

Service specification

Dental service for prisons in England

2020



Contents

1. How to use this document	3
2. The model.....	4
3. Introduction.....	7
4. Guiding principles	8
5. Core service delivery	11
5.1 Service vision.....	11
5.2 Days and hours of operation	13
5.3 Service availability.....	13
5.4 Inclusion criteria	14
5.5 Exclusion criteria	14
5.6 Equivalence for services in prisons	14
5.7 Setting.....	15
5.8 Demand management.....	16
5.9 Access requirements.....	16
5.10 Clinical governance.....	17
5.11 Safeguarding	18
5.12 Information governance	18
5.13 Information management and technology	18
5.14 Pharmacy and medicines optimisation.....	18
5.15 Learning disabilities and other vulnerabilities.....	20
6. Reconfigured estate.....	21
7. Health and justice objectives, outcomes and standards	22
8. Appendix 1 Objectives and outcomes for regional contract assurance.....	24
9. Appendix 2 Objectives and Outcomes for specific groups.....	31
10. Appendix 3 Safeguarding	33
11. Appendix 4 – Information governance, data protection, security and confidentiality	36
12. Guidance and reference documents.....	42

Note to local commissioners

This section is for guidance to assist you and does not form part of the final specification. It should be removed prior to publishing.

1. How to use this document

This service specification represents something of a departure from earlier iterations of health and justice service specifications. In previous specifications, the text has very much provided a clear steer as to:

- exactly what should be provided, in what context
- how to go about providing it and
- how much of it to provide.

What is presented in this document is a modular approach taking account of the following:

- Areas of focus that – nationally – providers are expected to prioritise.
- The outcomes that are expected from any provider, and examples of how evidence of their ability to deliver those outcomes may be demonstrated.
- The freedom for regional commissioners to tailor the specification to their needs and the needs of any specific prison population.

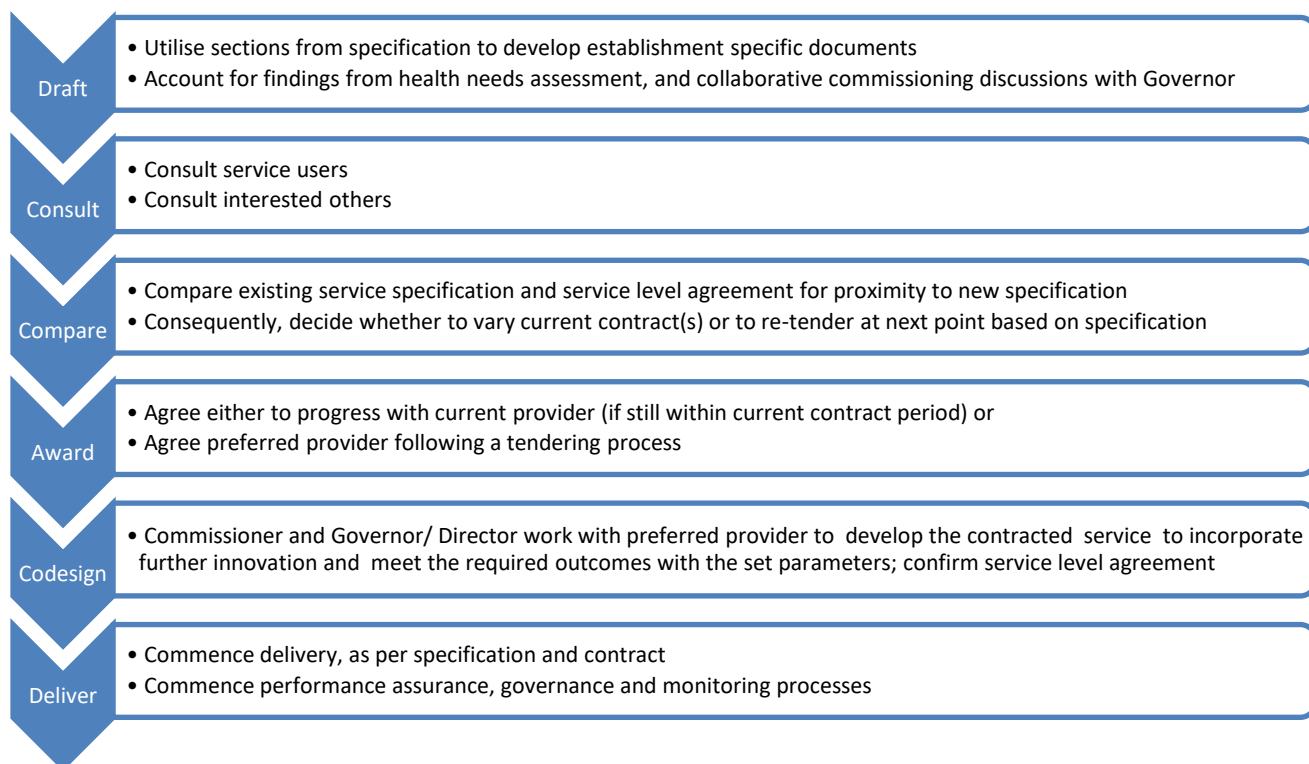
Where the following box is used, commissioners should insert local establishment/contract specific information or follow the instructions noted and delete the 'Note to local commissioners'.

Note to local commissioners

Insert local additions required to suit the individual establishment.

- The opportunity for providers to show their skill, experience and creativity in developing service models that will deliver the required outcomes.

The expectation is for the following process to take place:

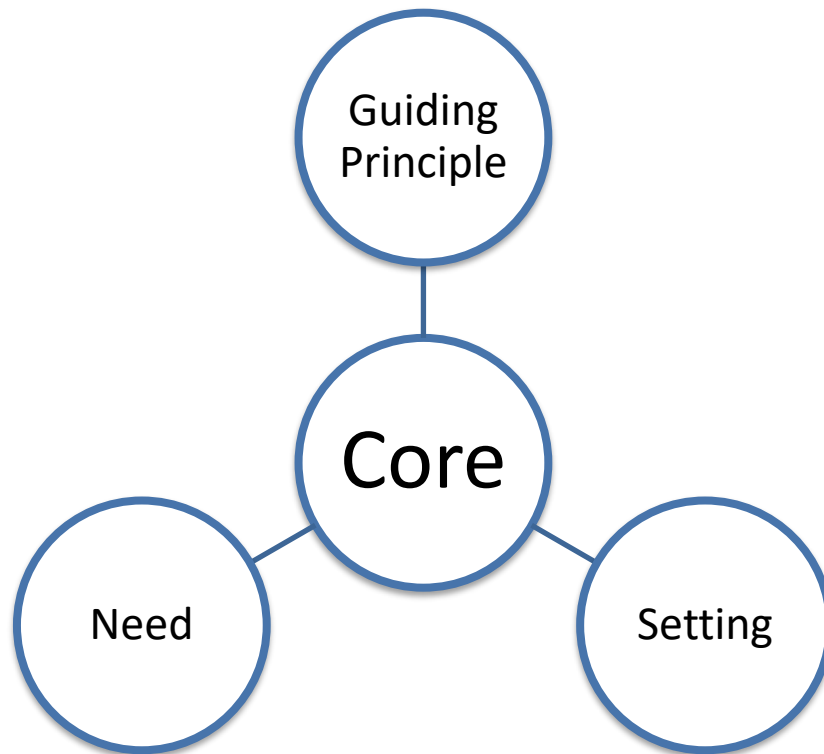


The specification also has appendices relevant to all health and justice specifications and are not all service-specific. These appendices form part of the overall specification and ensures that providers within an establishment, and nationally, are working to the same standards.

As a part of the process of exploring the specification, co-design and agreements between parties, a number of documents will need to be in place (which will vary according to commissioner, provider, prison/secure setting and regional / local approaches); further details of these will be included in other documents, such as the Personal Dental Services (PDS) Agreement.

2. The model

The dental health service specification is structured to enable the flexible use of the following concepts presented through four main considerations:



National specification:

- At its centre – a **core framework** that clearly outlines the required objectives, outcomes and standards of the service and the expected minimum levels of governance.
- An overarching **guiding principle**, that defines the basis upon which activities in the specification are delivered (i.e. safe, recovery focused, patient centred, integral peer approaches, and provided within a cohesive multi-disciplinary framework). The guiding principle element of the specification will also include signposting towards pre-existing reviews and recommendations (e.g. The Bradley Report 2009).

Localised elements of the specification:

- Full account of the **setting** within which delivery takes place should be taken, especially where this impacts on the type or duration of intervention that can be offered (e.g. reception prison, training prison or resettlement prison).
- A thorough examination of **need**, including (but not limited to) quantitative analysis, consultation and patient involvement. A comprehensive understanding of need is a cross-cutting issue across all elements of the specification. The flexibility offered by this specification places the emphasis on *an establishment-based service designed around the establishment's needs*, as evidenced through needs assessment.

The updated specification and its implementation from 2020 onwards provide an important opportunity to take into account:

- the changing profile of people in prison, such as the aging population
- service users, and their full and active involvement in the design and planning of services, service delivery, peer support and service evaluation
- the need for all parties to ensure all dental health services are commissioned and provided as services that are fit for purpose and take account of prison reforms.

It is proposed that the central core specification is the primary document – prefaced by the guiding principle statement – with guidance, signposting and links made to appendices/annexes/external sources to cover need, setting, and standards. These can then be utilised as appropriate by commissioners and providers in specifying the required service and evidencing delivery.

This model should ensure:

- requirements are delivered, whilst allowing for local flexibility and personalisation
- existing standards (e.g. clinical guidelines) are not repeated or interpreted for the specification, instead they are signposted to
- rather than telling providers how they should be doing their job, commissioners will be able to look for competence, creativity and innovation in evidencing ability to deliver the required outcomes. Once assured of the ability of the provider to deliver effectively against the 'must do' elements of the specification, commissioner/governor and provider can work in a process of co-design to develop a bespoke service tailored to the setting, focussed on achieving the desired outcomes.

3. Introduction

The 2012 Health and Social Care Act mandates NHS England and NHS Improvement to commission health services across prisons and other places of prescribed detention. As such, this specification describes the standard requirements for dental services that need to be delivered in these environments, ensuring that the principle of 'equivalence'¹ is adhered to enabling patient's access to dental, physical and mental health care as required in line with services offered in the community, working towards agreed health outcomes and being supported to manage their ongoing health care needs.

Taking into account the substantial health inequalities likely to be faced by most, if not all, patients within secure settings, it is imperative that any provision is not only equitable to community provision, but that it takes bold and innovative steps to improve the health of the most vulnerable and reduce health inequalities.²

This service specification outlines what should be included in a dental service being offered to patient populations in secure and detained environments. For ease of reference, throughout this document the term 'Learning Disability', unless otherwise stated, will encompass individuals with learning disabilities, autism, neuro-disabilities or other cognitive impairments. such as identifying people with a history of trauma, physical impairments including sight and hearing loss and broader cognitive impairments. It is an integral part of the primary care of a person in detention that such vulnerabilities are brought to attention of the detaining authorities. Compassionate care needs to be delivered to patients at all times mindful of the previous trauma a person may have received at the hands of others.

There are numerous clinical guidelines and best practice documentation that describe clinical practice and processes to steer best practice in the delivery of dental healthcare for people in secure and detained environments. This document does not aim to replicate these guidelines but provide a description of the minimum service requirements for a prison dental service. For specific clinical interventions please refer to the appropriate clinical guidance.

People in secure and detained environments may require additional health and social care support generally. Whilst social care is not the responsibility of the dental provider, there is a strong need for healthcare providers to work collaboratively with local authorities' social care teams and other healthcare providers. Appropriate support must be provided to people in secure and detained environments with an identified or suspected learning disability or difficulty to enable them to cope better within the secure environment and ensure that their health needs are met. Specific guidance in relation to meeting the needs of this particular patient population will be published by NHS England and NHS Improvement (NHSE/I) separately and can be read in conjunction with this specification. The dental service provider also has a role

¹ For NHSE/I the principle of equivalence across the detained estate does not mean 'the same as' but supports an approach where access to services is not compromised by a person's physical circumstances. There is a full definition of this principle of equivalence on page 15 of this document.

in providing general support and advising other agencies within a prison of their respective responsibilities to support patients in daily life.

This specification aims to build upon existing positive relationships between dental, primary and mental healthcare services, the prison services and patients and the vast body of work already successfully in place.

It is recognised that this is a significant time of change and transition in terms of NHS and criminal justice system (CJS) reforms, prison reconfiguration and commissioning pathways, therefore elements of this specification may be subject to review in response to variations. NHSE/I and Her Majesty's Prison and Probation Service (HMPPS) commissioners will fully engage with the service provider during the initial service co-design period and then for the lifetime of the contract to ensure this specification remains relevant and meets the needs of the population.

IT and the health and justice information system

All secure setting healthcare services will use the national IT solution provided by the NHSE/I health and justice information system (HJIS) as the primary medical record for the patient. Persons will be clearly identified as superusers for HJIS and the right level of training accessed to support this role throughout the prison healthcare service. The superuser will be able to assist the healthcare staff in accessing and using HJIS effectively.

All dental providers must ensure they have an accredited software solution to support the electronic submission of FP17 in line with the regulations all contracts need to be added to the Business Services Authority COMPASS system. This includes sub-contracts.

The provider will ensure there are standardised procedures and processes in place for the use of all clinical software solutions and that all clinicians and administrators receive thorough training in the correct use.

4. Guiding principles

The purpose of health care in secure settings is to provide an excellent, safe and effective service to all, ensuring that a person in prison has access to a dentist and that their dental treatment is of a quality that would be expected if they were in the community. Services should meet the objectives and outcomes of several frameworks and priorities and are expected to develop and implement measures to monitor these outcomes.

Care should be person centred and delivered by professionals and allied staff who are suitably competent, well led, properly supervised and operating within a clear quality and clinical governance framework supporting safe and effective delivery.

Dental services in secure settings should assist patients to achieve oral health and to be able to continue to maintain their oral health either within the secure setting or in

the community following release. People in secure settings should generally be able to access the same (NHS) healthcare services as the rest of the population. The way people in secure settings access dental services will differ from those in the community. However, as an overarching aim, it is expected that people in secure settings should experience an overall improvement in their oral health while they are detained.

The World Health Organisation describe oral health as:

‘a state of being free from chronic mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual’s capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing.’³

Achieving oral health will require provision of:

- initial assessment and oral health advice
- getting people out of pain
- more intensive oral hygiene instruction and behaviour modification to ensure clinical/surgical interventions are successful
- stabilisation of the dentition/mouth
- definitive treatment dependent on time constraints (due to length of stay in each setting) and patient compliance with oral hygiene (as advanced treatments may not be appropriate if plaque control is poor)
- equipping people with necessary skills to maintain oral health on release.

[The National Partnership Agreement for Prison Healthcare in England 2018-2021](#) works to three core, shared objectives, which are all relevant to dental services:

1. To improve the health and wellbeing of people in prison and reduce health inequalities.
2. To reduce re-offending and support rehabilitation by addressing health-related drivers of offending behaviour.
3. To support access to and continuity of care through the prison estate, pre-custody and post-custody into the community.

Oral health or people in secure settings

The oral health of people in secure settings is worse than the general population. There is no recent data for England but females in prison in Scotland were fourteen times more likely to experience extensive decay (into the pulp) than the general female population⁴. There is an increased use of urgent dental services and irregular

³ World Health Organisation. Dental diseases and oral health [Internet]. 2003. Available from: http://www.who.int/oral_health/publications/en/orh_fact_sheet.pdf

⁴ Scottish Oral Health Improvement Prison Programme: SOHIPP. "The Oral Health and Psychosocial Needs of Scottish Prisoners and Young Offenders" report Available from: <https://dentistry.dundee.ac.uk/sites/dentistry.dundee.ac.uk/files/media/SOHIPP-report.pdf>

dental attendance reported by patients^{5,6}. Provision of dental services in secure settings offers a real opportunity to reduce these health inequalities in a population who may not normally access dental services. Improving oral health increases the chances of finding employment⁷. This is an important aspect of rehabilitation. People in prison are less likely to have accessed dental services before entering the criminal justice system⁸. Supporting people to access dental services post-custody is important in maintaining any oral health improvements.

Integration with other healthcare services is essential in achieving health and oral health.

Healthcare for people in the CJS is influenced by a wide range of policy areas and developments. The provider will deliver prison community care services to meet the objectives and outcomes of the various frameworks and priorities and will be expected to develop and implement measures to monitor these outcomes. These include but are not limited to:

NHS Outcomes Framework

The NHS Outcomes Framework sets out the framework and indicators used to hold NHSE/I and commissioned services to account for improvements in health outcomes. The outcomes and indicators can be found here:

<https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework>.

NHS Long Term Plan

The NHS Long Term Plan (LTP) published in January 2019 sets out the vision for the NHS over the next decade. The document can be accessed here:

<https://www.longtermplan.nhs.uk/>.

⁵ Bolin K, Jones D. Oral health needs of adolescents in a juvenile detention facility. *J Adolesc Heal* 2006 Jun 1 38(6):755–757. Available from:

<https://www.sciencedirect.com/science/article/pii/S1054139X05003022?via%3Dihub>

⁶ Heidari E, Dickinson C, Newton T. Oral health of adult prisoners and factors that impact on oral health. 2014 Available from: <https://www.nature.com/articles/sj.bdj.2014.594.pdf>

⁷ Hyde S, Satariano WA, Weintraub JA. Welfare Dental Intervention Improves Employment and Quality of Life. *J Dent Res* [NIH Public Access; 85(1):79. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2248157/>

⁸ Wilson M. (2014) Oral Health Needs Assessment of the Prison Population in Wales. Public Health Wales. Cardiff.

Reconnect

Health and justice services are provided to some of the most vulnerable members of our society. Many people within the justice system experience greater problems than the rest of the population but do not regularly access timely healthcare. The NHS is already working with partners across government to improve the wellbeing of people in prison, reduce inequalities and address health-related drivers of offending behaviours. A priority in services for this group of patients is improving continuity of care. The care after custody service, Reconnect, starts working with people before they leave prison and helps them to make the transition to community-based services that will provide the health and care support that they need. Over the next five years, Reconnect will engage and support more people after custody per year.

5. Core service delivery

5.1 Service vision

Note to local commissioners

- If the lead provider can deliver the dental services themselves, via PDS contract alongside the main contract; or
- If the lead provider cannot deliver the dental services, NHSE/I contracts directly with the dental provider via a PDS contract alongside the main contract with the lead provider, with the additional requirement for an alliance contract to be in place between the lead provider and the dental provider. The commissioner must ensure that all contracts are inputted onto the COMPASS system to allow pension and superannuation payments as required to the providers.

This service is commissioned as part of the overall prison health pathway and as such this model will ensure an integrated treatment system both within the prison/secure settings and onwards into the community. The service will focus on delivering person-centred care within seamless and integrated clinical services in secure settings and facilitating arrangements through the gate into the community to ensure effective continuity of care. Close joint working with other healthcare services, as well as other departments within secure settings such as education, offender management, and physical education, is imperative to the success of the delivery of this service.

The service is to be made available to all people within the establishment. The provider must meet the unique needs of the establishment and take into account the needs of the population within that establishment.

Services should be familiar with the legal duties placed upon them by both the [Equalities Act \(2010\)](#) and the [Health and Social Care Act \(2012\)](#) as well as the [Mental](#)

[Capacity Act \(2005\)](#) [Mental Health Act \(2007\)](#) and the [Care Act \(2014\)](#) and include such considerations into the overall approach taken and any plans made.

The dental service will adhere to the requirements within PDS agreement specified by NHSE/I. This specification and the PDS Agreement should both be read in conjunction with oral healthcare in prison and secure settings in England ([British Dental Association Feb 2012](#)).

The service provider must ensure that the workforce is able to provide high quality, safe, effective, caring, responsive and well-led care to patients and that 'the right staff in the right place at the right time' are available to achieve better outcomes, better patient and staff experiences and effective use of resources.

The provider will ensure staff capacity and capability is consistent with operational and strategic planning processes. The provider will ensure that the workforce is able to work flexibly and provide cover where required and appropriately manage shortfalls in staff cover. The provider is expected to have a workforce contingency plan in place. The appropriate skill mix of dental staff will vary according the setting. Successful models include teams using the full range of dentists, dental hygienists and therapists, and dental nurses including extended duty dental nurses (EDDNs) for oral hygiene instruction and health promotion.

The workforce must have the essential and relevant qualifications and competencies to carry out their roles and responsibilities and have regular contact with other dental professionals working in secure settings. This should be supported through protected time allocation. This is particularly important for dentists working in secure settings due to the risk of professional isolation, and the need to address the particular challenges to providing equivalent dental surgery and care for patients in a secure setting. As a separate surgical specialty, dentists are generally less well integrated with other healthcare teams (e.g. medical and nursing) in secure settings. To ensure dentists can learn from each other, peer review should be a main component of protected sessions. Peer review is an important aspect of quality assurance where dental care is provided with little interaction with other dental professionals. It is also difficult for dentists new to providing care in secure settings to gain a suitable induction and peer support. Peer review/support sessions should take into account the needs of dentists new to providing care in secure settings. Appropriate Continued Professional Development (CPD) is required by the General Dental Council and differs for every dentist based on their Personal Development Plan. Whilst limited CPD specific to secure settings may be useful in these sessions, this would not be a main component of protected sessions and it should be clarified that these are not 'CPD sessions' as CPD is a separate requirement for individual dentists. Two sessions per year should be allocated for such peer support/peer review session. Where possible, this should include all members of the dental team. Organisation of peer support/peer review sessions should be agreed at the regional/local level. It is recognised that release of dentists for two sessions per year will impact on wait times. Where peer support/peer review sessions impact on wait times then the procedure for dealing with extended wait times, as outlined in 5.8 below, should be followed.

5.2 Days and hours of operation

Note to local commissioners

Local determination required but minimum offer must consist of service provision for 52 weeks per year.

5.3 Service availability

Specific times when a dental service is available will need to be agreed locally. The relatively small populations in many secure settings will mean availability of a dentist/dental team will differ to that in the community. This will require partnership working between the dental team and other healthcare providers to develop local protocols and commissioners should facilitate this. Access to urgent dental care can be particularly problematic. NHSE/I have published a commissioning standard for urgent dental care which should form the basis of a locally developed protocol. This includes definitions of 'emergency', 'urgent' and 'routine' dental care and these definitions should be used by all healthcare providers.

Note to local commissioners

Commissioners should use the following guidance to inform locally developed protocols in conjunction with other healthcare providers:

<https://www.england.nhs.uk/wp-content/uploads/2019/07/commissioning-standard-for-urgent-dental-care.pdf>

Local determination is required, but should be based on the above and at a minimum must include:

Dental emergencies include the following conditions, which require contact with a dentist or other appropriate clinician within one hour and are treated in a timescale appropriate to the severity of the condition:

- Trauma including facial/oral laceration and/or dentoalveolar injuries, for example avulsion of a permanent 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 such as diabetes (that is lead to acute decompensation of medical conditions such as diabetes).

Note to local commissioners

Urgent dental problems include the following conditions, which should receive self-help advice and treatment within 24 hours:

- 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.

5.4 Inclusion criteria

In carrying out the services the provider will be 'exercising public functions' for the purposes of section 149(2) of the Equality Act 2010. As such, the service provider must pay due regard to the Public Sector Equality Duty under section 149(1) of that Act and to deliver the services accordingly. The Equality Act 2010 relates to service users and employees.

5.5 Exclusion criteria

- Private procedures and practice - this is outside of the scope of this specification. If a patient wishes to obtain private treatment this can only be achieved if there is agreement with the healthcare provider, commissioner and prison/secure setting operator. Any private work must occur outside of the agreed sessions detailed within this specification and the patient must bear all costs for treatment including security procedures to be implemented.
- Treatment of all establishment staff and visitors (unless in an emergency arising at the establishment.)
- Dentists are expected to provide the skills commensurate with a general dental practitioner (GDP) under General Dental Council and NHSE/I regulations. Other dental services would need to be commissioned separately.
- Where a dentist feels that a patient would benefit from treatment that appears to be subject to exclusion, they should discuss this with the commissioner.

5.6 Equivalence for services in prisons

Patients within secure settings should receive the same level of healthcare as those people in the community – both in terms of the range of interventions available to them which meet their needs, and the quality and standards of those interventions.

As required and described in the Health and Social Care Act 2012, patients within secure settings should receive the same quality and access of healthcare as those people in the community – both in terms of the range of interventions available to them which meet their needs, and the quality and standards of those interventions. The following definition of equivalence has been agreed by the national prison health partnership and signed off by the Department of Health and Social Care, Ministry of Justice, HMPPS, NHS E/I and Public Health England.

'Equivalence' is the principle which informs the decisions of the National Prison Healthcare Board so that member agencies' statutory and strategic objectives and responsibilities to arrange services are met, with the aim of ensuring that people detained in prisons in England are afforded provision of and access to appropriate services or treatment (based on assessed population need and in line with current national or evidence-based guidelines) and that this is considered to be at least consistent in range and quality (accessibility and acceptability) with that available to the wider community, in order to achieve equitable health outcomes and to reduce health inequalities between people in prison and in the wider community'.

Equivalence here does not mean 'the same as'.⁹ For many, the secure setting may be the first time they access dental services regularly. Oral health is generally worse in people in prison. The aim should therefore be to ensure people in secure settings are supported to achieve better oral health than they experienced previously.

Note to local commissioners

Local additions will be required to suit the individual establishment.

5.7 Setting

Providing dental services in a secure setting presents particular issues due to the surgical nature of dentistry, requiring specific settings and equipment. Failure of key dental equipment (such as the dental chair or sterilisation equipment) can result in extensive delays to treatment. All such delays should be accurately recorded and reported to commissioners.

NHSE/I, as commissioners of services, do not hold responsibility for dental equipment. HMPPS are responsible for fixed, permanent dental equipment. This includes for example (but is not limited to) the dental chair (plus compressor and suction), fixed sterilisation equipment, fixed radiography equipment. The dental provider must be confident that this equipment is fit for use and is responsible for reporting and escalating this if there are issues. The dental provider is responsible for equipment which can be removed from the surgery. All parties should work together to facilitate a continuous service.

Note to local commissioners

Within the ethos of collaborative-commissioning between health commissioners and prison/secure setting governors and maintaining the flexibility of this specification to be adapted to local need, this section is where you would consider and iterate the specific needs of the setting within which the service is to be provided.

The impact of the different settings should help providers to consider their service model and the needs to be met through their service offer in collaboration with

⁹ NPA statement of equivalence:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/837882/NPHB_Equivalence_of_Care_principle.pdf

Note to local commissioners

other services provided in the prison and subsequently help commissioners and providers with co-designing the service.

Considerations of setting should also include the appropriateness of the estate to facilitate effective treatment and recovery interventions, such as a healthcare setting which actively promotes recovery, safe and appropriate dispensing facilities, and whether recovery wings and therapeutic communities could enhance the model of delivery.

Please insert local setting requirements here, e.g. establishment role (reception, training and resettlement), size, healthcare facilities and prison regime.

5.8 Demand management

The dental provider will manage keeping routine waiting times to a minimum by proactive management of demand and capacity and implementation of a flexible, reactive appointment system that is responsive to need. Extended wait times for dental services are often related to enablement issues within the secure setting (patients unable to attend appointment due to regime or miscommunication of appointments for example). There are no set time limits for routine dental care in the community. However, where wait times for routine dental care in any secure setting are consistently beyond eight weeks the commissioner and provider should work together to address this. Eight weeks should be measured from the request for a non-urgent appointment to the initial appointment. This would allow a dentist to assess the patient and allocate future treatment appointments according to need. Although 'time to treatment' is assessed in other areas of healthcare this generally relates to wait times in secondary care. If wait times are extended and dental clinical time is not fully used then the provider should work with the commissioner, healthcare staff and governors to resolve issues. Where dental clinical time is optimised and wait times are consistently extended then discussion between the commissioner and provider is needed to establish whether a review of current levels of commissioned activity is required. The dental provider will support the commissioner, through the provision health need, demand and capacity information, to undertake a review of commissioned activity.

5.9 Access requirements

- NICE guidance suggests that within seven days of arriving in prison people should be given advice on how to access dental services.
- Dental appointments are not automatically transferred when someone is transferred between secure settings and this should be made clear on transfer.
- Medical emergencies – immediately (via blue light ambulance services commissioned by clinical commissioning groups).
- Discharge plans for all – on release with follow-up in community if relevant.

- Systems are in place in the prison/secure setting healthcare provider to support access targets, including 18 weeks from referral to treatment (consultant led activity) and two weeks from referral to first outpatient appointment (cancer referrals).

It is the responsibility of the healthcare provider to ensure all activities take place within the timescales specified by a suitably qualified member of staff, within available capacity and to prioritise accordingly. The dental provider has a responsibility to work with the healthcare provider and make sure that they are aware of any issues which may affect this. This is also important in reducing professional isolation of the dental team.

5.10 Clinical governance

Clinical governance arrangements and structures will be in place which facilitate continuous service improvement by the utilisation and analysis of key information sources such as: critical incidents, complaints, best practice and clinical audit, audit of Deaths in Detention, Serious Case Reviews and Her Majesty's Inspectorate of Prisons (HMIP) action plans. There should be evidence of communication of these improvements across the range of organisations and partners operating within the system. Clinical governance concerns both clinical and non-clinical staff and acknowledges everyone's contribution to the patient's experience. Good integrated governance should combine and create consensus around the concerns of clinical staff, removal centre staff and managers, patients and their families. Key to effective governance is the availability of information sources on which to base decisions.

The provider will use a variety of methods to ensure that a high-quality service is provided. These will include, but not be limited to:

- patient questionnaires
- patient compliments/complaints
- clinical audit (including antimicrobial prescribing)
- waiting time surveys.

The provider will supply regular reports and any other reasonable additional information to enable the commissioners to monitor outcome measures.

CPD of the dental team should include learning and learning objectives specific to secure settings. Where protected time for peer review forms part of the contract (for those employed on a sessional basis as above), outcomes of these sessions should be reported back to commissioners as a formal method of quality assurance.

5.11 Safeguarding

Details of expected safeguarding can be found in **Appendix 3**.

5.12 Information governance

Details of expected information governance, data protection, security and confidentiality can be found in **Appendix 4**.

5.13 Information management and technology

The provider must have in place appropriate, secure and well managed information management and technology (IM&T) systems which properly support the efficient delivery of all healthcare services and which either includes or links with primary care and mental health. These must comply with specific requirements as specified in the PDS Agreement.

5.14 Pharmacy and medicines optimisation

Pharmacy services and the optimisation of medicines within care pathways delivered by health and justice primary care providers are commissioned such that they:

- Ensure patients get access to and a choice of the most effective treatments, and the outcomes that matter to them.
- Improve the quality (safety, clinical effectiveness, patient experience) of prescribing and medicines use.
- Make how we purchase and supply medicines more efficient, while ensuring the NHS retains its position as a world-leader in medicines.
- Provide clinical pharmacy services within health and justice services that deliver the services and pharmacy workforce expectations described in the Long-Term Plan.

Pharmacy service and medicines outcomes

- Patients have prompt access to medication in accordance with clinical need.
- A model of community pharmacy is provided with additional on-site clinical pharmacy services that support both patients and staff in optimising medicines. This includes arranging provision of a pharmaceutical supply service for the prison: For local/reception prisons this should be an on-site pharmacy.
- Outcomes are underpinned by on-site pharmacy workforce who are fully integrated into the healthcare team, provide services to people in secure settings that enable medicines optimisation and who are led by a senior pharmaceutical adviser or chief pharmacist.

Prison medicines and pharmacies

The dental services provider should collaborate with the healthcare and pharmacy services provider for the prison to deliver the dental service and use of medicines within it in line with the [Royal Pharmaceutical Society's \(RPS\) Professional Standards for Optimising Medicines for people in Secure Environments](#) . This provides detailed information about medicines handling and optimisation in prisons and should be read alongside the [RPS Safe and Secure Handling of Medicines 2018, NICE guidance, Royal College of General Practitioners Safer Prescribing in Prisons 2019](#) and other national clinical guidelines.

The domains in the RPS standards describe the standards needed within the detained person's time in custody, from admission to release or transfer:

- Domain 1: Arriving and meeting people's initial medicines needs.
- Domain 2: Meeting people's medicine needs during their stay.
- Domain 3: Continuing people's medicines on release and transfer.
- Domain 4: Employing and training a competent workforce to underpin optimising people's medicines.
- Domain 5: Maintaining a framework of safety and governance.

In addition, there are specific medicines and pharmacy elements which will apply to dental services in the prison. These elements along with any guidance referenced in them require delivery by the dental provider:

- Dental prescribing should be in line with the dental prescribing practice section and [Dental Practitioner's Formulary of the British National Formulary](#).
- Dentists should prescribe pain relief in line with the [national prison pain management formulary and implementation guide](#) and in collaboration with the local healthcare provider to ensure a consistent approach is used
- National guidance for the use of antimicrobials should be followed with regular audit. A toolkit can be found here: <https://bda.org/about-the-bda/campaigns/antibioticresistance>.
- The dental provider should support the healthcare provider to develop and use processes relating to the use of medicines for acute dental needs that present to healthcare when the dental team are not on-site.
- The dentist must prescribe medicines themselves directly onto the secure setting IT system (HJIS) including printing and signing the prescription forms in line with the local healthcare provider's processes.
- The dental provider should ensure that medicines needed in the event of a dental emergency are stocked and accessible by the dentist. This should be in line with national guidance: <https://www.cqc.org.uk/guidance-providers/dentists/dental-mythbuster-4-drugs-equipment-required-medical-emergency>.
- The dental provider will use medicines sourced by the healthcare provider so that the healthcare provider retains ownership of medicines used by the dental team. This simplifies the arrangements in order to comply with medicines legislation.
- The dental provider staff should comply with the healthcare provider's processes and policies relating to medicines handling, medication safety incident reporting and policy. This will require developing processes relating to

dental practice in partnership with the healthcare provider's lead pharmacist and the prison medicines management committee. Examples include:

- Prescribing based on the prison's in-possession policy.
- Disposal of pharmaceutical waste.
- Dental staff may be required to manage stock control (i.e. ordering and checking medicines held for dental use) and monitoring of fridges held in dental practice rooms. Clear accountabilities and responsibilities should be agreed with the healthcare provider and pharmacy team.
- Prescribing and use of any Controlled Drugs (CDs), in particular midazolam and other benzodiazepines, should be in line with regulatory and local operational requirements. This includes ensuring any CD incidents are reported to the healthcare provider, the dental provider's controlled drugs accountable officer (CDAO) if applicable and NHSE/I CDAO for the prison (or as relevant to other secure settings).
- The dental provider will be responsible for ensuring that they are aware of all Drug and Medical Device Alerts issued by the Medicines and Healthcare Regulatory Agency that are relevant for dental practice and that all necessary actions are carried out and documented within the required timescale. The dental provider should liaise with the healthcare provider's pharmacist to confirm the actions taken.

5.15 Learning disabilities and other vulnerabilities

Average estimates and research findings regarding the number of adults with learning disabilities in the prison population are between 1–10%, depending on various factors including the type of prison and the research methods used.

The number of adults with autism or Asperger's Syndrome in the adult prison population is unknown. 1% of the general population have an autistic spectrum condition and this percentage is thought to be slightly higher in the CJS. People with learning disabilities are more likely to experience certain physical and mental health conditions and are less likely or able to access healthcare services¹⁰. People with other vulnerabilities such as autism, Attention Deficit Hyperactivity Disorder (ADHD) or acquired brain injury, may also experience associated health problems and have difficulty communicating their situation or symptoms.

In 2015, *'Equal Access, Equal Care; Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities'*¹¹ was published, outlining the changes and standards for prison healthcare settings to ensure prison healthcare services are on par with services delivered to people with learning disabilities (LD) in the community.

Members of the dental team need to have a comprehensive understanding of learning disabilities.

¹⁰ [The health Equality Framework \(2013\)](http://www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf)
www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf

¹¹ <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/08/equal-access-equal-care-guidance-patients-ld.pdf>

This is to support the wider healthcare system in:

- helping prison and healthcare staff to identify possible learning disabilities
- implementing pathways to enable patients with learning disabilities to be referred, where appropriate, to local or regional services
- ensuring the service has access to learning disability expertise to advise and have input into planning and support, as required
- liaising with social care regarding any patients who require a social care assessment and ensure that any outcome of such an assessment is embedded within the patient's support plan
- raising awareness of learning disabilities across the prison
- working with the establishment operator and other healthcare services to manage specific patients with learning disabilities, whose behaviour is causing considerable disruption or concern. This includes contributing to case conferences.

The dental health team will also work with the primary care team in the development of learning disability registers that will enable an annual health check and health action plan to be completed. Dental teams should co-operate with this wherever necessary.

Individuals identified with a learning disability will be given a comprehensive physical and mental health assessment using an appropriate tool which healthcare staff are fully trained to use and which the patient is able to fully comprehend and take part in. This should include an oral health examination.

Appropriate support must be provided to patients with an identified or suspected learning disability in order that they are enabled to cope better within the secure environment and ensure that their health needs are met.

Patients identified with a suspected or confirmed learning disability must be clearly identified on a central establishment setting healthcare database and appropriate information shared with the establishment operator and other healthcare and prison/secure setting services.

All patients with a learning disability should be able to access all relevant information via clear communication, including accessible, easy to read information that meets their specific needs, including Easy Read health literature.

6. Reconfigured estate

The establishment types – reception, training, resettlement – will need to be considered when commissioning healthcare services in the reconfigured estate, as each will have different healthcare requirements. It should also be noted that most prisons will have a dual function (e.g. reception and resettlement), so the service will need to meet the needs of all patient populations within the establishment.

Local determination will be required based on the health needs assessment (HNA) for each establishment and the unique population of each site.

Below are general commissioning considerations for each type of prison function:

Reception

- Working with primary care providers in identification of immediate health, risk and safety needs.
- Appropriate care 10 days after reception and the transfer of health information to receiving prison where appropriate.
- Pathways across prison patient population and cluster may be needed to ensure continuous care.

Training

- Longer term management and treatment of oral/dental conditions.
- Referrals to secondary care.
- Oral health promotion (both individual (in clinics) and wider (on the wings); often by the use of EDDNs).
- Oral health promotion (both individual (in clinics) and wider (on the wings); often by the use of EDDNs with reference to [Delivering Better Oral Health](#)).
- Working collaboratively with the healthcare provider health promotion lead to support the integration of oral health into any developed health promotion strategy and activities.
- Supporting prison health trainers/champions or other similar schemes in the delivery of oral health promotion messages.
- Signposting patients to support services in the prison, e.g. smoking cessation and weight management.
- Working collaboratively with prison heads of healthcare to explore opportunities to embed oral health training for healthcare staff into any existing training programmes.
- Engaging with commercial providers and patient forums to promote the availability of affordable fluoride toothpaste, toothbrushes, interdental cleaning aids and low sugar food and drinks alternative options to promote both general and oral health.

The dental team will support the implementation of any emerging national guidance to support the delivery of the dental care pathway for people in prison.

Resettlement

- Discharge planning to ensure continuity of care on release.
- Healthcare contribution to resettlement planning.

7. Health and justice objectives, outcomes and standards

The service provider will work in partnership with the commissioners and other stakeholders to contribute towards the following objectives and outcomes (listed in Appendix 1) and will consider all opportunities to enhance the aims of the service.

All services should be commissioned to achieve the objectives and their respective outcomes. However how these are achieved will depend upon the service model provided within an establishment. Different establishments with differing functions will focus their service on achieving the most relevant outcomes for the need of the population. For example, this may mean that a local reception establishment will have a greater focus on screening and assessment, pain relief, and through the gate working, rather than long term treatment interventions. Previous guidance specified the types of dental treatment to be carried out based on sentence length. This is no longer appropriate. Instead, clinicians will work with patients to agree treatment plans which address individual needs. This will require local determination by Commissioners and providers on priorities based on the health needs assessment and the current population.

To assist with the evaluation against the objectives, the specification incorporates outcomes that cover the following four domains:

- PROMs: Patient Reported Outcome Measures
- PREMs: Patient Reported Experience Measures
- CROMs: Clinical Reported Outcome Measures
- PATOMs: Partnership Reported Outcome Measures.

It is important to recognise where a service is working well so good practice can be shared. It is also important that commissioners can identify potential issues with clinical quality/concerns around clinical practice which require further investigation. This could come from a composite of the following sources:

1. Outcome measures as below
2. Care Quality Commission (CQC) inspections
3. Prisons inspections
4. Reports from prisons healthcare
5. Patient questionnaires
6. Patient compliments/complaints
7. Clinical audit (including antimicrobial prescribing)
8. Waiting time surveys (noting that wait times are due to a number of factors often outside the control of dental providers).

FP17s must continue to be completed and sent. However, Units of Dental Activity or 'UDAs' are inappropriate for monitoring and comparing dental activity in prisons.

It is not anticipated that providers will report on each outcome routinely, these simply provide a mechanism by which providers can evidence they are achieving the outcome measures to commissioners when appropriate, for example, this may be part of an audit cycle or a thematic contract review.

This is for local determination and should not create an additional reporting burden but enable providers to demonstrate how their service meets the required outcomes for the populations they serve.

8. Appendix 1 Objectives and outcomes for regional contract assurance

In the table there are examples of ways in which you can evidence that each of the outcomes have been achieved. *These examples are not exhaustive and should be locally agreed to fit the need of the establishment and patient population, utilising data and information that is already in place in services.* There is not an expectation that all these examples will be implemented. They are provided to assist in determining the type of evidence that may be available. Healthcare within each prison can arrange focus groups to develop specific questions on dental provision based on the below. Due to differences in settings, local agreement is likely to be needed for most questionnaire settings. However, it may be useful to develop some regional or even nationally agreed questions for comparison as the specific wording of questions influences responses.

Objective 1	
To improve the health and wellbeing of people in prison and reduce health inequalities	
Outcomes <i>Note that these describe the experience the patient should have. Exact wording for questions needs local determination as above.</i>	Examples of how this could be evidenced (local determination required)
<p>PROMs:</p> <p>Patient views and feedback are regularly obtained, and their comments reflected in continuous service improvement</p> <p>All patients are involved in, and have access to, their own care plans</p>	<p>PROMs:</p> <p>Patient survey results with evidence of actions completed based on these</p> <p>Arrangements for this would differ in different settings. Evidence for this could be agreed in peer review/peer support sessions</p>
<p>PREMs:</p> <p>While I was in the waiting room I was informed if I would be unlikely to be seen that day</p> <p>The dental surgery was clean</p> <p>PREMs:</p> <p>My confidentiality is protected, but information is shared to keep me safe</p>	<p>PREMs:</p> <p>Patient questionnaire (locally/regionally agreed)</p> <p>Patient questionnaire</p> <p>PREMs:</p> <p>Patient questionnaire</p>

I got the care I needed	Patient questionnaire
I have been told what is next in my dental treatment plan	Patient questionnaire
I received an explanation when I raised a complaint	Evidence of patient engagement (e.g. patient forums)
I feel the service listens to me and hears my concerns	Patients inform the development of the service
Oral healthcare information can be understood by people who do not speak English and by people who use sign language	Oral healthcare leaflets in an appropriate format (i.e. diagrams and Easy Read)
Dental services are physically accessible to all	Compliance with relevant legislation on e.g. people with mobility issues

CROMs: Antimicrobial prescribing is as per guidance	CROMs: Regular antimicrobial prescribing audits (AMR audits)
Oral health advice is in line with most recent guidance	Regular Delivering Better Oral Health (DBOH) audits
Radiographs are according to most recent guidance	Regular radiography audits
Peer review for example by case based-discussion	Evidence of peer review for example attendance at local or regional meetings plus an action plan
Dentures (or other treatment requiring a dental laboratory) are provided where length of stay permits where appropriate	Evidence in FP17s where appropriate to the setting

<p>PATOMs:</p> <p>Providers work with partners to ensure reasons for clinic cancellations are accurately recorded and reported</p> <p>Regular contact with other key partners including recording of issues with equipment/regime</p> <p>Close working with other healthcare professionals (including GPs and nurse practitioners) to ensure adequate care when no dental service is available</p> <p>CPD relevant to secure settings</p>	<p>PATOMs:</p> <p>Where this is the fault of the provider, these are replaced. Where these are not the fault of the provider (faulty dental chairs, prison regime etc), these are reported, and an action plan developed. Accurate pressure reporting</p> <p>Records of contact made with improvements/solutions suggested by provider for action by the responsible body</p> <p>Development of a local protocol for urgent dental care and involvement in interdisciplinary clinical governance group (commissioners should facilitate this)</p> <p>Completed CPD or included in PDP</p>
---	---

Objective 2

To reduce reoffending and support rehabilitation by addressing health-related drivers of offending behaviour

Outcomes <i>Note that these describe the experience the patient should have. Exact wording for questions needs local determination as above.</i>	Examples of how this could be evidenced (local determination required)
<p>PREMs:</p> <p>I understand how to look after my teeth and mouth better than I did before I came to prison</p> <p>The dental team understand my personal goals and help me address my oral health needs</p>	<p>PREMs:</p> <p>Example of evidence based oral health promotion is available</p> <p>Patient questionnaire</p>

<p>CROMs:</p> <p>Treatment plans involve shared decision making with patients, documented in clinical records</p> <p>Services are physically accessible for all people in prison</p> <p>Care is informed by histories of psychological and physical trauma (abuse) and does not re-traumatise</p>	<p>CROMs:</p> <p>Peer review/peer support</p> <p>CQC and patient reports</p> <p>All staff have some knowledge of trauma informed care and training where appropriate. NB this refers to previous physical/psychological trauma rather than dental trauma; see https://www.victimfocus.org.uk/resources-for-professionals</p>
<p>PATOMs:</p> <p>All CQC and relevant HMIP healthcare recommendations and findings are responded to and actioned</p> <p>Dental providers/performers should contribute to wider prison leadership</p>	<p>PATOMs:</p> <p>Action plans are in place to implement recommendations</p> <p>Commissioners should facilitate dental providers input into wider prison leadership and initiatives and dentists</p>

<p>Oral health included in wellbeing plan supported by a whole prison approach where possible</p> <p>Dental team contribution to asset-based approach to healthy living including access to peer mentors, physical activity and education</p>	<p>should provide input/attendance when requested</p> <p>Evidence of communication to support this</p> <p>Dental teams are supportive of this</p>
---	---

Objective 3

To support access to and continuity of healthcare through the prison estate, pre-custody and post-custody into the community where appropriate

Outcomes	Examples of how this could be evidenced (<i>local determination required</i>)
<p>PROMs:</p> <p>Information/discussion on how to access dental services following release</p> <p>Where the release date is known to patients personal, written oral health care advice is given at the final appointment</p>	<p>PROMs:</p> <p>Written information available/posters in the dental setting</p> <p>Information on discharge summary and through the gate services are available to support patients to access dental services after release</p>
<p>PREMs:</p> <p>I am engaged in planning the treatment needed before and after my discharge</p>	<p>PREMs:</p> <p>Questionnaire (only applicable where release date is known)</p>
<p>CROMs:</p> <p>Arrangements are in place to support continuity of care on transfer to another prison</p> <p>Referral to Reconnect where required/possible</p>	<p>CROMs:</p> <p>Patients are aware that they will need to check any ongoing dental appointments are rebooked on transfer to another prison</p> <p>Engagement with the Reconnect programme as appropriate</p>

<p>PATOMs: Where appropriate, dental teams should assist with patient information flows across the patient pathway – including (but not limited to): Liaison and Diversion, Community Rehabilitation Community (CRC)/probation, community healthcare providers, local authority, Person Escort Records (PERs)</p> <p>Information sharing agreements are in place locally to support appropriate sharing of patient information</p> <p>Contributions to multidisciplinary teams for complex cases where appropriate</p>	<p>PATOMs: Engagement across delivery arms to be captured through partnership measurement mechanism</p> <p>As appropriate</p> <p>As appropriate</p>
---	--

9. Appendix 2 Objectives and Outcomes for specific groups

Foreign national offenders	
Outcomes	Examples of how this could be evidenced (<i>local determination required</i>)
<p>PROMs: Patients are provided with any urgent oral health requirements for release</p>	<p>PROMs: Medications etc provided as necessary</p>
<p>PREMs: Oral healthcare information can be understood by people for example people who do not speak English and by people who use sign language</p> <p>I have had appropriate access to translation, accessibility and language services</p> <p>I can request and use dental services and I know what is available</p> <p>I am supported to care for myself and maintain/improve my oral health</p>	<p>PREMs: Translation services are available and utilised; oral healthcare leaflets in an appropriate format (diagrams may be useful due to the large number of languages needed)</p>
<p>CROMs: Care is informed by histories of trauma and does not re-traumatise</p>	<p>CROMs: All staff have some knowledge of trauma informed care</p>
<p>PATOMs: Planning for release and resettlement – GP registration, NHS number</p>	<p>PATOMs: Pathways are in place for patients transferred from a Foreign National Offender (FNO) prison to an immigration removal centre (IRC) or to the community</p>

End of life care	
Outcomes	Examples of how this could be evidenced (<i>local determination required</i>)
<p>PROMs:</p> <p>Pathways are in place for end of life care, from diagnosis of a life-limiting illness and this includes oral health</p> <p>Dental treatment planning should take into account end of life care</p>	<p>PROMs:</p> <p>Full implementation of the Dying Well in Custody Charter</p> <p>Full record of agreed treatment plan in clinical notes (including record of no treatment decisions)</p>

10. Appendix 3 Safeguarding

The provider must ensure they have up to date organisational safeguarding policies and procedures for children and adults and robust governance arrangements in are in place for safeguarding in line with the local authority and the prison's safeguarding policies and procedures. They must work with prison/secure setting partners to ensure there are strong links between the establishments and local safeguarding boards. Safeguarding policies and procedures must give clear guidance on how to recognise and refer safeguarding concerns both within the prison and when necessary outside of these structures. All policies and procedures should be consistent with and make reference to safeguarding legislation, including in relation to mental capacity and consent, national policy/guidance and local multiagency safeguarding processes. The safeguarding policy must also detail safeguarding responsibilities and accountabilities within the service; whistle blowing procedures; safe recruitment; safe working practices; induction and training; complaints procedures; confidentiality and information sharing. Staff must have access to these policies and procedures at all times and practice in accordance with these policies. There must be a named designated healthcare lead within each prison to champion the importance of safeguarding and the dental practice safeguarding lead would link into the designated healthcare lead. In turn, these representatives must link in with the individual prison safeguarding managers and attend and contribute to any safeguarding case conferences/protection meetings within the prison/secure setting and/or the relevant local authority. There must be an effective system for identifying, recording, analysing and referring any safeguarding concerns, including potential neglect. Patterns and trends must be identified through governance arrangements including; risk management systems, patient safety systems, complaints and human resources functions and referred appropriately according to multiagency safeguarding procedures.

The provider must:

- review the effectiveness of its safeguarding policies, procedures and arrangements on an annual basis
- provide assurance through an annual safeguarding report to the Local Health Delivery Board and the commissioner.
- implement robust quality assurance programmes to ensure that safeguarding systems and processes are working effectively
- consider and implement the recommendations of any Serious Case Review and devise an action plan to ensure that any learning is implemented and shared.

All safeguarding concerns relating to a member of staff (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) must be effectively investigated and referred appropriately according to local multiagency safeguarding procedures. Disciplinary processes must be concluded irrespective of a person's resignation, and 'compromise agreements' must not be allowed in safeguarding cases.

Staff training

All staff must undertake safeguarding training appropriate to their role and level of responsibility. All new staff must undertake safeguarding training during their induction. The Training Needs Analysis and Training Plan will determine which groups of staff require further safeguarding training, how often and at what level for both safeguarding children and adults. Safeguarding training should include how to recognise and respond to abuse, how to report concerns, the principles of the Mental Capacity Act and consent legislation. All staff must be confident to report any suspicions of abusive practice, without fear that they will suffer as a result and are aware of their rights under the Public Interest Disclosure Act.

All staff must be aware of and fully comply with guidance in the documents:

- [‘Working Together to Safeguard Children’ \(Department for Education, 2018\)](#)
- [‘Safeguarding Adults: The Role of Health Service Practitioners’ \(Department of Health, 2011\)](#)
- [15/2015 - Safeguarding Vulnerable Adults](#)

Public Health England have produced a toolkit entitled [Safeguarding in general dental practice: a toolkit for dental teams](#).

The British Dental Association have produced the following guidance: www.bda.org/safeguarding

To promote the safety and protection of vulnerable adults, staff should:

- be aware that vulnerable adults may encounter abuse
- take reasonable steps to protect vulnerable adults
- identify vulnerable adults within the service
- report any concerns or risks to a vulnerable adult
- be alert to the risks that known abusers may pose to vulnerable adults
- ensure they are fully aware of the policy in relation to protecting vulnerable adults
- work in cooperation with all agencies involved in any investigation
- be aware of the referral procedures and refer as appropriate.

Plans must be in place from any Serious Case Reviews that are on-going or completed and implementation is monitored with a robust process to share lessons learnt.

This website should be helpful for answering general questions around safeguarding and dentistry: <https://www.bda.org/safeguarding>.

The training requirements of the various members of the dental team are outlined in the ‘expectations for training’ section. The majority of dentists and dental care professionals will require level 2 training. The training needs to meet the requirements for the General Dental Council’s enhanced verifiable CPD.

The recent safeguarding guidance document for general dental practitioners is:

- Safeguarding in general dental practice: a toolkit for dental teams (<https://www.gov.uk/government/publications/safeguarding-in-general-dental-practice>)

Safeguarding children

The provider must ensure that policies and procedures include the safeguarding and promotion of the welfare of children of patients in their care and there is a process in place to report concerns, actual abuse or neglect of a child.

The provider will ensure that all staff:

- recognise the risks of abuse to an unborn child
- contribute to child protection conferences, family group conferences and strategy discussions
- contribute to whatever actions are needed to safeguard and promote the child's welfare.

Prevent

Prevent is part of the UK's Counter Terrorism Strategy, known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity; this includes patients and staff. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed and become involved with criminal, terrorist activity. In April 2015, the Prevent Statutory Duty, under Section 26 of the Counter-Terrorism and Security Act 2015, was made a statutory responsibility for the health sector. The Duty states that the health sector needs to demonstrate 'due regard to the need to prevent people from being drawn into terrorism'. Within health, NHS trusts and foundation trusts are specifically mentioned in the Duty, however, Prevent is part of mainstream safeguarding and therefore all health staff must ensure vulnerable people are safeguarded. This includes ensuring there is a named Prevent lead for the whole healthcare setting and there is access to quality training for staff in their organisation and embedded processes to identify and protect those who may be at risk of radicalisation. The dental team must report relevant concerns to the healthcare Prevent lead. There must be a clear process for escalating concerns regarding potential terrorist events to the police and/or detention centre director/establishment pathfinder lead.

11. Appendix 4 – Information governance, data protection, security and confidentiality

The provider will ensure that they are fully compliant with the standards set out in the Data Security Protection Toolkit. This includes arrangements to ensure that personal identifiable information or information of a confidential nature is treated as such, including patients' records, and shall not be divulged to any unauthorised person. Evidence for the Data Security Protection Toolkit must be supplied and submitted as required by the predetermined submission dates to the NHS Digital and submissions must be available for external audit.

The provider will ensure that relevant legislation concerning confidentiality; data protection and freedom of information are complied with, along with compliance with Caldicott principles.

The provider will ensure the co-ordination of IT, data collection and quality assurance process to allow for timely and comprehensive reporting to the commissioner on agreed service parameters, and external health and social care needs assessments.

Compliance

The provider will adhere to all appropriate governance and security for the IM&T systems and paper records to safeguard person identifiable information as determined by the commissioner and the prison establishments including appropriate security measures and access controls. This includes adherence to relevant Prison Service Order (PSO) and Prison Service Instructions (PSI).

The provider will demonstrate compliance with the Data Security Protection Toolkit Standards for prisons working towards a minimum of 'satisfactory' compliance in all requirements and will co-operate fully with the commissioner in any submissions required by NHS Digital, Department of Health and Social Care and NHSE/I.

The provider will provide evidence of any registration under ISO.IEC 27002 -2005; ISO 27001 – 2005 and BS7799-2 or other appropriate information security standards.

Legislation and guidance

The provider will adhere to all statutory obligations for the management of information and the operation of IM&T within the NHS, including, but not exclusively, the following:

- [Common law duty of confidentiality](#)
- [Code of Practice on Confidential Information 2014](#)
- [Confidentiality Guidance for Doctors GMC 2009](#)
- [Confidentiality and Disclosure of Information BMA 2008](#)
- [Code of Professional Conduct NMC 2004](#)
- [Caldicott Report 1997 and Caldicott 2013](#)
- [Information – To Share or not to share? The Information Governance Review](#)

2013

- [National Data Guardian for Health and Care Review of Data Security, Consent and Opt-Outs 2016, Data Protection Act 1998, European Directive 1995/46C](#)
- [Access to Health Records Act 1990](#);
- [Freedom of Information Act 2000](#);
- [Environmental Information Regulations 2004](#)
- [European Directive 2003/4 EC](#)
- [Computer Misuse Act 1990](#)
- [Mental Capacity Act 2005 and Code of Practice 2007](#)
- [Human Rights Act 1998](#).
- [Health and Social Care Act 2015](#)
- [Health and Social Care Act 2008](#)
- [Health and Social Care Act 2001](#)
- [NHS Act 2006](#)
- [Crime and Disorder Act 1998](#)
- [Regulatory and Investigatory Powers Act 2000](#)
- [Records Management Code of Practice for Health and Social Care 2016](#)
- [Public Records Act 1958](#).

In addition to the statutory requirements, the provider must meet prevailing national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively the following:

- Use of the Caldicott principles and guidelines
- Appointment of a Caldicott Guardian
- Policies on security and confidentiality of patient information
- Records management policies and procedures
- Achievement of the data accreditation requirements
- Governance arrangements in line with the NHS Information Governance Toolkit
- Risk and incident management system
- Encryption standards in line with guidance from NHS Digital (formerly Health and Social Care Information Centre)
- For the avoidance of doubt, obligations apply in respect of information held in all formats including electronically and manually.

Data protection

The provider shall maintain the confidentiality of personal data entrusted to it in accordance with the provisions of the Data Protection Act 2018 (DPA), General Data Protection Regulation 2018 (GDPR) and any other relevant legislation.

The provider shall comply with the six principles of the Data Protection Act 2018 ('the 2018 Act') and in particular the provider agrees to comply with the obligations placed on the commissioner by the data protection principles as set out in the 2018 Act, namely:

- To maintain technical and organisational security measures sufficient to comply at least with the obligations imposed on the commissioner.
- Only to process personal data for and on behalf of the commissioner, in accordance with the instructions of the commissioner and for the purpose of performing the services in accordance with this agreement and to ensure compliance with the 2018 Act.
- To allow the commissioner to audit the provider's compliance with the requirements of this Clause on reasonable notice and/or to provide the commissioner with evidence of its compliance with the obligations set out in this clause. Both parties agree to use all reasonable efforts to assist each other to comply with the 2018 Act. For the avoidance of doubt, this includes the provider providing the commissioner with reasonable assistance in complying with subject rights (including right to be forgotten, right to amend etc.) requests served on the commissioner under Schedules 9 and 10 of the 2018 Act and the provider consulting with the commissioner prior to the disclosure by the provider of any personal data in relation to such requests. The provider will be registered for Data Protection with the Information Commissioner for all appropriate categories of processing of personal data. There is a statutory obligation to protect person identifiable data against potential breach of confidence when processing or sharing with organisations outside of the United Kingdom. No information under this contract should be processed outside of the UK without the prior written consent of the commissioner.
- The provider should be a signatory to a local Independent Sector Provision (ISP) developed by the local commissioner for all partnerships relevant to the establishment(s) concerned.

Clinical information systems

To ensure the quality and safety of patient care, the IM&T systems must also support the following:

- Maintenance of individual electronic patient health records within an audit function to control access in line with Registration Authority guidance.
- Inter-communication or integration between clinical and administrative systems for use of patient demographics.
- Access to knowledge bases for healthcare, such as Map of Medicine, at the point of patient contact.
- Access to research papers, reviews, guidelines and protocols.
- Seeking the consent of every patient to have their clinical records on SystemOne Prison or any subsequent clinical systems.
- Communication with patients, including seldom heard groups, such as service users with mental health problems, learning disability problems, hard of hearing and detainees to support the provision of quality care, including printed materials.
- Agreed arrangements and time scales for multi-agency audit of clinical record keeping including data quality.

Clinical records management

The provider will at its own cost retain and maintain all the clinical records in accordance with:

- good practice
- the requirements of the contract (IM&T schedule). The provider will at its own costs retain and maintain all the clinical records in chronological order and in a form that is capable of audit. Clinical records shall be retained and maintained in electronic form in accordance with the contract (IM&T schedule). The provider will ensure that all staff are trained and understand their responsibilities and legal obligations in relation to person identifiable records. The provider will be expected to ensure that all records follow the principles of confidentiality and are in line with legislation and professional codes of practice. Clinical records will include as a minimum:
 - a full account of the assessment
 - relevant information about the patient's condition at any time
 - the measures taken to respond to the needs of the patient
 - evidence that the duty of care has been understood and honoured.
 - a record of arrangements for continuing care (care plan).
 - recovery and discharge plans including integration with resettlement.

For liability all records should be retained in line with the NHS Retention schedule ([LINK](#)).

Consent

The provider is expected to operate a Patient Consent Policy, having regard to the [Department of Health Reference Guide to Consent for Examination or Treatment](#) ; [Health Service Circular HSC 2001/023 and the Good Practice in Consent Implementation Guide – Consent for Examination or Treatment](#), or to any amendment or reissue of them from time to time. Difficult situations can arise for healthcare professionals within prisons where concerns about an individual's capacity to consent are compounded by serious mental health issues and behaviour likely to result in self-harm. In such situations, the provider will have in place robust procedures in-line with the Mental Health Act Guidance 2007, which require extremely careful handling, and which contain guidance provided by the appropriate department of health on seeking consent. All actions taken in these circumstances will be fully documented.

The provider will follow the requirements of and procedures within PSI 64/2011(updated) 'Management of patients at risk of harm to self, to others and from others (Safer Custody)' and will share relevant information appropriately with all those managing such patients.

General contractual confidentiality

Subject always to the obligations of the Parties under statute or common law, in respect of Confidential Information it may receive from the other Party (the 'Discloser'), each Party (the 'Recipient') undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that the Recipient shall not be prevented from using any general knowledge, experience or skills which are in its possession prior to the commencement of this Agreement.

The provisions of this Clause shall not apply to any Confidential Information which is:

- in or enters the public domain other than by breach of this Agreement or other act or omission of the Recipient
- obtained from a third party who is lawfully authorised to disclose such information
- authorised for release by the prior written consent of the Discloser
- identified as no longer needing to be regarded as confidential in accordance with any relevant timescale relating to that class of information.

Nothing in this Clause shall prevent the Recipient from disclosing Confidential Information where it is required to do so by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable law or, where the provider is the Recipient, to the provider's immediate or ultimate Holding Company provided that the provider procures that such Holding Company complies with this Clause as if any reference to the Provider in this Clause were a reference to such Holding Company. The Receiving Party shall indemnify the Disclosing Party and shall keep the Disclosing Party indemnified against Losses and Indirect Losses suffered or incurred by the Disclosing Party as a result of any breach of this clause. The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 16 (Confidential Information) by the Receiving Party, and in addition to any right to damages the Disclosing Party shall be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause.

The provisions of this Clause shall continue following termination of this Agreement for any reason whatsoever and without limit in time.

Freedom of Information Act 2000 and Environmental Information Regulations 2004

The commissioner is a public authority for the purposes of the regulation and guidance and cannot contract for services in a manner which prevents it complying with its obligations. The commissioner also recognises the special circumstances and security issues arising from requests for information relating to offender establishments and would work with the Ministry of Justice where any conflict arises.

The provider will ensure that all applications for Freedom of Information will come through the commissioner or the respective prison.

The provider will acknowledge the requirements of the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 and shall assist and cooperate with the commissioner and/or the respective prison(s) (at their own expense) to enable them to comply with these information disclosure requests.

The provider will notify the commissioner and/or the governing governor receiving a request through Freedom of Information and shall where possible and appropriate:

- Transfer the request for information to the commissioner and/or the respective prison(s) as soon as possible after receipt and in any event within two working

days of receiving a request for information.

- Provide the commissioner and/or the respective prison(s) with a copy of all information in its possession or power in the form that the commissioner and/or the respective prison(s) requires within five working days (or such other reasonable period as the commissioner may specify) of the commissioner requesting that information.
- Provide all necessary assistance as reasonably requested by the commissioner to enable the commissioner to respond to a request for information within the time for compliance as set out in the legislation and regulations. If the provider determines that information (including confidential information must be disclosed), it shall liaise with the commissioner and the respective Prison(s) before this is approved. Public authorities who hold information (including the Commissioner) shall be responsible for determining at its absolute discretion whether the information is:
 - exempt from disclosure under the Freedom of Information Act 2000 or is covered by an exception under Environmental Information Regulations 2004
 - to be disclosed in response to a request for information.

The provider will acknowledge that the commissioner and/or the respective prison(s) may, acting in accordance with the Department of Constitutional Affairs' [Code of Practice on the Discharge of Functions of Public Authorities](#) under Part 1 of the Freedom of Information Act 2000, be obliged under the Freedom of Information Act 2000 to disclose information without consulting with the provider, or following consultation with the Provider and having taken their views into account. The Freedom of Information Act 2000 provides an exemption for information covered by the Environmental Information Regulations 2004 and information within that category will be considered under that guidance.

The provider will acknowledge that any lists or schedules provided by it outlining confidential information are of indicative value only and that the commissioner and/or the respective prison(s) may nevertheless be obliged to disclose confidential information.

12. Guidance and reference documents

This section contains guidance and reference documents as appropriate to a service specification. As stated previously, dental services should be commissioned under a separate Personal Dental Services (PDS) agreement. This PDS agreement should cover relevant clinical regulations and guidelines to ensure the dental services is compliant with current regulations.

Note that the document: ‘Strategy for modernising dental services for patients in England, Department of Health (2003)’¹² contains some recommendations that would not be legal under the current (2006) dental contract. Other guidance and recommendations have collectively superseded the 2003 ‘Strategy for modernising dental services for patients in England’ and this should no longer be used to inform dental contracting.

Dentistry/oral health

General Dental Council (2013) Standards for the dental team

<https://www.gdc-uk.org/information-standards-guidance/standards-and-guidance/standards-for-the-dental-team/>

General Dental Council (2013) Scope of practice

<https://www.gdc-uk.org/information-standards-guidance/standards-and-guidance/scope-of-practice>

NICE (2015) Oral health promotion: general dental practice

<https://www.nice.org.uk/guidance/ng30>

PHE (2017) Delivering Better Oral Health

<https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention>

Continuity of Care in Oral Health for People Leaving Secure Settings in the East Midlands

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/817850/Public_Health_England_Health_and_Justice_Annual_Review_2018-2019.pdf

¹² Department of Health. Strategy for Modernising Dental Services for Prisoners in England [Internet]. 2003. Available from: www.doh.gov.uk/prisonhealth

Prisons

HMIP (2017) Expectations – Criteria for assessing the treatment of and conditions for men in prison.

<https://www.justiceinspectrates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/02/Expectations-for-publication-FINAL.pdf>

MSO Smoking Cessation - <https://www.england.nhs.uk/wp-content/uploads/2017/08/smoke-free-mso-national.pdf>

NAT Guidance – Tackling Blood-Borne Viruses 2017 -

https://www.nat.org.uk/sites/default/files/tackling_BBVS_in_prison2017.pdf

NICE (2016) Guidance – Physical health of people in prison (NG57).

<https://www.nice.org.uk/guidance/ng57>

NICE (2017) Quality Standard – Physical health of people in prison (QS156).

<https://www.nice.org.uk/guidance/qs156>

Public Health England (2019) – Survey of prison dental services England, Wales and Northern Ireland 2017 to 2018

<https://www.gov.uk/government/publications/national-survey-of-prison-dental-services-2017-to-2018>

World Health Organization (2014) Prisons and Health.

<http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health>

Older patients

Public Health England (2017) Health and social care needs assessments of the older prison population. A guidance document.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662677/Health_and_social_care_needs_assessments_of_the_older_prison_population.pdf

Women in prison

HMIP (2014) Expectations – Criteria for assessing the treatment of and conditions for women in prison.

https://www.justiceinspectrates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/02/final-womens-expectation_web-09-14-2.pdf

Public Health England (2018) Women in prison: standards to improve health and wellbeing.

<https://www.gov.uk/government/publications/women-in-prison-standards-to-improve-health-and-wellbeing>