissioners and PHE, Her Majesty's Prison and Probations Service (HMPPS) previously National Offender Management Service (NOMS), Public Health Wales (PHW) and Public Health Authority Northern Ireland (PHA NI) to review the implications 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 those in prison to be of poorer physical, mental and social health (3). Those entering prison have a higher dependency on tobacco and recreational drugs and alcohol misuse is high (4, 5). This pattern transfers to oral health, with the oral health of people in prison reported as being poorer than their peers in the community (6).

The prison population generally has poor oral health, with reports of periodontal disease and dental decay levels around 4 times higher than the general population (7, 8). People in prisons are more likely to have come from socially excluded or disadvantaged backgrounds and areas with high levels of unemployment (4). People in prison have a

lower educational attainment which may relate to learning difficulties, which may be 'hidden' or specific (5). Studies have shown that oral health is poorer in a population of criminally convicted people before entering prison (9). Therefore, the oral health needs on admission to prison are high, with significant levels of unmet dental treatment need. Research in North West England showed the decayed, missing and filled (DMFT) scores of people entering prison are around twice as high as those of the general population (10). This has been attributed to lifestyle choices such as; drinking alcohol, smoking tobacco, using illicit substances (8, 11), and high sugar diets. Chaotic lifestyles, the lack of oral health literacy and not valuing oral health also have a role (8). There is a higher incidence of learning difficulties and mental health problems in this population, potentially contributing to poorer maintenance of oral hygiene (3, 5).

Despite the increased need for treatment, evidence suggests that people in prison infrequently seek dental care (10). Shortcomings in dental care have been attributed to infrequent clinical sessions and poorly equipped clinical services. This problem is exacerbated by the rising numbers of people in prison. In 1993, the population of people in prisons in England and Wales was 44,246 and in December 2017 the population was 84,373 of which 3,919 were females (see Appendix 1). It is also recognised that there is an ageing prison population which may increase the pressure on all healthcare provision in the prison service to manage more complex dental needs. 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). Providers of dental healthcare services are faced with challenges, including funding for healthcare services and staffing (including recruitment, retention and training) in prison and detainee settings (13).

### 1.3 Commissioning prison dental services

In the last 2 decades, there have been several changes in the way prison dental services are commissioned. In 2003, prison healthcare services underwent a major reformation when the funding for prison healthcare services was transferred from the Home Office (HO) to the Department of Health (DH) (3). Contracts for prison dental services vary across the country and provision is provided by general dental services, personal dental services, community dental services or private contracts. In some areas, there were and still are difficulties in recruiting dentists to work in prisons, especially those with a high turnover of staff.

The Department of Health issued a series of publications to support commissioning of dental services in prisons including 'Strategy for modernising dental services for prisons in England' (3), and 'Reforming prison dental services in England: a guide to good practice' (7). Due to the focus on prison dentistry at the time, funding was made available to update dental equipment, and support new initiatives.

In April 2006, Primary Care Trusts (PCTs) in England and Local Health Boards in Wales were given the responsibility for the commissioning of prison dental services (7). There were variations across England and Wales with commissioning teams 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 (14). 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 people who are detained in prison or in other secure accommodation. 'Securing excellence in commissioning for offender health' (15) was developed collaboratively with stakeholders across the NHS and the youth and criminal justice team, with the ambition of supporting 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 (15). 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 2013 reform of the health system in England presented opportunities for health and criminal justice partners to work together more effectively and efficiently. Partner agencies were able to work with NHS Health and Justice Area teams to develop prison health needs assessments, informing the commissioning of health services for people in prison. Following the reforms, NHS England inherited many and varied contractual agreements for prisons locally procured and negotiated by PCTs.

NHS England is now the sole commissioner of prison healthcare contracts. Recently there has been a rise in the number of larger companies winning dental/healthcare contracts to deliver services in prisons. Some dental contracts are subcontracted to other providers for clinical dental services. Subcontracted dentists may lose NHS benefits, particularly those who have been working in the prison dental services for some time, so employment of this kind can deter people from working in the prison dental services.

In Wales, local health boards are responsible for provision of prison dental services in majority of prisons. These services are either provided through Local Health Board's Community Dental Service or commissioned from the general/personal dental service (GDS/PDS) providers. Where a prison is privately managed in Wales, the prison has a

direct contract with a private dental service. The dental public health team within Public Health Wales carried out an oral health needs assessment of people in prison in 2014 to inform future commissioning/service provision (16). This survey found that the oral health of the prison population in Wales was much worse than that of the wider population and a number of recommendations were made for this population.

In Northern Ireland, the Community Dental Service delivers dental health services to people in prisons and young offenders centres (17). The Health and Social Care Board (HSCB) and Public Health Authority (PHA) support the commissioned South Eastern Health and Social Care Trust which is responsible for delivering health services to people in prison across 3 establishments (18). They work in collaboration to improve existing healthcare in relation to prisoner health services.

## 1.4 Policy priorities

In England, the NHS outcomes framework (19) 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) (20) 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. The PHOF has several 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'. 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' are also of relevance to this survey.

The Department of Health and Social Care (DHSC) document 'Public health services for people in prison or other places of detention, including those held in the Children & Young People's Secure Estate' (21), 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 access to continuity of care on return to the community.

'Securing excellence in commissioning NHS dental services' (14) 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 (22). 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 (22). The PHPQIs have been replaced by the Health and Justice Indicators of Performance (HJIPs) and now include a basic indicator set for dental services in prisons. These new indicators were introduced nationally in July 2014.

All healthcare services in England and Wales require registration with the Care Quality Commission (CQC) or Healthcare Inspectorate Wales (HIW) (23, 24). 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). They each have a memorandum of understanding which sets out their roles and responsibilities (25, 26). The CQC has mapped out all 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 Northern Ireland, the Regulation and Quality Improvement Authority (RQIA) is an independent body that oversees the health and social care in the three prisons in the area. The RQIA inspects the healthcare services of prisons and play a role in assuring the quality of services delivered and encouraging improvements (27).

In Wales, a framework of standards, 'Health and Care Standards' sets out the requirements of what is expected of all health services in all settings (28). Dental services' compliance with the standards for health services in Wales is monitored through annual Quality Assurance Self-assessment (QAS) and the three-yearly dental practice inspection programme delivered by the HealthCare Inspectorate Wales (HIW).

'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 (29). 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. In addition, the Welsh Government produced the document 'A Healthier Wales: our Plan for Health and Social Care, The oral health and dental services response'. This document highlighted how oral health and dental services in Wales will continue to develop in line with the changing needs and lays out the key priorities between 2018 to 2021 (30).

NHS England is responsible for the commissioning of healthcare in secure and detained settings. The Health and Justice team published a strategic direction (31) that sets out the objectives to improve health and care outcomes of children, young people and adults in the criminal justice system between 2016 to 2020. Seven priority areas were identified to work towards reducing existing health inequalities between those in the criminal justice system and population. The document, principally for NHS England, was

written in collaboration with commissioning leads, service users, HMPPS and PHE and recognises the importance of commitment to partnership working with all those involved in providing care for people in prison. It aligns with recommendations from other reports such as that in the Five Year Forward View for Mental Health (32). This includes working closely with clinical commissioning groups and local authorities when an offender moves through the justice system.

A National Partnership Agreement between the Prison Health Partnership (HMPPS, NHS England and PHE) was put into place to support the co-commissioning and delivery of best healthcare services for people in prisons in England. It was first published in 2013 following the introduction of the Health and Social Care Act 2012. The most recent agreement was published in 2018 with the partnership now joined by the Ministry of Justice and the Department of Health and Social Care. The agreement defines the roles of the 5 partners working together and their commitment to working collaboratively in policy, commissioning and delivery of health and social care services in public and private sector prisons in England (2).

## 2. Aim

The aim of this survey was to review prison dental services in England, Wales and Northern Ireland commissioned by NHS England, local health boards in Wales and Northern Ireland.

The objectives were to:

- assess if there have been any changes in prison dental services since the last survey undertaken in 2014
- review any challenges which prison dental services are currently facing
- make recommendations for the delivery of high quality equitable dental services in prisons



## 3. Methodology

### 3.1 Study design and sampling

A cross-sectional survey of the prison estate in England, Wales and Northern Ireland was carried out between November 2017 to January 2018.<sup>1</sup> One hundred and nineteen (119) prisons across the 3 countries were contacted and invited to participate. This included 110 prisons in England, 6 prisons (including a satellite site) in Wales and 3 prisons in Northern Ireland.

### 3.2 Inclusion and exclusion criteria

This document refers to Her Majesty's Prison and Probation Service (HMPPS) commissioned adult places of detention. The inclusion and exclusion criteria for the survey follows that of the previous survey and is as follows:

Included: HMPPS commissioned prisons (public and privately managed), in England, Wales and Northern Ireland holding 18-year olds and over

Excluded: young people's estate (including Youth Justice Board (YJB) funded places operated by HM Prison Service) and Immigration Removal Centres (IRCs)

### 3.2 Questionnaire design

A working group was established consisting of representatives from PHE, PHW, PHA NI, HMPPS and NAPDUK. The 2014 survey questionnaire was modified to ensure all questions being asked were relevant and updated to reflect current commissioning arrangements.

All stakeholders involved with this survey were consulted on the questionnaire to ensure inclusion of relevant questions. The questionnaire was piloted and amended in line with feedback and the final questionnaire is included in Appendix 2.

The questionnaire centred on:

- the prison dental workforce
- the previous prison dental survey
- the dental surgery, including location and design

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<sup>1</sup> N.B. Northern Ireland was not included in the previous 2014. The 2014 survey only included England and Wales.

- equipment
- cross-infection control
- information technology
- appointments
- dental surgery safety and security
- training
- oral health promotion
- communication
- prison dentistry managed clinical networks (MCN)

The survey was then entered onto Select Survey, a web-based survey builder used by PHE. This survey was then trialled to ensure ease of completion before being disseminated.

### 3.3 Dissemination

A letter addressed to the Dentist was sent on behalf of the working group from PHE to all healthcare prison managers/leads in England, Wales and Northern Ireland. They were requested to disseminate the survey link to the lead dentist delivering dental services at the prison site (Appendix 3). 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 by the lead dentist. Dentists were given 3 weeks to respond. Responses were monitored and, after 3 weeks a follow up letter was sent out as previously described for further completion. Further to this, a final request was made for all remaining prisons to disseminate the survey to the relevant prison dentists for completion.

To raise awareness of the survey and encourage completion of the questionnaire, information about the survey was:

- raised at dental public health network meetings
- raised at the PHE Health and Justice Network Meeting
- raised with NHSE Health and Justice commissioning leads
- brought to the attention of those prison dentists who are affiliated with the NAPDUK

### 3.4 Data analysis

Data was cleaned, organised in Excel and analysed accordingly.

## 4. Results

### 4.1 Response rates and details of responders

A total of 102 out of 119 prisons responded, with a response rate of 86%. All 3 prisons in Northern Ireland responded to the survey. The responses received 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**

	<b>Category*</b>	<b>Number</b>
<b>Prison security categorisation (out of 90 prisons)</b>	A	8
	B	33
	C	38
	D	11
<b>Gender</b>	Male	91
	Female	9
	Mixed	2

\*see Appendix 1 & 4 for an overview of the prison population and definition of categories

### 4.2 The prison dental workforce

A third of dental services in prisons are delivered by a single dentist at a particular site (38%). In the remaining sample, 2 dentists (36%), 3 dentists (16%) and 4 or more dentists (10%) delivered care. The number of clinical sessions being delivered by dentists ranged from 1 to 10 sessions a week; 56% worked between 2 to 4 sessions per week, 28% worked between 6 to 8 sessions. There was a total of 6 dentists who reported being on the General Dental Council Specialist list, 5 on the special care list and 1 on the periodontal specialist list.

Forty percent of dental services have 1 dental nurse working with them in the prison, 33% had 2 nurses and 27% had 3 or more nurses employed. In terms of additional staff within the dental team, dentists reported this included dental therapists (39%), hygienists (4%), clinical technicians (3%) and oral health promoters (13%), however around half (48%) of prisons did not have any of the wider team members.

It was reported that hygienists worked between 1 to 4 sessions, the majority working between 2 to 3 sessions. Therapists delivered 1 to 8 sessions weekly, with the majority

having 2 to 4 sessions a week. The clinical technicians employed worked mainly 1 session a week, with a few working 2 sessions. The oral health promoters delivered 1 to 2 sessions a week.

Most sites reported having a healthcare manager (92%), however only 39% had a healthcare receptionist to support with making appointments. More than three-quarters of dentists (77%) reported that there were cover arrangements if a dentist was unable to deliver their session due to sickness, leave or unforeseen circumstances.

### Dentists' experience in prisons dental services

For most respondents, the length of time the reporting dentist has worked as part of a prison dental service is similar to the length of time they have worked at their current site, however for some there is variation. This variation is seen amongst those who have worked in the prison service for a longer period of time, however have been employed at their current site for a shorter period of time. Overall differences between the time worked in prison dentistry and the time worked at their current site can be seen in Table 2 below.

**Table 2. Length of time dentists have worked at their current site and within the prison dental services**

Length of time working	Time worked in prison dentistry	Time worked at current site
Less than 1 year	10%	21%
1 to 3 years	35%	43%
4 to 5 years	10%	8%
6 to 10 years	29%	18%
11 to 15 years	10%	9%
16 to 20 years	1%	0%
More than 20 years	5%	2%

### Employment of prison dentists

Dental services commissioned by NHS England, Local Health Boards in Wales and Health and Social Care Board in Northern Ireland shows that dentists were employed under the CDS (20%), GDS (22%), private contract (27%) and PDS (17%). Other responses included 'unsure of the type of contract' they were employed under, 'being self-employed', or 'not having a contract'.

Table 3 below shows the contract types that dentists are employed under, almost a third being employed under private contract. Just over a third (37%) reported being employed without a pension.

**Table 3. Type of contract prison dentists are employed under**

<b>Contract type</b>	<b>Percentage (%)</b>
Community Dental Service (CDS)	20%
General Dental Service (GDS)	22%
Other*	15%
Personal Dental Services (PDS)	17%
Private	27%
Total	100%

\*Other: this includes those reporting as independent and self-employed dentists

Of the respondents, 74% were not holders of the prison dental contract; contract holders were either corporate bodies (63%) or partnership or independent providers (26%).

Over half (55%) reported that the dental contract was part of a larger healthcare provider contract. Of these, a further half (52%) were from corporate bodies and a large proportion (40%) were from health trusts or boards. A small percentage (8%) was from non-corporates and single entities.

A recurrent theme in the additional comments was the way in which contracts were subcontracted and NHS pensions. Examples of comments made by respondents include:

“The subcontracting agreement doesn’t allow the dentists to claim their entitlement for NHS Pension. Even though they do work entirely within the NHS, they have no basic right to NHS pension.”

“...Our dentists are working purely within the National Health framework, but still have no right to basic pensions, maternity/paternity benefits at all...”

## Training

Regarding training of the dental team in support of their role, 56% had received a prison induction and 83% reported to have received prison key training. Nineteen percent reported undergoing Assessment, Care in Custody and Teamwork (ACCT) training and 15% received Suicide Awareness and Self Harm (SASH) training (Table 4).

Expectations about 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. A total of 6% reported not having

received any of the above training. Other training was also carried out in some prisons, 4% of respondents noted to have received prison training programmes on grooming, training in prison radio usage, or Project ECHO (Extension for Community Healthcare Outcomes) in Northern Ireland prisons.

**Table 4. Types of training received by the dental team delivering services in prisons**

<b>Type of training</b>	<b>Percentage (%)</b>
Prison induction	56%
Prison key training	83%
Personal protection training	32%
Fire training	30%
Assessment, Care in Custody and Teamwork (ACCT) training	19%
Suicide Awareness and Self Harm (SASH) training	15%
Reported having no training	6%
Other*	4%

\*Other: this includes those reporting to have received training in grooming, prison radio usage and programmes such as Project ECHO in Northern Ireland

A fifth of dentists (19%) reported receiving regular updates for their prison training. In some prisons, additional training (such as risk management and cardiopulmonary resuscitation) is arranged through the prison services (13%), employer (63%) and prison dentist (6%); 17% did not receive any additional training.

Part of the requirements for maintaining registration with the General Dental Council (GDC) involves fulfilling continuing professional development (CPD) requirements. Professional development and educational needs were met through a combination of training resources provided by NAPDUK organised events (38%), Health Education England (HEE, Deanery) events (25%), employer organised training (56%), other verifiable CPD courses (74%) and other categories (4%) including journals, online CPD and independent organisations. Approximately 4% of dentists reported not having educational needs met with respect to their role in prison dentistry.

Although dentists reported a wide range of organisations that supported prison dental education, 79% of them felt they would have benefitted from receiving training on working in prisons prior to commencement of their post.

## The dental surgery

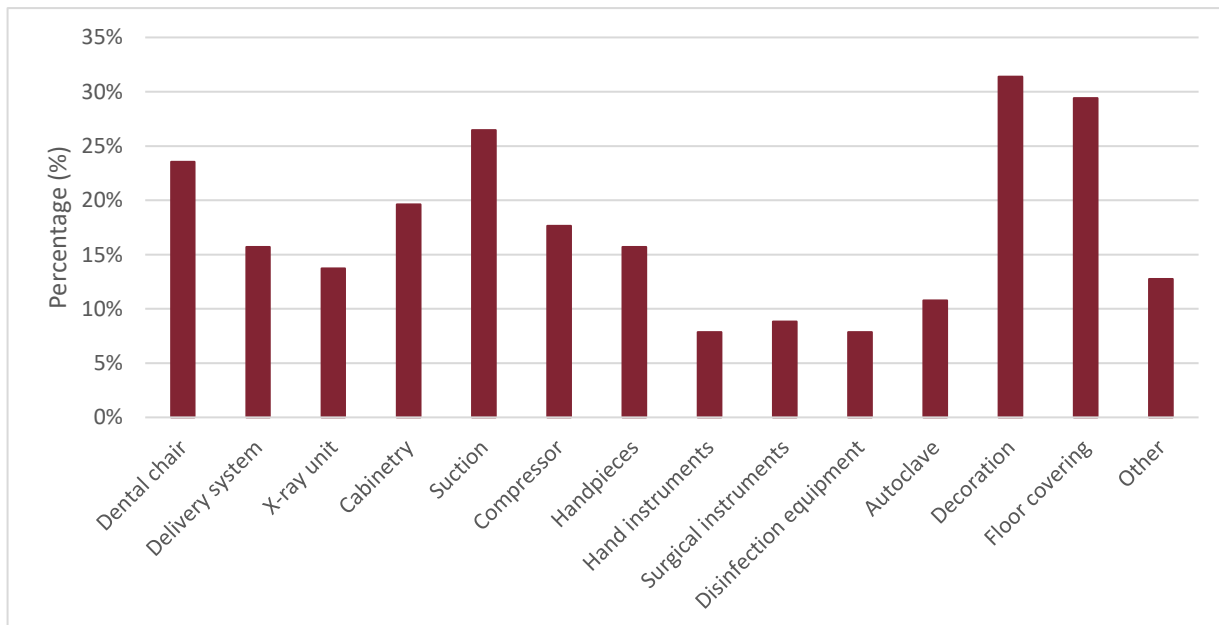
Most prisons have 1 dental surgery on site (93%), 7% of sites had 2 and reported that both were in use. These surgeries were mainly located in the healthcare department (93%), the remaining 7% being based in locations such as porta cabins, prison wings separate to healthcare or off-site. Whilst most of the surgeries (85%) were wheelchair accessible, 66% of dentists were unsure of when the last Disability Access Audit had been carried out.

A quarter (25%) of surgeries underwent a refurbishment (for example new equipment such as dental chairs, suction unit, autoclave) approximately 5 years ago and approximately a third of dental surgeries were redecorated (painted, new flooring) in this same period. For 16% and 17% of dental surgeries, refurbishment and redecoration respectively took place over 6 to 10 years ago. Only 28% of dental surgeries were designed for ambidextrous use.

## Equipment

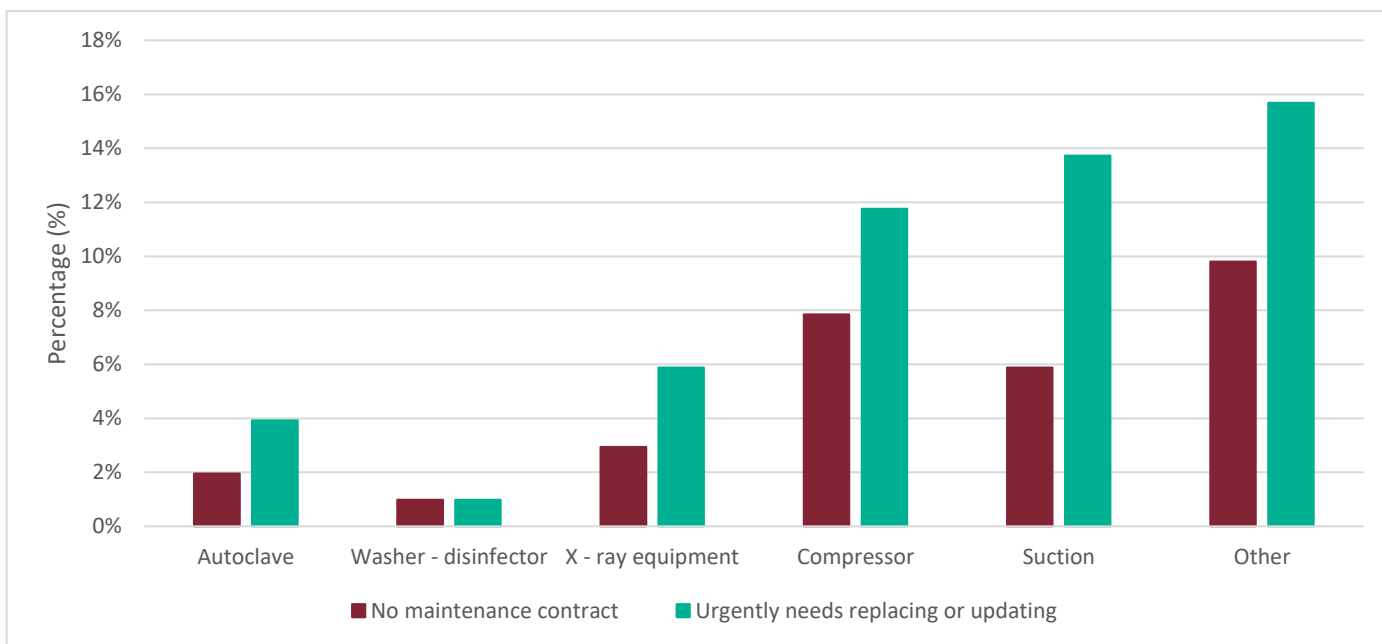
Just under three-quarters (72%) reported that at least 1 item of equipment needed updating or replacement; the remaining 28% reported that no equipment required this. Figure 1 below shows the breakdown of reported equipment.

**Figure 1. Reported equipment needing updating or replacement**



Around a third (31%) reported that items needed to be replaced or updated urgently, with a similar figure reporting that there were agreed plans in place to replace items. Most commonly was the suction and others reported equipment such as the cabinets, operator chair and dental chair, 3-in-1 units, decontamination room, floor, handpieces (including surgical handpieces) and the ultrasonic bath. The graph below (Figure 2) shows a further breakdown of the main categories.

**Figure 2. Reported equipment which has no maintenance contract or urgently needs replacing or updating**



Maintenance contracts were in place in 75% of sites for equipment that requires regular servicing and certification. At some sites 10% reported that ‘some but not all’ had certificates; most commonly the compressor. Other frequently reported equipment without maintenance contracts included dental chairs.

Almost half of respondents (47%) recognised the prison as being responsible for the organisation of the maintenance of equipment. Almost a third (29%) saw this responsibility to be with the contract holder. Additional comments highlighted the concern from a respondent:

“... constantly flagging issues with service delivery related to inadequate dental surgery facilities... This severely impacted waiting times... it is impossible to provide restorative dentistry at present to an acceptable level... this is placing patients and staff alike at considerable risk.”



## Radiography

Over half (56%) of respondents used digital radiographs, whilst 44% used film, the majority being developed through an automated film processor onsite. Both Radiation Protection Advisors (RPA) and Radiation Protection Supervisor (RPS) are in place at 89% and 91% of sites respectively, with 6% being unsure if this was in place. It was reported that 8% of respondents had access to a panoramic radiography machine at the site.

## Infection control

Over half (54%) of prison dental services are using autoclaves to sterilise instruments and 39% use a mixture of autoclave and disposable instruments. Around 6% of services used a Central Sterile Supply Department (CSSD), with 1% using a mix of CSSD and disposable instruments.

Where autoclaves were being used, vacuum and non-vacuum autoclaves were used equally across the sites. Sixty four percent of prison dental services which had a separate decontamination room. Only 46% of surgeries had a fully functioning clinical washer/disinfectant.

Where CSSD is being used, most instruments were returned in less than 3 days, the longest reported period of wait of return was 8 to 10 days.

Eighty-one (77%) of prison sites had an infection control (HTM01-05) audit that had been carried out. Half of these had taken place within the last 3 to 6 months and 18% had been carried out within 7 to 12 months. Thirteen percent were unsure of when the most recent audit had been carried out. The results were that:

- 20 sites were awarded 'best practice'
- 47 sites reported being awarded 'compliant'
- 6 sites reported being 'non-compliant'
- 8 sites were unsure of the result

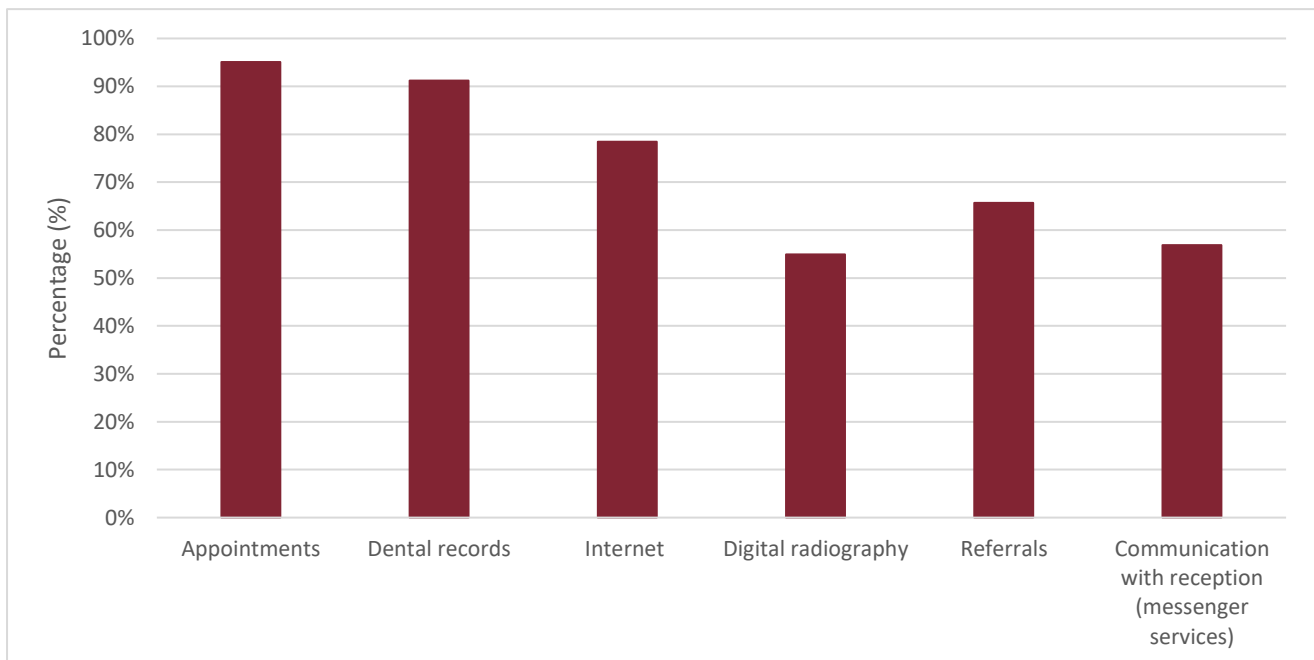
Sixty-three percent of prison dental services had received a full Care Quality Commission (CQC) inspection (England), Healthcare Inspectorate Wales (HIW) or Regulation and Quality Improvement Authority (RQIA) inspection (Northern Ireland). Almost a quarter were unaware if this had been carried out. Of those who had received visits, approximately 75% had been carried out within 12 months of the questionnaire being administered and had an overall result of 'good'.

### Information technology

Computers are used in nearly all prison dental service sites (96%), with 45% using dental specific software. The main programme was Software of Excellence 'Exact' but other software programmes included Kodak R4 and Egton Medical Information Systems (EMIS). Uses of the computer in prison dental services included booking appointments, for dental records and referrals. Figure 3 below shows the reported uses of the computer.

Almost half (48%) of respondents reported to submit paper claims to the BSA, one quarter reported doing this electronically and another quarter reported that they do not submit claims.

**Figure 3. Reported use of computers in prison dental services**



SystemOne is the main programme which is used in offender health and allows patient data to be shared securely across services, however there is no dental specific software available. Respondents reported using it for a multitude of reasons, including to update prescriptions, dental appointments, and access medical history or to prescribe medication.

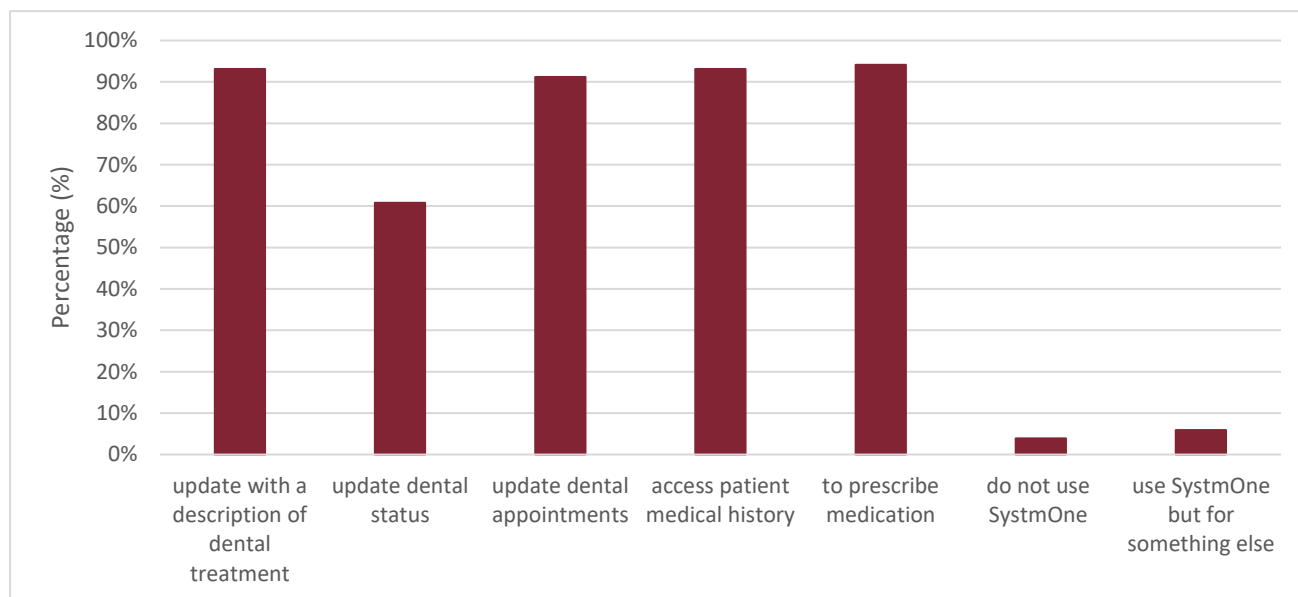
Figure 4 below shows the use of SystemOne in prison dental services. The main reason for not using SystemOne was due to an alternative system being used, EMIS. In cases where SystemOne was not used to prescribe medication, other methods included:

- paper prescriptions provided needed to be submitted to healthcare via the patient to collect medication

- requests made to the General Practitioner (GP) due to not having access rights to prescribe
- electronic prescribing to the pharmacist

It was also reported that SystmOne was also being used to communicate with other healthcare professionals.

**Figure 4: Reported use of SystmOne**



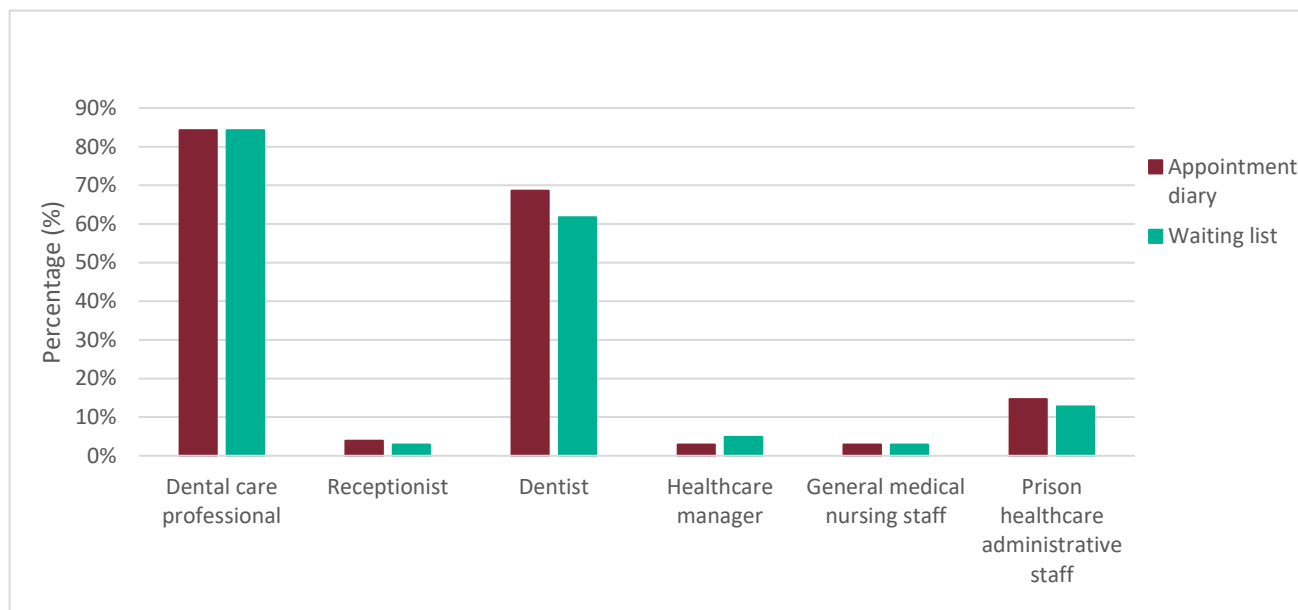
Telephone access within the dental surgery was reported to be present by 59%, the remainder did not have this access in the surgery. A third responded that the dental surgery was registered with the Information Commissioner’s Office (ICO), the majority did not know if this was the case.

### 4.3 The oral care pathway

#### Waiting lists, appointments and referrals

The management of waiting lists and appointment diaries in the prison dental services varies, Figure 5 below shows the breakdown of what has been reported. The majority of diaries and waiting lists are managed by a dental care professional or the dentist, with around 15% of prison healthcare administrative staff carrying out these duties.

**Figure 5. Reported management of appointment diaries and waiting lists**



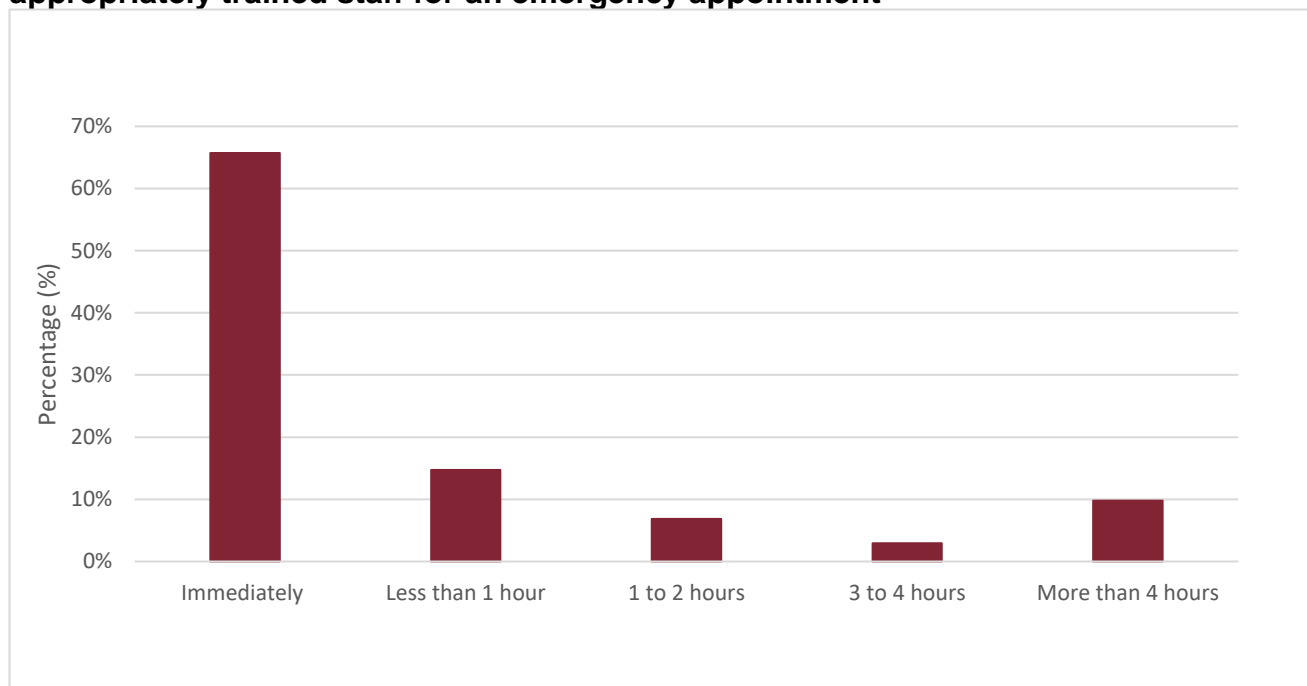
At the time of the survey, the average waiting time for an examination was 6 to 12 weeks in 46% of cases, with 36% being seen in less than 6 weeks. Fourteen percent (14%) of dentists reported a waiting time for examinations of longer than 18 weeks. For treatment, a third of patients (34%) were reported to be seen within 3 to 4 weeks of examination for treatment. Almost half (46%) were seen in more than 5 weeks and 8% waiting more than 10 weeks. The remaining 13% were seen for treatment in 1 to 2 weeks after their examination appointment.

Most people in category A, B, and C prisons were likely to wait 6 to 12 weeks for an examination, in category D prisons most people were seen less than 6 weeks, closely followed between 6 to 12 weeks. Follow up appointments were offered to patients in category A prisons between 7 to 10 weeks after examination appointment, category B and D prisons were 3 to 4 weeks, and category C prisons ranged between 3 to 10 weeks.

Half of the dentists that completed the survey (52%) had booked on average 15 minutes for a new patient examination, closely followed by 31% booking 20 minutes. For each clinical session, 37% reported that 7 to 8 patients were booked and 29% reported this to be between 9 to 10 patients.

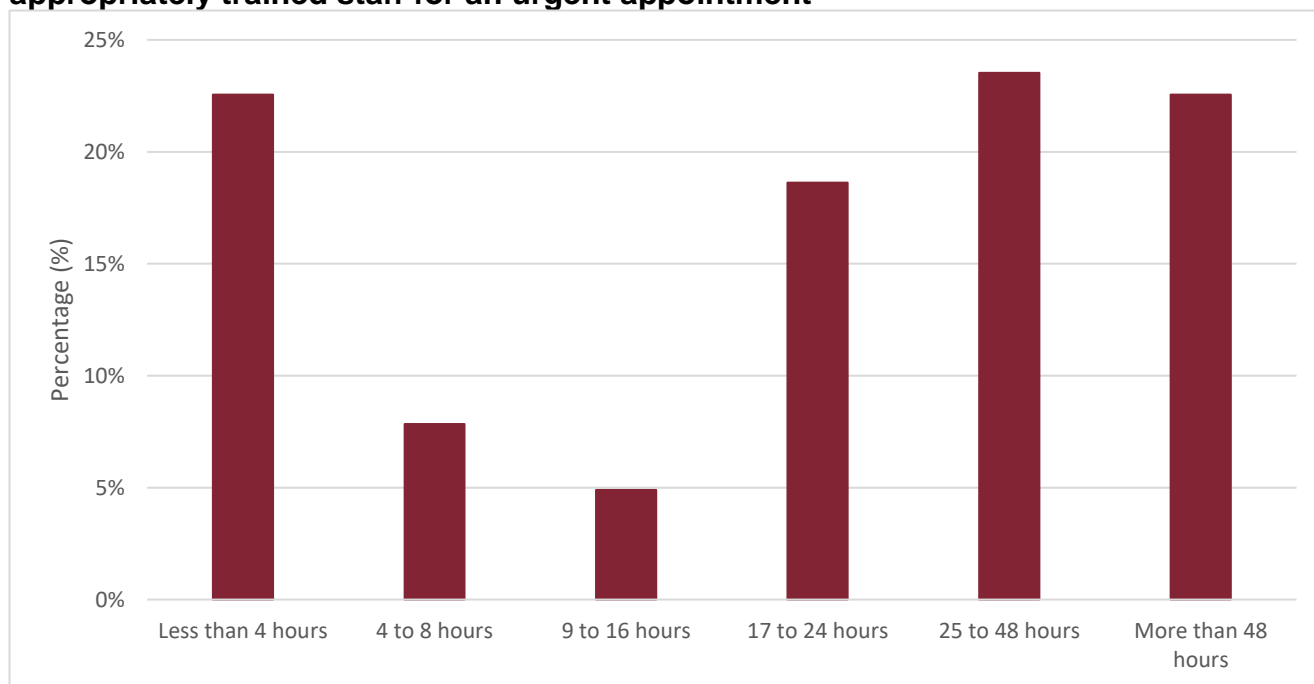
For emergency dental treatments such as severe trauma, haemorrhage or infection involving the airways, two-thirds (66%) of respondents reported that patients were seen immediately by the dentist or other appropriately trained staff, as shown in Figure 6.

**Figure 6. Reported time for people in prison to be seen by either a dentist or appropriately trained staff for an emergency appointment**



Likewise, for urgent dental treatments including significant pain and a fractured tooth, 24% of dentists reported that it took 25 to 48 hours for this to be seen by a dentist or another appropriately trained staff, as shown in Figure 7.

**Figure 7. Reported time for people in prison to be seen by either a dentist or appropriately trained staff for an urgent appointment**



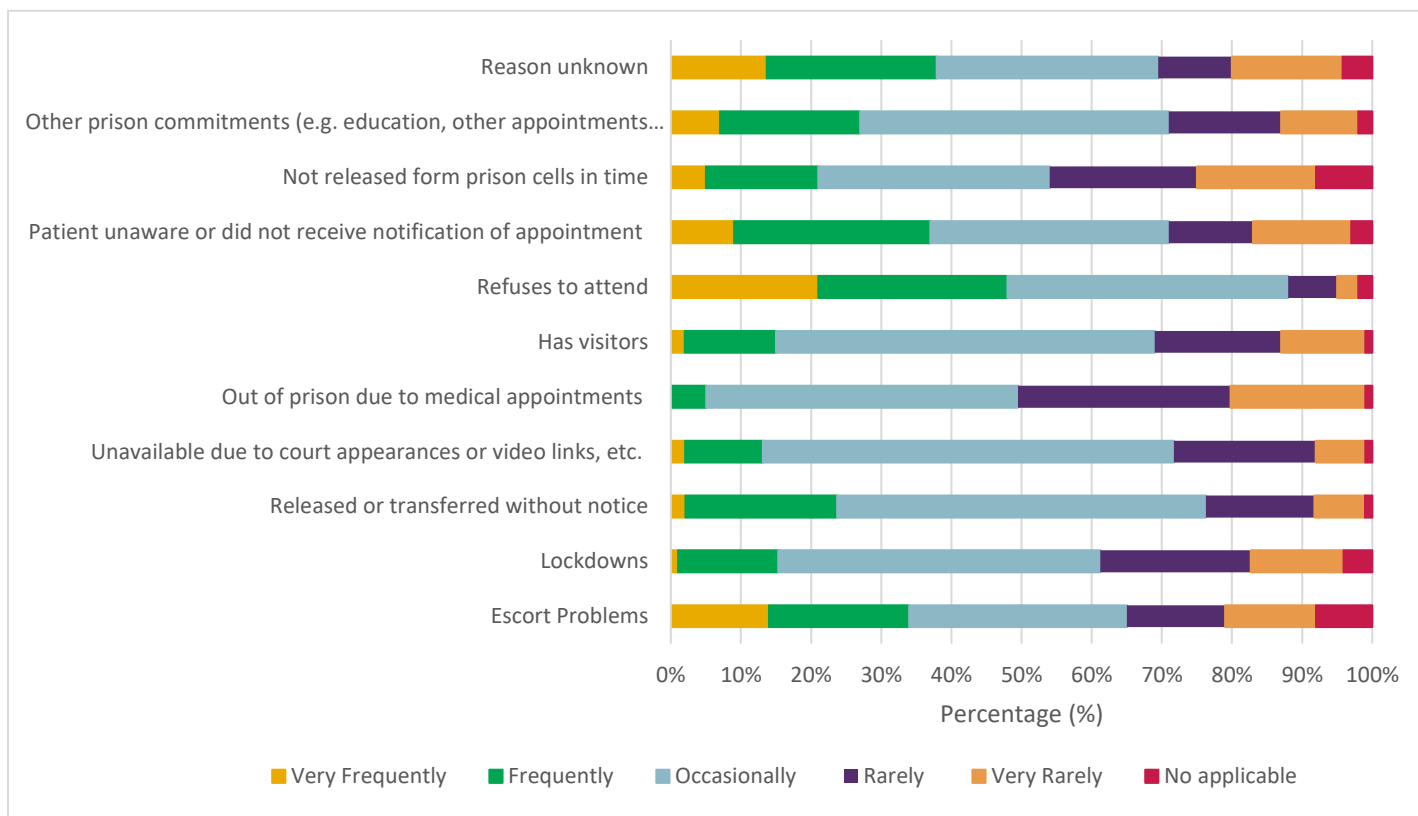
Most dentists (80%) referred between 1 to 3 people in prison per month for external specialist treatment, the majority were referring predominantly to oral surgery (86%) or oral medicine (58%).

Thirty percent of dentists reported that there were problems when making referrals for specialist dental care in the area or for patients attending these appointments, including a shortage of escorts on the day of appointment (87%), the length of the waiting list exceeds patients' expected stay in the prisons (61%) and 55% reported difficulties in coordinating between all parties involved. Other issues that were raised included the local referral centres not being security assessed, no recovery options for those requiring sedation, the prison ICT facilities not allowing the referrals and inability to submit referrals electronically.

For those who require external care for referrals, 64% reported that there are sometimes administrative problems or a work-force capacity issues in providing escorts for such appointments. A quarter of these problems happened frequently, with 4% reporting always happened and 8% never having this problem.

Failed appointments were reported to be quite high in prison dental services and the reasons for this varied. Figure 8 shows the possible reasons for failed appointments and the breakdown of percentage of frequency of occurrence. Patients refusing to attend appointments occurred 'frequently' or 'very frequently' (48%). Additional reasons included prison regime and enablement such as lockdown, escort problems, patients not being released in time or lack of communication of appointment times. Likewise, clashes with prison commitments such as court appearances or video links, being released or transferred without notice, or having visitors were the main reasons for 'occasionally' missing an appointment. Sixty-five percent of dentists were unaware when patients are transferred.

**Figure 8. Reasons patients did not attend (DNA) dental appointment and the frequency of occurrence**



Patients who require lab work to be fitted, may not always complete their treatment due to transfer to another prison or release out of prison or failure to attend appointments. A total of 44% of dentists reported this to be a problem. Of those reporting:

- 59% reported less than 10% of laboratory work is unfitted due to patient transfer, however 10-40% reported this to be a problem 36% of the time
- 57% reported that the laboratory work was sent on to the prison where they were being transferred to

Additional comments made by respondents highlighted the challenges which are being faced, again concerning prison regime and enablement issues, such as shortage of prison staff to escort patients to appointments, as well as lack of communication between the prison staff and healthcare staff. The comments also reflect how the shortage of prison staff have impacted clinical sessions and patient waiting lists.

“Prison dentistry is a difficult job with numerous different challenges. One of the main problems is the large waiting list and the lack of prison officers to retrieve patients. Prison resources to transfer patients to referral appointments need to be improved.”

“Since I have been working at this prison, my clinical sessions have decreased...as a result the sessions we have, have got even shorter and our waiting lists have got longer. Of course, the reason for this is staffing levels, this is having a great impact on dental care.”

“Healthcare in general appears to be the lowest priority as far as the prison is concerned and staff shortages for call up staff as (are) relatively common and inexperienced staff (some have never done healthcare call ups before) very common - consequently there is no organisation and it is common to be waiting up to an hour before any dental patients are brought down and then sometimes many will be brought down late with the expectancy that we can see and treat them all despite very limited time left [...] very little communication (and/or appreciation) between the prison and healthcare with the added problem [...] of lack of communication between healthcare and the dentist.”

Conflict of timing also seemed to be an issue in attendance to training and prison healthcare meetings:

“...conference(s) should be held at the weekend to allow registrants to attend without this effecting patient care.”

## 4.4 The prison environment

### Safety and security

The majority of responding dentists (89%) considered the dental surgery to be a safe and secure environment, with 84% reported having an appropriately placed panic button in the surgery. Only 13% of respondents are issued with a prison radio and of the 87% who do not have these, 34% felt that they should be issued with one.

Three-quarters did have keys issued to them (78%). In terms of security, 65% reported regular security audits being carried out by the prison staff and in many cases (83%) sessional tool checks were routinely carried out by staff and submitted to security, although some noted that these were carried out and not submitted. In almost all cases (97%) the door to the dental surgery did not lock on closure for safety reasons. Three-quarters of staff (74%) felt security staff were readily available during the clinical sessions. Thirty one percent of respondents provided information of safety concern, the reasons included:

- lack of core training such as de-escalation in the prison environment.
- general lack of prison security staff and the observation that they are often sitting far away from the surgery or are inadequately trained. In some cases, the dental staff had to unlock cells and escort patients to the appointment. There is also



encouragement to see people in prison without a prison officer, however some dental staff refuse to see a person in prison without an officer present.

- surgery design; poorly positioned panic button, no locking on surgery doors or drawers containing surgical equipment.
- location of the surgery; some are in a separate building without a prison radio or the surgery is adjacent to a crowded waiting room or near a holding room with surgery doors that do not lock.
- the lack of permanent settings and inadequate working equipment have caused increased abuse or violence towards dental/healthcare staff

Additional comments made by respondents regarding safety and security included:

“Surgery [...] is situated next to holding room where up to 30 prisoners wait for various healthcare appointments [...] dental staff have been subjected to fumes from smoking (spice) which have affected [...] health and the sessions have had to aborted.”

“Dental staff have to unlock and escort prisoners from holding cells”

“No officers present on healthcare. No radios for dental staff. Relying on panic button.”

“Many drawers and cupboards in the surgery containing instruments including surgical items do not lock as the locks are broken [...] Security is aware but does not appear to think it is an issue Prison / healthcare manager / contract holder are all aware..”

“Some officers prefer to sit away from the surgery which is a concern as they cannot be easily located if needed.”

“The dental surgery is just next to the waiting room which is often crowded and disruptive, with prisoners who could easily come through and enter the dental surgery if the waiting room door is unlocked. The panic button in the surgery is positioned on the other side of the room far from the main treatment area/dental chair, very difficult to access in an emergency when patient is in the chair. The door does not lock to the outside. There is no readily available security staff. There is no regular security audit.”

“Due to problems with the fixed dental equipment on site, service provision has been seriously affected. This has led to increased risk of abuse or violence to dental and healthcare staff”

“Have serious concerns about welfare of dental staff - have received zero training in de-escalation etc.”

## Oral health promotion

Ninety-three percent reported having a specialist smoking cessation team in the prison as part of the smoke-free prisons transition programme. Dentists working in prisons reported offering advice to patients including smoking cessation advice (80%), alcohol misuse (58%) and diet advice (99%). A third of dentists (33%) were unsure if any other health professionals deliver oral health promotion within the prison and 20% reported that this was being delivered. There was range of those who delivered this advice, such as nurses, dieticians, healthcare assistants, oral health educators, nursing staff and the smoking cessation team. The main method of delivering oral health promotion (OHP) were mainly one-to-one in the surgery (95%). Other methods included posters and OHP information leaflets (71%), prison health fayres and other educational events (24%), participation in events such as ‘smile week’ (21%), oral health educators providing education events (10%) and other methods such as commissioned to third sector (2%).

## Liaison between dental staff and other prison staff

Cooperation and liaison between dental staff and other healthcare staff was mainly positive with 78% reporting it as good or very good. It was reported by 30% that the dental team regularly met with doctors and nursing staff to discuss healthcare issues.

Approximately a third (34%) of respondents reported that they were invited to healthcare governance meetings that report to the Partnership Board. Of those who were invited, 78% had attended them and 96% found these worthwhile. However, it was commented that these meetings are held during clinical sessions which make it difficult to attend or result in cancelling of clinical sessions.

“Invitations to meetings have been received but the meetings are held for full days of clinical session so over 15% of clinical sessions would be lost - this is unacceptable with treatment needs being so high - 1 day a month is already lost to prison training days (another 15%).“

In addition, 12% of respondents belonged to a prison managed clinical network (MCN), 79% would be interested in being part of a prison MCN and 64% are prepared to set one up.

## Complaints

A complaints process was present in 97% of prisons responding to the survey and 3% were unsure if this was in place. Forty two percent (42%) of responders reported that this process was

both dental specific and part of a wider prisons healthcare complaints policy. Table 5 below shows the percentage of complaints received in the past 12 months. Reasons for complaints were predominantly due to the length of the waiting list for treatment, requests for treatment that were clinically inappropriate and dissatisfaction with the care and treatment which had been provided and escort issues (for example patient missing an appointment due to this).

**Table 5. Percentage of the number of complaints over a 12-month period**

Number of complaints	Percentage of respondents (%)
0	12%
1 to 2	21%
3 to 5	32%
6 to 10	14%
11 to 20	11%
More than 20	11%

### Patient pathway into prisons and patient satisfaction

On entry into prison, 21% of respondents noted that there was a clinical or non-clinical dental assessment that took place. A third (35%) were unsure and 44% reported that there was no dental assessment on entry. Of those who responded 'yes', 52% were completed by a registered nurse, 24% a trained healthcare assistant under supervision of a registered nurse, 14% by a dental care professionals (DCPs) and 5% by a dentist. One other reported comment was that people in prison were being asked about their dental issues at their reception interview.

A patient care pathway was in place at 61% of prisons, 29% were unsure if this was in place. A written treatment plan (including FP17DCs) were widely provided to patients (69%). The language line translation service or equivalent service was reported to be available for dentists at 62% of prisons, but 16% were unsure of availability. The majority of responding dentists were unsure when patients were going to be transferred to another prison, so no clinical information was prepared for other dentists. Only 9% of dentists reported that they prepared information and almost a third (26%) do not prepare information routinely.

Feedback from patients was reported to be mainly gained through satisfaction surveys (82%), informal discussion from dental patients in the surgery (54%) or prison staff (34%); other methods were through patient feedback boxes (29%), broader healthcare prison feedback (22%) and other (13%) such as compliment forms, surveys for quality

improvement projects, user voice committees, dedicated healthcare professionals or through prisoner forums.

## 5. Discussion

Previously published literature reported variations in contracting arrangements, delivery of dental services, and barriers to people in prison accessing dental care (6), and findings from this current survey and previous survey from 2014 are in line with reported variations.

It is acknowledged that providing dental services in prison settings presents unique challenges, due to complex health needs, lifestyle choices and other risk factors. Standardisation across the service is necessary and prison dental services should be of the same standard and quality as services offered in general dental services. Accessible quality care should still be the goal, with essential compliance of legal standards. Although current policy and guidance lays out the steps to reduce health inequalities, a more formal service specification is required to fully integrate oral healthcare into the prison healthcare service. 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.

Many findings of this current survey of dental services across the prison estate in England and Wales are similar to the previous survey carried out in 2014. It must be mentioned that the current survey also includes 3 prisons located in Northern Ireland. Even with these prisons included, the findings were still consistent with those of the previous survey and are therefore representative of the prison estate across England, Wales and Northern Ireland.

There were challenges to the delivery of this survey. Although it was specified in the circulation letter that only the lead dentist should complete the survey per prison, 7% of surveys were completed by dental care professionals (dental therapist or dental nurse). It is difficult to tell if this was carried out alongside the dentist. Despite asking for the lead dentist at the prison to only submit 1 per prison there were still instances of multiple surveys submitted for a single prison. After clarification from prisons and for consistency, only the last survey submitted was included in the analysis. Additionally, in some cases the dentist who held a cluster of dental contracts replied on behalf of all sites, instead of the lead clinician at each of the individual sites. There were also several dentists who were unable to answer some of the questions as they had only just commenced in the post. Known barriers to completing the survey included prison dental services undergoing a transition period being covered by locum dentists.

Previous literature indicates that many prison dental surgeries are in need of modernisation (7). Like the 2014 survey, there is still a reported need for consultation with professionals on surgery design.

In this survey, 56% of surgeries had undergone refurbishment or redecoration approximately 1 to 5 years ago. This is similar to the previous 2014 survey which saw refurbishment or redecoration to be reported by 55% of responses. In this current survey, the equipment and facilities in many sites were reported as needing replacing, in some cases urgently (31%). Additional concerns raised from participants included having a lack of adequate functioning equipment meaning that there is inadequate delivery of services and treatment. Lack of adequately functioning equipment disrupts service delivery and increases waiting lists. 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 the current survey, a quarter (35%) reported not having maintenance contracts in place, which was less than the previous survey where this was 42%. This indicates that there has been some improvement. Infection control compliance was also reported to be higher in the 2018 survey, with 83% reporting meeting 'best practice' or being 'compliant' with the HTM01-05 standards, compared to 61% reporting to have met this standard in 2014.

When looking at who had responsibility for maintenance, there was confusion if this was the responsibility of the prison (47%) or contract holder (29%). Lack of clarity around whose responsibility this is can cause delay in managing the maintenance of equipment. In addition, maintenance contracts form part of the CQC inspection process in England, three-yearly practice inspections in Wales and once yearly in Northern Ireland.

A similarly high percentage of respondents felt the prison was a safe and secure environment (89% in 2018 and 92% in 2014) but concerns about security such as accessibility of the panic button, continue to exist. Some participants did voice concerns over safety which could be addressed through key training and increased staffing for assisting patients to, during and from appointments. Responsibility for better surgery design, such as locking of equipment drawers and surgery drawers would be beneficial for security purposes; however there seems to be dispute over whose responsibility it is to do this. In terms of lack of prison security staff supporting dental staff, some prisons have a blanket approach to security however a thorough individual risk assessment

should be carried out when it comes to treatment with or without prison security staff being present. The results of this survey, in addition to the previous survey, has provided a greater insight to the different safety concerns and provide a basic insight to prison dental surgery design specifications.

In terms of waiting times, almost half (46%) of those reporting said that people in prison waited over 6 weeks for an initial examination and treatment. This figure is higher than the 2014 result of 35%. This could be due to a number of factors, such staffing issues and inadequate functioning dental facilities. For people in prison requiring urgent care, 66% were reported to be seen immediately, which is higher than the 2014 result of 51%; however emergency care was 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 people in prisons' dental needs when considering waiting time standards.

The findings around failed appointments were similar to those of the 2014 survey and this remains a significant issue. This shows the importance of the dental team working in partnership with prison staff to minimise failed appointments for example, through better communication to keep up to date with patients planned activities. Where patients are refusing to attend appointments, better understanding is needed as to why this is happening. Efforts should be made to ensure appointments are made available for other people in prison at short notice in a bid to minimise wasted surgery time.

The majority (65%) of dentists were unaware of when patients are going to be transferred, interrupting treatment plans and resulting in failure to organise information for other dentists for continuity of care. The high number of failed appointments, incomplete courses of treatment and unfitted laboratory work limit the productivity of the prison dental workforce. The challenges presented with people being transferred between prisons are unavoidable, but those people in prison re-entering society 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.

A proportion (21%) of respondents noted that a clinical or non-clinical dental assessment took place on a patient's entry into prison. Having information such as this on arrival to prison may help to support the adequate provision of services, in line with actions needed to reduce failed appointment rates.

Communication within healthcare for example, between dental and healthcare staff, was reported by 78% as being good or very good and similar to that in the 2014 report, of 73%. Dentists should be actively encouraged to link with other healthcare services to promote the integration of oral health into other prison health improvement

programmes. Although it was reported that there was mainly positive communication between dental staff and the healthcare team, there is still lack of effective communication on healthcare issues and problems being faced. Attendance at healthcare meetings, although invited, can prove challenging due to conflicting service sessions, making addressing issues difficult and reducing the communication between healthcare staff and dental staff and having an impact on efficiency and delivery of service. In addition, delaying appointments can have a knock-on effect on waiting list and treatment times. The general feeling seems to be that oral healthcare is not a big priority, and lack of prison staff disrupts the delivery of care.

It is vital that opportunities to embed oral care into wider healthcare initiatives are taken and a common risk factor approach to overall health improvement is followed. For example, the smoke free transition programme which is being rolled out nation-wide in a move to reduce health inequalities. Supporting people in prison through this change will be in line with guidelines such as delivering better oral health.

A small percentage of dentists completing the survey belong to a managed clinical network and there was a lot of interest among others to set one up. Managed clinical networks provide an opportunity to link clinicians together to support delivery of effective and high quality service and may enhance the delivery of prison dental services.

In the 2014 survey, 43% of prisons reported having received 1 to 5 complaints in the past year where as in the 2018 survey this figure was 53%. 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. Almost all prisons had a complaints process, either part of a prison or dental policy. Complaints such as waiting lists and escort issues are in line with findings of reasons for failed appointments, so commitment is needed from both patient and provider aspects to resolve these issues. It was encouraging to find that there was a variety of ways for patients to provide feedback. These included satisfaction surveys, informal discussion, patient feedback boxes and through other methods such as compliment forms or prisoner forums. In addition, Her Majesty's Inspectorate of Probation (HMIP) pre-inspection from the CQC survey includes questions about access to, and quality of, dental services.

In terms of the workforce, many dentists are sole providers of dental care and mainly work on a part-time basis, which in itself may pose an access issue. The majority of dentists work in single-handed surgeries supported by dental nurses, and there is a need to monitor provision and continuity of care in their absence. The contract holder should ensure that arrangements are in place for business continuity and currently just over three-quarters (77%) of prison estates have this arranged if a dentist is unable to deliver a clinical session.



There is also variation in the number of dental sessions across the estate. In addition, the dental capacity in prisons are reduced due to the increased prison population. Dental services for this population needs to be re-visited and evaluated to ensure adequate provision of services, consequently having a more appropriate dentist/dental session to prison population ratio developed. Additional comments made by respondents showed that lack of staffing in dental services and prison services causes concerns amongst clinicians, even when the prisons are not at capacity.

Changes in the commissioning of prison dental services have been mirrored by changes in the way dental services have been contracted. The 2018 survey found that the number of dentists employed under CDS and PDS contracts was lower than those found in the 2014 survey. For the CDS, the reduction was from 30% to 20% and for PDS the reduction was from 24% to 17%. Around a quarter (27%) of dentists reported employment under a private contract in this current survey. Recent changes of the ways in contracting and subcontracting of dental services has resulted in some clinicians' loss of right to having an NHS pension, even though the contractors are part of a larger organisation. However, at the time of writing the report, it appears that these issues have been resolved.

All dentists are required to undertake mandatory continuous professional development (CPD) and audit in core areas. These include medical emergencies, radiography and infection control and with new enhanced CPD guidance, courses should reflect their personal development plan and the work delivered in prisons. The 2018 survey found the majority of dentists have undertaken prison key training (83%), however fewer prison dentists had a prison induction, fire training, personal protection, ACCT and SASH. There has been a 13% reduction in the number of dentists reported to receiving personal protection training, despite 89% reported to feeling that the dental surgery was a safe and secure environment. Less than a fifth (15%) of dentists received SASH training, this question was not asked in the previous dental survey. Reported ACCT, prison induction/key training and fire training were found to be similar to the previous survey, however only just over half (56%) had reported undertaken prison induction. Some reported it being very difficult to get on to the induction programme. There has been anecdotal evidence that some prison dentists reported that some providers are not allowing time for training or continuing professional education, and some do not cover the cost of training. It is important for managers or contract holders to make the necessary allowance and arrangements to allow dentists to attend such days and for contingency plans in place.

Integral to running an efficient service is information technology (IT). 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, less than half (45%) reported having access to dental specific software, however almost a majority had been using the computerised dental records, and reported using SystemOne by updating it with a description of dental

treatment. However, it is not clear if this is the only way in which dental notes are recorded. There were variations in the way in which medications were prescribed, and this ranged from systems of having to go to a GP, prescribing straight to the pharmacist or handing prescriptions straight to the patient to give to healthcare staff. Although half of respondents submitted paper claims to the NHS Business Services Authority (NHS BSA), the IT system should enable the transfer of dental data directly to the NHS BSA so that comparisons on dental prescribing can be made with other prisons.

The previous 2014 survey was the first commissioned survey looking at prisons across England and Wales. From the third of dentists who had read the report of the findings of the previous survey, only a fifth of these dentists were aware that recommendations had been delivered. The reported improvements by respondents included improved and formalised induction and training, greater use of dental therapists, improved dental surgery facilities and systems such as appointment slips to improve attendance to appointments. Other improvements included improved protocols and frameworks for reporting failed equipment, there was greater provision of oral health promotion and improved facilities such as new chairs and decontamination rooms. However, the current survey highlights that there are still problems and further changes need to be made to improve efficiency of delivery of services and safety of staff across the estates.

## 6. Conclusions

There are many challenges within prison dentistry that are unique to this environment; the findings of this survey are in line with the previous 2014 report. Although some improvements have been made, such as compliance with infection control guidance, there is still room for improving standards. In addition, concerns around waiting times, safety, equipment and training still need to be addressed. These areas are set out as recommendations in the next section.

## 7. Recommendations

This survey reflects some challenges that are unique to this healthcare environment. To ensure that users of prison dental services receive high quality equitable care, key partners should consider taking forward the following recommendations and agree actions and responsibilities.

1. Develop a standard specification for dental services in prisons, including definition of the specific equipment required and consideration of recommendations on waiting times to ensure consistent delivery of a high-quality service.
2. Agree on indicators for assessing the quality of service provision to ensure what is measured will inform and lead to remedial actions and improvements for patients.
3. Safeguard patient experience and safety by ensuring that the equipment and environment meet national safety standards.
4. Explore opportunities to improve transfer communication and/or systems so that patients can be assessed, triaged and have access to care according to their need.
5. All members of the dental team working within the secure environment should receive formal induction and undergo core establishment training, with regular updated training, to ensure safety of staff and smooth integration within the prison.
6. All members of the dental team should have access to and complete training and development which reflects the needs of working in a prison environment, such as an appreciation of mental health, substance misuse, learning disability etc. This will create a better understanding of the patient group and prepare staff for opportunities for dental career development in prisons.
7. Ensure that oral health is integrated into other health activities in prison, including health promotion programmes and care pathways to make every contact matter.
8. Facilitate engagement between dentists in prisons and local dental networks to inform the local system and encourage co-operation between community and prison dental services.

9. Explore the possibility of setting up regional resourced Managed Clinical Networks for prison dentistry to share best practice and offer peer support.
10. Explore the integration of healthcare software informatics to support dental and healthcare staff with accessing contemporaneous notes for patients in prisons.
11. Information Technology infrastructure and systems should be in place so that all dental service providers submit FP17 data to NHS Business Services Authority (and 'risk-need' data in Wales) electronically so that activity can be monitored and reported on a regular basis.
12. Engage with dentists working within prisons to encourage participation in research, engaging with the Health and Justice Research Collaboration (HJRC), Offender Health Research Network, National Association of Prison Dentistry (NAPDUK) and academic institutions to consider wider dental research programmes for prisons. Alongside this, collaborate with the worldwide prison health research and engagement network (WEPHREN).
13. Ensure contribution of dental teams within the prison infrastructure, including attendance at healthcare governance meetings where necessary, so that they can raise issues and support any remedial actions to improve the smooth running of the service.

## 8. Acknowledgements

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### Partners

The working group would like to express its thanks to the PHE Health and Justice team, NAPDUK, the Office of the Chief Dental Officer (England), Chief Dental Officer of Wales, Chief Dental Officer of Northern Ireland, the British Dental Association, HMPPS, the Dental Public Health team Public Health Wales, and the dental team at South Eastern Health and Social Care Trust for their contributions to the development of the survey questions.

We would like to thank the NHS Health and Justice teams and Healthcare Managers for their support distributing and enabling completion of the questionnaire.

### Respondents

The working group would like to express its thanks and appreciation to all those who responded to this survey of prison dental services in England, Wales and Northern Ireland.

## 9. Abbreviations

ACCT: Assessment, Care in Custody and Teamwork

DHSC: Department of Health and Social Care

HMIP: Her Majesty's Inspectorate of Probation

HMPPS: Her Majesty's Prison and Probations Service previously National Offender Management Service (NOMS)

IRCs: Immigration Removal Centres

NAPDUK: National Association of Prison Dentistry UK

NHS BSA: National Health Service Business Service Authority

NHSE: National Health Service England

PHA NI: Public Health Authority Northern Ireland

PHE: Public Health England

PHW: Public Health Wales

SASH: Suicide Awareness and Self Harm

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# 11. Appendices

## Appendix 1: Overview of the prison population up to 2017

### England and Wales

Since the 1940s the prison population in England and Wales has risen steadily; there has been an average growth rate of 2.5% per year. The growth in the prison population started to pick up pace from 1993, with an average increase of 3.4% per a year. There was rapid growth up until 2008, and this was due to the increase in the number of people sentenced to immediate custody from 1993 to 2002, increases in the average custodial sentence length and use of indeterminate sentences, and increased of number of offenders being recalled into prisons. The population of people in prison has stabilised in England and Wales from 2012.

Since 1993, the prison population has grown by around 40,000 people. In 1993, the population of people in prisons in England and Wales was 44,246 and in December 2017, the population was 84,373 of which 3,919 were females. Of this population, 30% were aged 30 to 39 years. The number of people in prison aged 60 and over has increased by 7% from the previous year and account for 6% of the adult prison population. There was no change in the overall prison population at the end of December 2017 when compared to that of December 2016.

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%. At the end of December 2017, the total population 88.6% of the population were British nationals, 11.1% were foreign nationals from 163 different countries. Poland, the Irish Republic, Romania and Jamaica have the most nationals in prison. The remaining 0.3% of people in prison not having their nationality recorded.

Sources:

- [www.gov.uk/government/collections/prison-population-statistics](http://www.gov.uk/government/collections/prison-population-statistics)
- [www.gov.uk/government/collections/offender-management-statistics-quarterly](http://www.gov.uk/government/collections/offender-management-statistics-quarterly)
- [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/702299/oms-guide-apr-2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/702299/oms-guide-apr-2018.pdf)
- [www.gov.uk/government/statistics/story-of-the-prison-population-1993-to-2016](http://www.gov.uk/government/statistics/story-of-the-prison-population-1993-to-2016)

## Northern Ireland

The average daily prison population fell for the second year in a row from 1,661 in 2015 to 1,482 in 2016, and this was evident across all 3 prison establishments in Northern Ireland. In Northern Ireland, most of the population comprises of males (96.4%); the average daily prison population for females has remained at the same level between 2015 to 2016. The largest age group was between 21 to 29 years of ages (33.9%), however is showing a downward trend. There was no available information regarding the ethnicity of people in prison based in Northern Ireland.

Sources:

- [www.justice-ni.gov.uk/sites/default/files/publications/justice/northern-ireland-prison-population-2016-2016-17.pdf](http://www.justice-ni.gov.uk/sites/default/files/publications/justice/northern-ireland-prison-population-2016-2016-17.pdf)

## Appendix 2: Survey questions for prison dentists

### Survey questions for Prison Dentists.

This survey is to be completed by the lead prison Dentist.

#### Your Details (these are kept confidential)

1. Your full name\_\_\_\_\_
2. Your e-mail address\_\_\_\_\_
3. Name of Prison or Facility \_\_\_\_\_
4. Employment status (Employed with pension/employed without pension/independent practitioners with pension/ independent practitioners without pension/ other please specify \_\_\_\_\_)
5. Which country is the prison you work in located (England/Wales/Northern Ireland)

#### ABOUT YOU AND THE PEOPLE WHO WORK WITH YOU

6. How many dentists deliver services in the prison? (1/2/3/4 or more)
7. How many dental nurses deliver services in the prison? (1/2/3/4 or more)
8. Do any of the following dental professionals work at the prison? Please tick all that apply. (Hygienist/dental therapist/clinical technician/ oral health promoter/none of the above/other, please specify\_\_\_\_\_)
9. If so, how many clinical sessions a week are delivered by these dental professionals? N.B. each half day equates to a clinical session; one week (Monday – Friday) = 10 sessions

Hygienist	(1/2/3/4/5/6/7/8/9/10)
Dental Therapist	(1/2/3/4/5/6/7/8/9/10)
Clinical Technician	(1/2/3/4/5/6/7/8/9/10)
Oral Health Promoter	(1/2/3/4/5/6/7/8/9/10)
Other (free text)	(1/2/3/4/5/6/7/8/9/10)
Other (free text)	(1/2/3/4/5/6/7/8/9/10)

10. Is a healthcare manager employed in the prison? (Yes/No/Don't know)
11. Is there a healthcare receptionist? (e.g. someone to make appointments, etc.) (Yes/No/Don't know)
12. How long have you worked in **this** prison? (Less than 1 year/1 to 3 years/4 to 5 years/6 to 10 years/11 to 15 years/16 to 20 years/more than 20 years)
13. In **general**, how long have you worked in prison dentistry? (Less than 1 year/1 to 3 years/4 to 5 years/6 to 10 years/11 to 15 years/16 to 20 years/more than 20 years)
14. 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)
15. Are there cover arrangements if a dentist is not able to deliver their session (e.g. due to sickness, leave, unforeseen circumstances)? (Yes/No/Don't know)
16. Did you have a formal induction when you started working in this prison? (Yes/No)
17. Are you on a GDC specialist list? (Yes/No)
18. If 'Yes', 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/Periodontics/Paediatrics/Other \_\_\_\_\_)
19. Under what type of contract are you employed? (GDS/PDS/CDS/Private/Other)
20. If other, please specific (\_\_\_\_\_)

21. Are you both the performer and the contract holder? (Yes/No)
22. If 'No': Who is the contract holder? ( \_\_\_\_\_)
23. Is the dental contract part of a larger health care provider contract for this prison? (Yes/No/Don't know)
24. If yes: Who is the healthcare provider? (\_\_\_\_\_)

### **ABOUT THE PREVIOUS PRISON DENTISTRY SURVEY**

25. Have you read a copy of the 2014 report? (Yes/No)
26. Are you aware if any of the broader recommendations have been delivered? (Yes/No)
27. If 'Yes': What changes have been made in the prison? \_\_\_\_\_

### **THE DENTAL SURGERY**

28. How many dental surgeries are there in the prison? (1/2/3/4 or more)
29. If '2 or more': How many dental surgeries are regularly in use? N.B. Regularly defined as more than 5 sessions a week. (2/3/4 or more)
30. Where is the dental surgery located? (Healthcare department/prison wing/mobile site/other, please specify\_\_\_\_)
31. Is the dental surgery designed for ambidextrous use? (Yes/No)
32. Is the dental surgery wheelchair accessible? (Yes/No)
33. Has a Disability Access Audit been carried out on the dental surgery? (Yes/No/Don't know)
34. When was the dental surgery last refurbished (e.g. with new equipment such as dental chairs, suction unit, autoclave etc.)? (In the last 12 months/1 to 5 years ago/6 to 10 years ago/more than 10 years ago/Don't know)
35. When was the dental surgery last redecorated (e.g. painted, new flooring, etc.)? (In the last 12 months/1 to 5 years ago/6 to 10 years ago/more than 10 years ago/Don't know)

### **THE EQUIPMENT**

36. Does any of the following equipment need to be updated or replaced? Please tick all that apply. Dental chair/ Delivery system/ X-ray Unit/ Cabinetry/ Suction/ Compressor/ Handpieces/ Hand Instruments/ Surgical Instruments/ Disinfection equipment/ Autoclave/ Decoration/ Floor covering/ None/ Other, please specify\_\_\_\_\_)
37. Who is responsible for organising the maintenance of equipment? Please tick all that apply. (Contract holder/ Prison/ NHS/ Performer/ Don't know)
38. Are maintenance contracts in place for equipment that needs regular certification? (Yes/ For some but not all/ No/Don't know)
39. If 'No' or 'Some but not all': What items are currently without a maintenance contract? Please tick all that apply. (Autoclave/ Washer-disinfector/ X-ray equipment Compressor/ suction/ Other, please specify\_\_\_\_)
40. Are there any items of equipment that urgently need replacing or updating? (Yes/No)
41. If 'Yes': What equipment urgently needs replacing or updating? (Autoclave/ Washer-disinfector/ X-ray equipment Compressor/ suction/ Other, please specify\_\_\_\_)
42. Are there any agreed plans in place to replace such equipment? (Yes/No/Other, please specify)
43. What type of radiograph is used? (Film/Digital)
44. If 'Film': 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)
45. Are radiographs processed at the prison? (Yes/No)
46. Which of the following have been appointed? Please tick all that apply. (Radiation Protection Advisor (RPA)/ Radiation Protection Supervisor (RPS)/ Neither/ Don't know)
47. Apart from intraoral radiographic equipment, is any other radiographic equipment used: (Yes/No)
48. If 'Yes': What other radiographic equipment is used? (OPG/ Lateral ceph/ Other, please specify\_\_\_\_)

## CROSS INFECTION CONTROL

49. Which of the following are used by the surgery? Please tick all that apply. (CSSD (Central Sterile Supply Department)/ Autoclave/ Disposable instruments)
50. If 'CSSD': How quickly are instruments generally returned from CSSD? (Less than 3 days/ 3 to 7 days/ 8 to 10 days/ 11 to 14 days/ More than 14 days)
51. If 'Autoclave': What type of autoclave is used? (Vacuum/ Non-vacuum)
52. Is there a dedicated, separate decontamination room? (Yes/No)
53. If 'Yes': Is the decontamination room adjacent to the surgery? (Yes/No)
54. Is there a fully functioning clinical washer/disinfector? (Yes/No)
55. Has an HTM01-05 audit been carried out? (Yes/No/ Don't know)
56. If 'Yes': When was the most recent HTM 01-05 audit carried out? (Less than 3 months ago/ 3 to 6 months ago/ 7 to 12 months ago/ 13 to 24 months ago/ More than 24 months ago/ Don't know)
57. What was the result of the HTM 01-05 audit? (Best practice/ Compliant/ Non-compliant/ Don't know)
58. Has a full CQC inspection (England), Healthcare Inspectorate Wales (HIW) or Regulation and Quality Improvement Authority (RQIA) Inspection (Northern Ireland) been carried out? (Yes/No/ Don't know)
59. If 'Yes': When was the CQC, HIW or RQIA inspection carried out? (Less than 6 months ago/ 6 to 12 months ago/ 13 to 24 months/ More than 24 months/ Don't know)
60. What was the overall result of the CQC inspection? (Outstanding/ Good/ Requires improvement/ Inadequate)

## INFORMATION TECHNOLOGY

61. Do you use a computer for the dental services? (Yes/No/ Not available)
62. If 'Yes': Does the computer have dental specific software? (Yes/No)
63. Which dental software do you use? (Software of Excellence 'Exact' / Kodak R4/ Other)
64. What is the computer used for? Tick all that apply. (Appointments/ Dental records/ Submission of FP17 to NHS Business Services Authority/ Internet/ Digital radiography/ Referrals/ Communicating with reception (messenger services))
65. Do you submit FP17 claims to the NHS Business Services Authority (BSA)? (Paper/ Electronically/ We do not submit claims)
66. Do you have access to a telephone within the dental surgery? (Yes/No)
67. Is the dental surgery registered with the Information Commissioner's Office (ICO)? (Yes/No/ Don't know)
68. Do you use SystmOne to do the following? Tick all that apply (Update with a description of dental treatment/ update dental status/ update dental appointments/ access patient medical history/ to prescribe medication/ I do not use SystmOne/ I use SystmOne by for something else, please specify\_\_\_\_)
69. If you do not use SystmOne for prescribing, how is medication prescribed (e.g. EMIS)? (\_\_\_\_\_)

## THE DIARY

70. Who manages the dental appointment diary? Please tick all that apply. (Dental care professional/ Receptionist/ Dentist/ Healthcare manager/ General medical nursing staff/ Prison healthcare administrative staff)
71. Who manages the dental waiting list? Please tick all that apply. (Dental care professional/ Receptionist/ Dentist/ Healthcare manager/ General medical nursing staff/ Prison healthcare administrative staff)
72. How long is the waiting list for routine examinations? (Less than 6 weeks, 6 to 12 weeks, 13 to 18 weeks, 19 to 26 weeks, more than 26 weeks)

73. After the initial examination, how soon is a follow-up appointment for treatment available? (1 to 2 weeks/ 3 to 4 weeks/ 5 to 6 weeks/ 7 to 10 weeks/ More than 10 weeks)
74. How many patients, on average, are booked into a clinical session? (6 or less/ 7 to 8/ 9 to 10/11 to 12/ 13 to 18/ More than 18)
75. How long do you book for an average new patient exam? (5 minutes/ 10 minutes/ 15 minutes/ 20 minutes/ 25 minutes/ 30 minutes/ More than 30 minutes)
76. How quickly are patients requiring **emergency** dental treatment (severe trauma, severe haemorrhage or severe infection involving airways) seen by the dentist or other appropriately trained staff? (Immediately/ Less than 1 hour/ 1 to 2 hours/ 3 to 4 hours/ More than 4 hours)
77. How quickly are patients with an **urgent** dental problem (significant pain, fractured tooth, etc.) normally seen by the dentist or other appropriately trained staff? (Less than 4 hours/ 4 to 8 hours/ 9 to 16 hours/ 17 to 24 hours/ 25 to 48 hours/ more than 48 hours)
78. On average, how many external dental referrals are arranged each month for specialist dental care outside the prison? (0/1/2 to 3/4 to 5/ 6 to 7/8 to 10/ More than 10)
79. If referrals are made: Which of the following specialities are referrals made to? Please tick all that apply. (Oral Surgery/ Oral Medicine/ Restorative/ Periodontics/ Prosthodontic/ Orthodontics/ Endodontics/ Other\_\_\_\_\_)
80. Are there any problems with making referrals for specialist dental care in your area or for patients attending these appointments? (Yes/No)
81. If 'Yes': 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\_\_\_\_\_)
82. Are there administrative problems in providing escorts for external referrals? (Always/ Frequently/ Sometimes/ Never)
83. The table below considers various reasons for patient DNAs. For each reason, please rate how frequently the reason results in DNAs (Very frequently /Frequently/ Occasionally/ rarely/ Very rarely/ Not applicable) (Escort problems/ Lockdowns/ Patients being released or transferred without notice/ Patients unavailable due to court appearance or video links, etc./ Patients out of prison due to medical appointments/ Patient has visitors/ Patient refuses to attend/ Patient unaware or did not receive notification of appointment/ Not released from prison cells in time/ Due to other prison commitment (e.g. education, other appointments or schedules)/ Reason unknown)
84. If there are any other reasons for patient DNAs that are not stated above, please specify in the box below: (\_\_\_\_\_)
85. Is there inability to fit laboratory work in this prison a problem due to: patient unavailability, transfer of patient to another prison, release of patient out of prison or failure to attend? (Yes/ No/ Don't know)
86. If 'yes': What percentage of lab work is unfitted as a result of prisoner transfer? (Less than 10%/ 10% to 20%/ 20% to 30%/ 30% to 40%/ More than 40%)
87. Is the lab work sent on to the prison where they are transferred to? (Yes/No)

## DENTAL SURGERY SAFETY AND SECURITY

88. Do you consider the dental surgery to be a safe and secure environment? (Yes/ No)
89. Is there an appropriately positioned panic button in the surgery? (Yes/No)
90. Are the dental staff issued with a prison radio? (Yes/No)
91. If 'No': Do you think that the dental staff should be issued with a prison radio? (Yes/No)
92. Are all dental staff issued with keys? (Yes/No)
93. Are regular security audits carried out for the dental surgery by prison staff? (Yes/No)
94. Are sessional tool checks carried out and submitted to security? (Yes/No)
95. Does your surgery door automatically lock to those outside the surgery when the door closes? (Yes/No)



96. Are security staff readily available during your clinical sessions? (Yes/No/Don't know)

97. If you have any safety or security concerns, please provide details \_\_\_\_\_

## TRAINING

98. Which of the following prison training programmes have you received? Please tick all that apply. (Prison Induction/ Prison key training/ Personal protection training/ Fire Training/ Assessment Care in Custody and Teamwork (ACCT) Training/ Suicide Awareness and Self Harm (SASH) training/ Other training, please specify\_\_\_\_)

99. Do you receive regular updates for your prison training? (Yes/No)

100. Who provides any additional training (e.g. risk management, CPR, etc.)? Please tick all that apply. (Prison services/ Employer/ Prison Dentist/ I do not receive any additional training/ Other, please specify\_\_\_\_\_)

101. 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/ Employer organised training/ Other verifiable CPD courses/ Other, please specify \_\_\_\_\_)

102. Which of the following organisations support your need to participate in prison dental education? (Prison services/ Employer/ Local deanery/ I do not receive support to participate in prison dental education/ Other, please specify\_\_\_\_\_)

103. Do you feel you would have benefitted from receiving training on working in dental prisons prior to commencing your post? (Yes/No)

## ORAL HEALTH PROMOTION (OHP)

104. In what ways is oral health promotion (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 event/ Oral health educators providing group work/ Posters and OHP information leaflets/ Other, please specify\_\_\_\_\_)

105. Is there a specialist smoking cessation team in the prison as part of the smoke-free prisons transition? (Yes/No)

106. Do you offer smoking cessation advice to your patients? (Yes/No)

107. Do you offer advice on alcohol misuse to your patients? (Yes/No)

108. Do you offer diet advice to your patients? (Yes/No)

109. Are you aware if any other health professionals deliver oral health promotion within the prison? (Yes/No/ Don't know)

110. If 'Yes': Who else is delivering this information? Please specify. (\_\_\_\_\_)

## COMMUNICATION

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

112. Does the dental team meet regularly with doctors and nursing staff to discuss healthcare issues? (Yes/No)

113. Are you invited to attend healthcare governance meetings that report to the Partnership Board? (Yes/No)

114. If 'Yes': Have you ever attended any of these meetings? (Yes/No)

115. If 'Yes': Do you find these meetings worthwhile? (Yes/No)

116. Is there a complaints process in place? (Yes/No/Don't know)

117. If 'Yes': Is this dental specific or part of a wider prisons health complaints policy? (Dental policy/ Prison policy/ Both/ Don't know)

118. How many patient complaints have been received in the last 12 months concerning the dental service? (0/ 1 to 2/ 3 to 5/ 6 to 10/ 11 to 20/ More than 20)

119. Which of the following have been the subject of complaints? Tick all that apply. (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, please specify\_\_\_\_\_)
120. Is there a clinical or non-clinical dental assessment on entry to prison? (Yes/No/ Don't know)
121. If 'Yes', Who undertakes this assessment? (Dentist/ Dental Care Professional/ Doctor/ Registered nurse/ Trained healthcare assistant under supervision of a registered nurse/ Other healthcare professional, please specify\_\_\_\_\_)
122. Is there a patient care pathway in place? (Yes/No/Don't know)
123. How often do you provide your patients with a written treatment plan? (All the time/ Most of the time/ Some of the time/ Almost never/ Never)
124. Is Language Line translation service or an equivalent service available for your use in the surgery? (Yes/No/Don't know)
125. If a patient is transferred to another location, do you prepare information for transfer of treatment to another dentist? (Yes, I do prepare information/ No, I do not prepare information/ I do not know when patients are being transferred)
126. Are patient satisfaction audits for dental patients carried out in the Prison? (Yes/No/Don't know)
127. How do you get feedback from Patients? Tick all that apply. (Satisfaction surveys/Patient feedback boxes/ Informal discussion with prison staff/ Informal discussion from dental patients in the surgery/ Through broader healthcare prison feedback/ Other, please specify\_\_\_\_\_)

#### **PRISON DENTISTRY MANAGED CLINICAL NETWORKS**

128. Are you part of a wider prison dentist network such as NAPDUK? (Yes/No)
129. Do you or someone from your organisation belong to a Prison MCN? (Yes/No)
130. Would you or someone from your organisation like to be part of a prison MCN? (Yes/No)
131. Are you prepared to get involved in setting up a Prison MCN? (Yes/No)
132. This is the end of the survey, we would like to thank you for taking your time to complete this questionnaire. if you have any further comments that you would like to make, please enter these details below.

Thank you for your time and taking part of this survey

## Appendix 3: Letter of invitation to complete survey



Protecting and improving the nation's health

Dental Public Health  
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80 London Road  
London, SE1 6LH

T +44 (0) 20 7854 8000

[www.gov.uk/phe](http://www.gov.uk/phe)

14 November 2017

Dear Dentist,

### Re: National survey of Prison Dentistry

Public Health England, NHS England, Her Majesty's Prison and Probation Service (HMPPS, previously the National Offender Management Service), Public Health Wales, Public Health Agency Northern Ireland and the National Association of Prison Dentistry UK (NAPDUK) are working in partnership to undertake a national survey of prison dental services throughout England, Wales and Northern Ireland.

A previous survey was carried out in 2014, and the aim of this follow-up survey is to gain an accurate understanding of current service provision across the estate. The information collected will be used as a driver to make improvements in the commissioning and delivery of dentistry services for people in prison.

We are writing to all establishments across England, Wales and Northern Ireland to ask that the **lead dentist** at your prison completes a short survey. Please note that only **one questionnaire** should be completed **per prison** by the **lead dentist**. It should take approximately 20 minutes to complete. We are asking for the survey to be completed by the lead dentist for each prison by **Thursday November 30, 2017**. The link to the online survey is below.

The survey is available online at:

<https://surveys.phe.org.uk/TakeSurvey.aspx?SurveyID=725J77mK>

**Survey ID: 725J77mK**

We understand that your time is valuable, and your input to this survey will be most appreciated and will serve to drive forward improvements nationally to dental provision for people in prison and other detainees.

The results of the survey will be published in early 2018 and a report will be disseminated to stakeholders throughout England, Wales and Northern Ireland.

If you have any further questions, please contact [Aditi.Mondkar@phe.gov.uk](mailto:Aditi.Mondkar@phe.gov.uk).

Yours sincerely,



Sandra White  
National lead for Dental Public Health  
Healthy People Division | Health Improvement Directorate

**Public Health England**, Dental Public Health, 2<sup>nd</sup> Floor, 80 London Road, SE1 6LH  
**NHS England**, Public Health, Armed Forces and their Families and Health & Justice  
Commissioning, Birch House, Southwell Road West, Rainworth, Nottinghamshire, NG21 0HJ  
**HMPPS**, Clive House, 70 Petty France, London, SW1H 9EX  
**Public Health Wales**, Dental Public Health, 5<sup>th</sup> Floor, No.2 Capital Quarter, Tyndall Street  
Cardiff, CF10 4BZ  
**HSC Public Health Agency**, Linenhall Street Unit, 12-22 Linenhall Street, Belfast, BT2 8BS  
**NAPDUK**, PO Box 32, Stroud, Gloucestershire, GL6 1DL

## Appendix 4: 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