Response to the Parliamentary Health and Social Care Committee inquiry into prison healthcare from the British Dental Association and the National Association of Prison Dentistry (UK)

May 2018

Introduction and overview

1. The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. BDA members are engaged in all aspects of dentistry including general practice, salaried primary care dental services, the armed forces, hospitals, academia and research, and our membership also includes dental students.

2. The National Association of Prison Dentistry UK (NAPDUK) is an association for dental professionals working in prisons and other secure environments. NAPDUK has a membership of over 200 dentists and dental care professionals. NAPDUK works with other bodies to promote best practice and improve the care of people in prison with the aim of improving oral health for this patient group.

3. The oral care delivered to people in prison and secure settings is provided by primary dental care teams across both the community and general dental services.

4. The BDA and NAPDUK agree and recognise the importance of the principles laid out by the Department of Health in *Choosing Better Oral Health, an Oral Health Plan for England (2005)*[1] which includes:

> *Key factors that lead to poor oral health are risk factors for other diseases. People living in areas of material and social deprivation and other vulnerable groups in society have poor oral health and they often access dental services less frequently.*
>
> *Oral health is an integral element of general health and wellbeing.*

However oral health and general health cannot be mutually exclusive.

5. Those within the prison population have a higher prevalence of oral health needs than the general population. In fact "*prisoners are likely to exhibit a higher degree of oral disease, a lower level of treatment and less motivation to maintain their oral health in comparison to the general*

[1] Department of Health, Choosing Better Oral Health, an Oral Health Plan for England (2005)

population."[2] The WHO also note the contributing factors to poor oral health including substance misuse and that "*prisoners with substance misuse problems are likely to report toothache very soon after entering prison, as any opiate drugs they took suppressed the toothache."* [3]

6. Public Health England state that *"the risk factors for many general health conditions are common to those that affect oral health, namely smoking, alcohol misuse and a poor diet. It is therefore important that all clinical teams make every contact count and support patients to make healthier choices. By doing this not only will patients' oral health benefit but their general health will be at lower risk as well."*[4] It is this integrated approach to care delivery that we would welcome.

7. It is now clear from epidemiological studies that a potential link exists between periodontal disease and cardiovascular disease. There are also potential links with other non-communicable disorders such as diabetes, colorectal cancer and COPD[5].

Commissioning of dental care in secure settings

8. Dental care in prisons is a commissioned service. NHS England Health & Justice (NHSE H & J) commissions services with an individual or company. Since the changeover of commissioning in 2013, a single provider model has been adopted by NHSE H&J. The single provider then often sub-contracts the dental services to a dental provider. The budget for healthcare is apportioned by the primary provider. There is no ring fencing to protect the funding for the dental service. There is anecdotal evidence to suggest that funding for dental services has been reduced resulting in a reduction of the number of clinical sessions across the estate. Money commissioned to be spent on dentistry should stay within dentistry, a highly valued service by patients in secure settings. Dentistry, however is under-commissioned in prisons and those commissioning dental care in prisons need to be better equipped to understand dental commissioning and contracting.

9. Waiting lists for dental treatment are often high and this in conjunction with the perceptions and values of oral care in prisons means that patients may choose the option of tooth extraction to relieve pain rather than choosing more complex treatments that take longer[6]. Long waiting lists for treatment are indicative of an under-commissioned service which needs careful management by commissioners in conjunction with practitioners delivering the service. The true waiting list figures are often obscured by providers who sometimes introduce complex list management systems that make it difficult to understand the actual waiting times and the number of patients awaiting treatment. Some providers also limit treatment for patients who have short sentences, are on remand or likely to be transferred to another secure facility. For example, dentures and crowns are sometimes only provided to patients who have sentences longer than six months, which is not in the

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[2] Heidari, E., Dickinson, C., Newton, T. (2014) Oral health of adult prisoners and factors that impact on oral health. British Dental Journal 217:2 pp 69-71.

[3] WHO (2007) Health In prisons; a WHO guide to the essentials of prison health. Chapter 24. Dental health in prisons. http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf?ua=1 accessed 16 May 2018

[4] Public Health England (2017) Delivering Better Oral Health March 2017 edition. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605266/Delivering_better_oral_health.pdf. Accessed 15May2018.

[5] Hobbins S, Chapple ILC, Sapey E, Stockley RA (2017) Is periodontitis a comorbidity of COPD or can associations be explained by shared risk factors/behaviors? International Journal of Chronic Obstructive Pulmonary Disease Volume 2017:12 pp 1339-1349.

[6] Heidari E, Dickinson C, Wilson R, Fiske J. Oral health of remand prisoner in HMP Brixton; London. *Br Dent J* 2007; **202:** E1.

best interests of the patients. Time spent in prison provides a window of opportunity for patients to access care they would otherwise find difficult to receive. The oral health of people in prison has been estimated to be four times poorer than those in the community. There is no evidence to indicate that the oral health of this group has improved over the last 20 years.

10. NHS England is currently producing a new standard service specification for prison dentistry. It is doing so with the help of the BDA and NAPDUK. This is welcome and we hope it will bring a more consistent and comprehensive NHS service within prisons. There are workforce issues however, the present contractual models do not always provide the dentists working within the service with NHS pensions and other benefits enjoyed by NHS practitioners working within other NHS primary care services. We are trying to address this with NHS England but it remains a concern because it does affect recruitment to the service.

Management of physical, mental health and social care needs of prisoners

11. On entry into the prison, it is important that the healthcare interview includes an assessment for dental issues. We have petitioned for NICE to include oral health screening as part of general health screening for people on arrival at secure settings in their guidance but sadly the importance of this link was not included. In the NICE publication, *Physical Health of People in Prison* (Nov 2016), dentistry and oral health were excluded. We recommend that oral healthcare form part of that initial assessment because early assessment and identification of oral health status and treatment need would assist with treatment of urgent conditions and general care. Preventative advice and care such as oral hygiene instruction and the use of high fluoride content toothpaste could be instituted early on arrival in prison which would have an immediate impact on patients' oral health prior to seeing the dentist. The idea of training people in prison to become health educators and provide oral health promotion could be a cost effective way to deliver this.

12. Including oral healthcare as part of early needs assessment would ensure that those prisoners using medication (for example methadone) which can cause detrimental side effects on oral health can be swiftly identified and their treatment planned accordingly. We recommend that dentists and their teams are fully integrated into the prison health team to ensure open channels of communication and opportunities for learning.

13. There are many opportunities for multi-professional working in the prison environment which would be of real benefit to the patient for example management of chronic conditions such as diabetes. We welcome the smoke-free prisons initiative but this needs to be supported by smoking cessation initiatives. The prevalence of anti-microbial prescribing for dental problems by non-dental clinicians is an area to be addressed and key to this is for dental patients to have access to a dentist for their oral health needs out of normal dental service hours. In turn this will reduce the need for antibiotics and reduce resistance.

14. Our members report that there is training available within the prison specifically for suicide awareness and self-harm but this must be available to dental teams along with other training such as personal protection training. Specific prison training for dental care teams has been an ongoing concern to the BDA and NAPDUK. As the personnel providing dental care in prisons changes, then it is vital that those professionals are supported to work with patients in settings that pose different and specific challenges.

15. The 2014 recommendations from the PHE a survey of prison dental services in England and Wales[7] are only just beginning to be addressed by NHS England, which includes:

> *a need to monitor workforce training and identify opportunities for dental career development in prisons, appreciating the specialist needs of prison dentistry such as substance misuse, learning difficulties and mental health.*
>
> *Ensure that all dentists working within the secure environment receive formal induction and undergo core establishment training.*

16. Training is not widespread and we would like to see more provided for those new to the prison setting. We would welcome specific dental training for those working in secure environments that specifically addresses working with patients who have substance misuse issues, mental health issues, and other complex health issues and their specific oral health needs.

The importance of continuing care

17. Transfer of prisoners between settings is important to understand in the provision of consistent healthcare. At 31 March 2018 there were 83,263 prisoners in England and Wales[8]. The number of individuals passing through the system in any one year will be approximately double this. For the final quarter of 2017 there were 22,355 incidences of prisoner transfer (routine or for reasons of overcrowding). It is vital that for their continuing care, that patient dental records transfer with them. Currently there is no way of ensuring that patients' dental records, including x-rays, transfer with them resulting in patients undergoing repeat examinations and additional radiographic exposure.

18. There is also the need to ensure that on release into the community there are arrangements in place for ongoing care particularly for patients whose treatment is not complete.

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[7] Public Health England (2014) A survey of prison dental services in England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/328177/A_survey_of_prison_dental_services_in_England_and_Wales_2014.pdf accessed 16 May 2018.

[8] MOJ (2018) Offender Management Statistics Bulletin, England and Wales https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/702297/omsq-q4-2017.pdf accessed 16 May 2018