

# **Oral Health Improvement and Dental Services in Scottish Prisons**

## **Guidance for NHS Boards**

**July 2015**

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## **1. Background**

**1.1** The 2005 *Action Plan for improving oral health and modernising NHS dental services in Scotland*<sup>1</sup> recommended that NHS boards develop oral health promotion programmes for prisoners.

**1.2** Additionally, the Scottish Government recognised the importance of addressing the health of prisoners in *Equally Well, report of the ministerial taskforce on health inequalities, 2008*,<sup>2</sup> which also included a specific recommendation that measures should be put in place to improve the oral health of prisoners.

**1.3** In July 2008, Scottish Ministers approved the transfer of responsibility<sup>3</sup> for the health care of prisoners from the Scottish Prison Service to NHSScotland. As a result, responsibility for healthcare services, including dental services, transferred to NHS Boards on November 1, 2011. This Framework sets out a range of measures to improve the oral health of prisoners and describes how dental services for prisoners should be delivered in future.

**1.4** There are currently fifteen prison facilities in Scotland,<sup>4</sup> thirteen of which are directly managed by the Scottish Prison Service. A further two establishments, HMP Kilmarnock and HMP Addiewell are operated by private companies.

**1.5** The prison population of Scotland has increased steadily over the last decade reaching an average daily population of 8,178 during 2011/12. Male prisoners accounted for 7,710 of the prison population, and there were a further 468 women prisoners. It is projected that the average daily prison population will reach 9,500 by 2020/21.<sup>5</sup>

**1.6** Mirroring the general population the prison population is ageing with a significant increase in the number of prisoners now aged 60 years or more.<sup>6</sup>

**1.7** Additionally, many prisoners have complex health and social care needs.<sup>7,8</sup> An assessment of the health needs of the prison population in Scotland identified a number of underlying health and social problems which affect many of those in prison and which are of direct or indirect importance to improving oral health:<sup>9</sup>

- Drug and alcohol abuse
- High levels of tobacco use
- High incidence of blood-borne virus infection
- Low levels of literacy
- Mental health concerns
- High levels of dental disease
- Poor nutritional status

**1.8** Frequently, oral health problems are more severe in prisoners than those seen in the general population. Indeed, the Scottish Prisons' Dental Health Survey<sup>10</sup> in 2002 and revisited in 2011,<sup>11</sup> found a number of issues amongst prisoners. One of the principal findings being that the Care Index (the amount of treated decay) had remained at a low level (30%) over the period. Other key oral health findings are detailed below:

#### Tooth decay

- Prisoners had significantly more decayed teeth, fewer filled teeth and fewer standing teeth than the general population.
- Severe decay was three times higher in the male prison population than the general population, and was fourteen times more prevalent in female prisoners than in women in the general population.
- Overall, 60% of adult males examined were found to have decayed teeth

#### Tooth Loss

- An estimated 6.2% of those examined were found to have no natural teeth remaining.
- Of those who had lost all their own teeth, 88% wore full dentures.

#### Oral Cancer

The prison population is one with a history of behaviours which increase the risk of oral cancer, with higher levels of smoking and alcohol consumption than is found in the adult population as a whole.

**1.9** The quantity and level of decay experience was associated with the demography of the prisoner group, the frequency of remands and the length of sentence. Prisoners with longer sentences tended to have received more dental care than those serving shorter sentences and had improved oral hygiene.

## **2. Oral health improvement**

**2.1** Oral health is determined by diet, hygiene, smoking, alcohol use, stress and trauma. As these causes are common to a number of other chronic diseases, adopting a common risk factor approach addresses risk factors common to many chronic conditions is more rational than one that is disease specific. Most oral diseases can be prevented, through healthy dietary choices which limit sugar consumption, good oral hygiene, abstinence from smoking and moderation in alcohol intake.<sup>12</sup>

**2.2** Core preventive messages, which should be adapted to take account of specific patient needs and the patient's medical and social history, are listed below. These include:<sup>13</sup>

- Brushing twice daily with a fluoride toothpaste containing at least 1,350 ppm fluoride.
- Reducing the amount and frequency of consumption of sugary foods and drinks, and restricting sugary foods to mealtimes.
- Regular check-ups with a dentist to provide an opportunity to diagnose and treat oral diseases early.

**2.3** For adults with obvious, current and active dental decay consideration should be given to additional measures to prevent decay.<sup>12</sup>

- Using a fluoride mouthwash (0.05% Na F) in addition to toothbrushing if appropriate.
- Having fluoride varnish (2.2% F) professionally applied twice yearly.
- Using a professionally prescribed 2,800 or 5,000 ppm fluoride toothpaste.

**2.4** All adults should have the support they require to prevent gum disease. The following measures are effective:<sup>13</sup>

- Cessation of smoking.
- Brushing teeth twice daily.
- Cleaning between the teeth using interdental brushes or floss.

**2.5** The risk of developing oral cancer is linked to smoking and alcohol misuse. Alcohol acts together with smoking to multiply the risk of developing the disease.<sup>12</sup> Groups such as

prisoners, where a history of alcohol consumption and smoking is more common, are at particularly increased risk of developing oral cancer.

**2.6** Oral cancer or pre-cancerous oral conditions may be difficult for patients to detect and are often painless in the early stages, resulting in late presentation to health professionals. Having an examination by a dental professional is important, both to receive advice which will help to prevent the disease, and to help detect any signs of disease as early as possible.<sup>14</sup> Any ulcer which has no other obvious cause and which has not healed after three weeks should be referred for specialist investigation.

**2.7** Health professionals also have an opportunity to provide advice on smoking cessation and have a valuable role in signposting clients to smoking cessation services.<sup>15</sup> A number of resources are available, for example, “A Guide to Smoking Cessation in Scotland”.<sup>16</sup>

**2.8** Achieving and maintaining oral health requires effective partnerships between the prisoner and the prison staff, the dental team and the NHS Board. All staff have an important role to play in supporting prisoners in health-behaviour change such as smoking cessation, drug substitution programmes and therapeutic substance abuse care programmes. Prison staff can play an important role in co-ordinating access to services and are normally the first point of contact when requesting dental appointments.

**2.9** A number of oral health promotion initiatives, have already been put in place in locations across Scotland. These have been largely NHS Board-led, and supported by the Scottish Prison Service staff within prisons. These have highlighted the importance of a “whole prison” commitment to implementing actions that improve oral health through improved dietary regimes, better access to toothbrushing with fluoride toothpaste and increased staff and prisoner awareness of what is needed to maintain good oral health.<sup>17</sup> The key learning points from these pilots were brought together in NHS Health Scotland’s “Mouth Matters”<sup>13</sup> training guide and are detailed below. These reinforce the recommendations contained within; “Better health, better lives for prisoners: A framework for improving the lives of Scotland’s prisoners”.<sup>18</sup>

**Leadership:**

Senior prison staff commitment to the programme.

Dedicated oral health promoter involvement.

**Needs assessment:**

Early assessment of prisoners' dental needs – clinical and information.

**Create a health-promoting environment:**

Plumbed-in drinking water across the prison.

Increase range of sugar-free products on canteen sheet.

Increase access to fresh fruit and vegetables.

Affordable artificial sweetener and sugar-free drinks on canteen sheet.

Distribution of an oral health pack, containing a toothbrush and fluoride toothpaste on remand and on release.

**Information and skills:**

Increase awareness of the oral health benefits of fruit and vegetables.

Oral health promotion at induction, within purposeful activities and integrated into other health improvement activities, such as smoking-cessation courses.

Development of oral health champions.

Signposting to NHS dental services on liberation.

**Prison staff support:**

Improve oral health awareness in all NHS and SPS staff.

Joint oral health improvement initiatives by NHS and SPS staff.

### **3. Dental services**

**3.1** Many prisoners come into custody from areas of substantial deprivation with very high levels of treatment need. These circumstances are often compounded by a history of prolonged substance misuse, tobacco use, excess alcohol consumption and infrequent dental attendance when outside the prison.

**3.2** Prisoners entering a custodial environment who have been using drugs can undergo detoxification in prison. This process leads to renewed awareness of oral problems which may have been ignored whilst using drugs. Acute dental pain may also be experienced by prisoners experiencing withdrawal, with consequent demands for care. It is important under these circumstances to balance the important long-term benefit of prevention with short-term pain relief.

**3.3** Prison is often viewed as an opportunity to take stock and to address health concerns during what is for many prisoners, a period of relative stability. Approximately 70% of prisoners reported attending the dentist whilst in prison; this is demonstrated in the 2011 study<sup>11</sup>. This would indicate that there is a clear opportunity to tackle dental disease and provide oral health information and oral health education.

**3.4** Currently, a prisoner accesses dental treatment within Scottish prisons by making a request for a dental appointment and being placed onto a waiting list. Prisoners with more serious needs are seen more urgently. However, achieving consistency remains challenging, particularly in remand and short-stay prisons, where transfers of prisoners are frequent and courses of dental treatment may not be able to be completed.<sup>19</sup> Also, the service has historically been mainly directed at relief of pain and delivery of routine dental treatment, with limited time available for prevention of disease within the dental surgery setting.

**3.5** Dental teams within prisons have traditionally consisted of a dentist and dental nurse. Hygienist services were available in only a limited number of establishments, dental therapist services were not available within the pre-NHS transition prison dental service and technician services were outsourced on a local basis. All establishments offered part-time services and the adequacy of the level of provision was unclear.

**3.6** Prior to November 1<sup>st</sup> 2011, each individual prison was responsible for the level of dental service provided and the associated contractual arrangements. For each establishment the need, demand, supply and resource available for service provision varied;

**Issues to be considered when addressing need:**

- Very high levels of need
- Dental self-care neglect
- Balancing treatment need with health promotion
- High levels of drug misuse and smoking
- Poor nutrition

**Issues to be considered when addressing demand:**

- Very high levels of demand
- Interruptions to treatment
- Continuity of care affected by prisoner transfer and release
- High levels of failed attendance

**Issues affecting supply**

- Staff availability
- Availability of surgery time
- Sessions shortened by security procedures
- Availability of oral health promoting activities

**Issues impacting on resources**

- Increasing cost of dental care products
- Replacement cycle for equipment
- Availability of health promotion and dental treatment sessions

**3.7** Following November 1<sup>st</sup> 2011, funding to support the delivery of dental services was transferred from the Scottish Prison Service to NHS boards on the basis of historical allocations. The Memorandum of Understanding<sup>20</sup> underpinning the transfer intended that NHS boards and the Scottish Prison Service funding and resources be jointly and regularly

reviewed, taking account of value for money. It was intended that key variances, investment and disinvestment should be subject to joint appraisal, with sufficient time given to stakeholders to assess and respond to developments. Additional investment in dental services would therefore be subject to this process.

**3.8** At induction prisoners will have the opportunity to make staff aware of any dental or oral problems they are experiencing and will be informed of the arrangements to access dental care.

**3.9** It is clear that prison staff and prison health centre nursing and medical staff can support dental teams. This can be achieved by providing initial advice and management, including appropriate access to oral analgesics, to prisoners experiencing an acute dental problem when the dental team is not on the premises. Prison staff and healthcare teams should agree protocols which allow for this. The care pathways described in the guidance for Managing Acute Dental Problems<sup>21</sup> are a particularly useful resource.

**3.10** A dental service will be available to all prisoners. Prisoners historically should have had access to an examination by a dentist within ten weeks of placing a request. It is hoped that in the medium-term this timescale could be reduced. However the ability to reduce the waiting time will be dependent on the demands for emergency care made on the dental team and is therefore dependant on the stability of the prison population within each establishment.

**3.11** Following examination, the care pathway will be based on need and will take account of the length of sentence. The level of healthcare to the prison population should be similar to that which is available to the community outside prison.<sup>22</sup> Therefore Boards should provide dental care and treatment to prisoners in line with that care and treatment available under Determination One of the Statement of Dental Remuneration,<sup>23</sup> taking full account of each individual's clinical need and suitability for that treatment and the degree of post treatment supervision available. Boards should consider what 'prior approval' and quality assurance arrangements should be in place in prison settings.

**3.12** Where a prisoner is on remand, sentenced to one year or less, or due for release within six months, treatment equivalent to that detailed in Section XII (Occasional

Treatment) of Determination One of the Statement of Dental Remuneration should be provided, unless exceptional circumstances dictate that additional care is essential.

**3.13** The service will be delivered by an appropriately trained and qualified dental team, registered with the General Dental Council.

**3.14** It is recognised that the length of dental sessions will vary for each establishment due to different regimes. The length of the session should be agreed between the NHS Board and the prison to maximise the availability of the dental team. Prison staff are key to ensuring that the session is as efficient as possible by delivering the expected number of prisoners at agreed intervals to the dental surgery. The number of sessions provided will in the first instance be based on the historical level of provision. It is noted that prisoners in Scotland have poorer dental health than their UK counterparts, that the demography of the prison population is changing and that the stability of the prisoner cohort varies between establishments. Therefore Boards should keep the level of provision under review with a view to increasing it to meet the oral health needs of the local prison population rather than meeting a notional target of sessions per week.<sup>23</sup>

**3.15** Access to out of hours care will follow general guidance from the NHS in Scotland and should reflect the timescales currently in use in NHS Scotland.<sup>25</sup> Examples of care pathways are shown in Appendices 1 and 2;

- Emergency – contact with health professional provided within 1 hour.
- Urgent – contact with health professional provided within 24 hours.

**3.16** Encouraging prisoners to have ongoing dental care during their sentence will enable the dental team to complete all dental treatment in advance of release. Qualitative data from the 2011 study<sup>11</sup> showed that many prisoners knew how to access dental care within the prison setting but were unsure of how to access care on release. All prisoners being released should be offered support to maintain their oral health and to register with a dentist, in order to build on any improvement in oral health achieved whilst in prison. Clear throughcare pathways should be developed for prisoners.

## **4. Operational responsibilities**

**4.1** A Memorandum of Understanding (MOU)<sup>20</sup> was developed to provide a framework of guidance on the respective responsibilities of the Scottish Prison Service, Scottish prisons, and health boards. The responsibilities of key partners are described below.

**4.2** NHS Boards will be responsible for:

- The smooth day to day running of the prison health centre
- Contracted dental services delivering care to prisoners.
- Information management, technology and governance.
- Maintenance and replacement of all clinical fixed and non-fixed assets.
- Clinical dental service-related complaints.
- Clinical performance management and monitoring

**4.3** In relation to dental services the SPS will be responsible for:

- Ensuring an environment within prisons that promotes oral health.
- Security and good order within dental surgeries.
- Structural maintenance, facilities management and cleaning services of the dental surgeries; including all fixed and non- fixed non clinical assets
- Escorting functions to facilitate attendance at dental appointments.
- Non-clinical dental service related complaints.

**4.4** NHS Board and SPS joint responsibilities.

- Development of a prison oral health strategy and delivery plan.
- The management, training and support of the dental team.
- Good governance and effective monitoring of the service.
- Introduction of a networked dental clinical IT system.
- Reporting and investigation of critical and adverse incidents.
- Business continuity planning.
- Effective and appropriate sharing of management and necessary clinically-related information.

## 5. Governance

### Monitoring

**5.1** The monitoring of prison dental services will be at a range of levels and each will have an identifiable lead officer:

- Scottish Government - Deputy Chief Dental Officer;
- NHS Board - Prison Health Lead;
- Public Dental Service - Clinical Dental Director;  
- Dental Team;
- NHS National Services Scotland - Practitioner Services Division;  
- Information Services Division;
- Scottish Prison Service - Prison Governor;  
- Prison staff.

**5.2** Responsibility for dental services within each prison establishment is by the Health Board. However the Deputy Chief Dental Officer will maintain a strategic overview regarding the development and delivery of dental services to prisoners to ensure a consistent national approach.

**5.3** NHS Board health centre manager will ensure that the usage of the dental facilities is maximised by helping the dental team manage the dental clinical activity by ensuring available appointments are filled whilst the dental team are not on the premises. The manager will also monitor and respond to all clinically related complaints where appropriate.

**5.4** The Public Dental Service clinical dental director will ensure that the dental surgery and associated decontamination processes are compliant with all extant guidance including practice inspections, decontamination and quality improvement. The director will ensure that the dental team has training to enable them to work effectively within a custodial environment.

**5.5** The dental team working in each prison shall engage with all relevant local and national clinical governance, quality improvement and training initiatives.

## **Information Sharing**

**5.6** An Information Sharing Protocol (ISP) has been developed by NHSScotland and the Scottish Prison Service; this is intended to identify the commitments required by each organisation to enable sharing of personal information. Sign up and ownership is at the highest level. It is a statement of the principles and assurances which govern the activity of information sharing. It ensures that the rights of all those who are involved in the process are protected.

**5.7** Agreement has been reached to allow healthcare staff to have read/write access to the SPS Prisoner Record (PR2).

**5.8** The prison identifiable information in the prison clinical system (establishment, hall, and cell) should not transfer to clinical systems outwith the prison. Healthcare staff are asked to ensure prison identifiable information contained within the electronic dental record is kept to an absolute minimum.

**5.9** Appointment letters should be addressed where possible to the Health Centre and PO Box address for the appropriate prison establishment as opposed to an individual prisoner. By sending appointment letters direct to prisoners, security risks arise in the prison and will ultimately result, after further delay, in the appointment being changed by healthcare staff.

**5.10** A patient's medical condition can have an impact on the dental care provided. Previously dentists had access to a prisoner's paper medical record, this should continue with an appropriate level of access within the new medical IT system.

## **Email**

**5.11** NHS staff should be set up with \*.nhs.net email addresses as outlined in the Information Sharing Protocol (ISP) so that emails containing personal or sensitive information can securely be sent between SPS using \*.pnn.gov.uk and NHS using \*.nhs.net email addresses. Any emails of a sensitive nature should be appropriately marked e.g. restricted or NHS confidential.

## **Dental Registration**

**5.12** An R4 prison dental record form must be completed for every prisoner coming into prison. The record should be marked to make clear whether the prisoner is eligible for occasional or full registration status.

**5.13** Prisoners who are on remand or have sentences of one year or less, or due to be released within six months, should be marked as occasional on the R4 record. All other prisoners who should be marked as fully registered on the R4 record.

**5.14** Further guidance will be required regarding the prisoners existing registration status within the community upon admission.

## **Consent**

**5.15** There is no requirement to gain consent from the prisoner to provide healthcare and medication. The legislative changes allow for the Health Boards to provide prisoner healthcare instead of SPS from 1st November 2011. The R4 prison dental record form acts as a practice registration and consent to data sharing not consent to treatment.

**5.16** Legislative changes, implied consent, privacy notices and the ISP are the combined basis for all healthcare provision, system access and data sharing between organisations.

**5.17** PDS dentists can access a prisoner's Emergency Care Summary. Wherever possible access should only be made once and the prisoner's dental record updated accordingly. This is to avoid unnecessary repeat access to ECS for the same patient.

## **Community Health Index (CHI)**

**5.18** A PO Box address has been created for each prison and should be recorded in the R4 clinical system. The address field on CHI will be updated to include the PO Box for the prison (thus not identifying people as being in prison). This will remain on CHI until a prisoner registers with their community general medical practitioner post-liberation.

## **Dental Health Records**

**5.19** Historically, prison dental records have not been connected to national data collection systems in Scotland. Dental records were maintained by the contractor dentist and were the property of the dentist. As dental services are now managed by the local NHS board the sharing and transfer of dental notes can be progressed.

**5.20** The movement of prisoners within the prison system is significant and can be challenging in terms of timely access to dental records to support delivery of care.

**5.21** A high level review of the options available to allow key dental clinical information to be shared between sites across the Scottish Prison Service estate is currently being undertaken. This will ensure seamless transfer of care between establishments and result in more meaningful throughcare.

**5.22** With a prisoner's agreement, Boards should seek to ensure that this continuity of care is maintained on release by communication with the prisoner's registered dentist, where available.

## **Clinical Activity Reporting**

**5.23** Dentists working in prisons should have a unique identifier and use a dedicated clinical management system to record activity. Practitioner Services Division (PSD) has a key role in information management for dentistry. Activity in prisons should be submitted electronically to PSD using the standard NHS systems and appropriate activity reporting tools for prisons dental services should be developed by Information Services Division (ISD).

## **6. Education and Training**

**6.1** Prison is a unique and particularly challenging place to deliver dental care. The complex issues facing prison dental teams in the day to day delivery of their professional duties include:<sup>26</sup>

- Patients with very high levels of dental need and neglect
- Patients with history of alcohol and substance abuse
- High turnover and prisoner transfer
- Security constraints
- Litigation culture
- Variable availability of oral health promoting activities

**6.2** NHS Education Scotland provides a core educational programme to address the educational requirements of dental professionals in Scotland. NES will work with dental teams working in prison settings to provide specific continuing professional development for prison dental teams.

**6.3** Some education and training will be unique to the general custodial setting and may need to be addressed jointly with between the local NHS Board and the Scottish Prison Service or delivered on a regional basis to make the programme viable. This may include:

- Situation de-escalation
- Personal protection
- Suicide risk assessment

**6.4** There will be some mandatory induction training which will be specific to the individual prison and will require SPS staff from the specific prison to deliver it. This may include:

- Security protocols
- 'Key' Training

**6.5** Prison dental teams should provide training and guidance to prison staff and prison healthcare staff. This may include:

- The management of the acute dental problem
- Oral health improvement activities

## **7. Recommendations**

### **7.1 Oral Health Improvement**

1. A survey of the oral health of prisoners in Scotland should be undertaken every 5 years to monitor improvements and inform service design.
2. All establishments should through a whole-prison approach have comprehensive, evidence-based oral health improvement programmes in place.
3. In partnership with the SPS, NHS Boards should work towards a seamless throughcare process including liberation to ensure oral health gains are not lost.

### **7.2 Service provision**

1. Boards should involve the wider dental team, hygienist/therapists and oral health promoters, in delivering services
2. Information on arrangements to access dental care should be part of the induction process for those entering prison
3. The level of dental care available to those in prison should be equivalent of that available to the community outside prison
4. NHS prison dental teams and SPS staff should promote a pattern of dental check-ups according to each prisoner's need
5. Boards should monitor the level of treatment provision in each establishment in order to meet the oral health needs of the local prison population
6. Boards and SPS should agree local arrangements for managing the acute dental problem
7. Boards should ensure that the principles of throughcare are embedded in local prison dental service policies

### **7.3 Governance**

1. A national IT and uniform dental clinical software systems should be in place to allow dental clinical information to be transferred quickly across Scotland.

2. Dentists should be able to access relevant areas of the prisoners medical casenotes to ensure the safe delivery of patient care.
3. NHS Boards should collaborate to determine what 'prior approval' and quality assurance arrangements are required.
4. Clinical activity reporting for the prison dental service should be submitted electronically and reported separately.
5. The Deputy Chief Dental Officer of Scottish should retain a national strategic overview of dental services in prisons.

#### **7.4** Education

1. NHS Education Scotland to assume responsibility for the continuing professional development for dental teams working in prisons
2. NHS Boards and SPS should work jointly to ensure that:
  - dental teams are prepared for working in a custodial environment
  - SPS staff are prepared for supporting oral health improvement

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## **9. Appendices**

1. Emergency Care Pathway
2. Urgent Care Pathway
3. Membership of Working Group

## EMERGENCY CARE PATHWAY

### Emergency Care

Approximately 1% of dental problems fall into the 'Emergency Care' category

Conditions include:

- Trauma including facial/oral lacerations and/or dentoalveolar injuries (e.g. avulsion of tooth)
- Oro-facial swelling that is significant and worsening
- Post-extraction bleeding that the patient is not able to control with local measures
- Dental conditions that have resulted in acute systemic illness or raised temperature as a result of dental infection
- Severe trismus
- Oro-dental conditions that are likely to exacerbate systemic medical conditions (e.g. diabetes)
- 

Timescale:

- Contact with a health professional within 60 minutes
- Treatment within a timescale appropriate to the severity of the condition

### ARRANGEMENTS

	Arrangements	Point of Contact	Contingency
<b>In-hours</b> Mon-Fri 0830-1700 Fri 0830-1430	As per prison protocol for medical emergency	As per prison protocol	Local NHS Board Dental Helpline
<b>Out-of-hours</b> Mon-Thurs 1800-0800 Fri 1800-Mon 0800	Health professional contact	Prison Nurse (OoH)	As per prison protocol for medical emergency

## URGENT CARE PATHWAY

### Urgent Care

Approximately 75% of dental problems fall into the 'Urgent Care' category

#### Conditions include:

- Dental and soft tissue infections without a systemic effect
- Severe dental and facial pain, that is, pain that cannot be controlled by the patient following self-help advice
- Fractured teeth or tooth with pulpal exposure

#### Timescale:

- Provide self-care advice
- Reassess if clinical condition deteriorates
- Treatment within 24 hours

### ARRANGEMENTS

	Arrangements	Point of Contact	Contingency
<b>In-hours</b> Mon-Fri 0830-1700 Fri 0830-1430	As per prison protocol	As per prison protocol	Local NHS Board Dental Helpline
<b>Out-of-hours</b> Mon-Thurs 1800-0800 Fri 1800 - Mon 0800	Health professional contact	Prison Nurse (OoH)	Local NHS Board Dental Helpline

## Membership of Working Group

Mary McCann	Associate Chief Dental Officer, Scottish Government (Chair)
Dawn Adams	Clinical Dental Director, NHS Fife
Mike Devine	Clinical Dental Director, NHS Lanarkshire
Kieran Fallon	General Dental Practitioner, HMP Barlinnie
Paul Cushley	Clinical Dental Director, NHS Forth Valley
Tom Ferris	Deputy Chief Dental Officer, Scottish Government
Anne Hanley	Prisoner Health Network, NHS Health Improvement Scotland
Sarah Pettie	Prisoner Health Network, NHS Health Improvement Scotland
Jim Kerr	Governor, HMP Greenock, Scottish Prison Service
Andrew Lamb	National Director, British Dental Association (Scotland)



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