



Spring/Summer 2008

Foreword

Dear Colleague,

Springtime sees the end of one business year and the start of another. Reflecting back on the business year that has just ended, we have seen unprecedented levels of additional funding going into health service dentistry.

In all, the Department made available an additional £7.9 million for GDS dentistry in the 2007/08 year which is the most I can remember in my professional lifetime. Some will say that this is merely recycling the under-spend but it has to be remembered that this under-spend would normally be returned to the Department of Finance and Personnel but by reinvesting it back into the GDS, those practitioners who have remained committed to the Health Service have been able to receive significant additional support.

The year ended with a further £1.5 million being made available through the Quality Improvement Scheme in February. This presented a very tight timescale for both the Boards and profession to spend the additional funding against agreed criteria, but I am pleased to say that deadlines were met and the allocation spent.

I would like to thank all those involved who made this possible. In all, £3 million was made available to general dental practitioners to help with improvements to cross infection control standards in their practice which, on a pro-rata basis, is more than anywhere else in the UK.

The new financial year sees further investment in dental services; funding for five extra dental students at Queens which will bring the intake up to 45, an additional two Specialist Registrar posts for the hospital dental service and regional funding for dental implants to be undertaken at the School of Dentistry on behalf of the four Boards.

On other fronts, negotiations on the new contract continue with the BDA and now with the help of John Finnerty we hope to progress the recommendations from the Review of the Community Dental Service quickly.

The proposals for the new health structures under the Review of Public Administration are out for consultation as we go to print. By the time of next newsletter it is hoped to be able to report on how these new proposals will impact on dentistry.

Donncha O'Carolan

Acting Chief Dental Officer
April 2008

Antibiotic Prophylaxis against Infective Endocarditis

NICE clinical guideline 64: Prophylaxis against infective endocarditis (March 2008). This clinical guideline issued by National Institute for Health and Clinical Excellence (NICE) has made important recommendations regarding the use of antibiotic prophylaxis against infective endocarditis.

In summary, this guideline recommends that **antibiotic prophylaxis solely to prevent infective endocarditis (IE) should not be given to people at risk of IE undergoing dental and non-dental procedures.**

This NICE guidance and recommendations are now effective in Northern Ireland.

The basis to support this recommendation is:

- There is no consistent association between having an interventional procedure, dental or non-dental, and the development of IE;
- Regular tooth brushing almost certainly presents a greater risk of IE than a single dental procedure because of repetitive exposure to bacteraemia with oral flora;
- The clinical effectiveness of antibiotic prophylaxis is not proven;
- Antibiotic prophylaxis against IE for dental procedures may lead to a greater number of deaths through fatal anaphylaxis than a strategy of no antibiotic prophylaxis, and is not cost effective;
- Patients should not be offered chlorhexidine mouthwash as prophylaxis against infective endocarditis as this has not been proven to be effective.

Infective endocarditis is a rare condition with significant morbidity and mortality. It may arise following bacteraemia in a patient with a predisposing cardiac lesion. In an attempt to prevent this disease, over the past 50 years, at-risk patients have been given antibiotic prophylaxis before dental and certain non-dental interventional procedures.

In the absence of a robust evidence base, antibiotic prophylaxis has been given empirically to patients with a wide range of cardiac conditions including a history of rheumatic fever. The efficacy of this regimen in humans has never been properly investigated and clinical practice has been dictated by clinical guidelines based on expert opinion.

Recent guidelines by the British Society for Antimicrobial Chemotherapy (Gould et al. 2006) and the American Heart Association (Wilson et al. 2007) have challenged existing dogma by highlighting the prevalence of bacteraemias that arise from everyday activities such as tooth brushing, the lack of association between episodes of IE and prior interventional procedures, and the lack of efficacy of antibiotic prophylaxis regimens.

Against this background, the Department of Health, in 2005, asked NICE to produce a short clinical guideline which would give clear guidance on best clinical practice for prophylaxis against IE in patients undergoing dental and certain non-dental interventional procedures.

The full guideline can be found at www.nice.org.uk. This new guidance is also contained in the current edition of the British National Formulary (BNF 55, March 2008).

List of all recommendations from NICE clinical guideline 64:

Adults and children with structural cardiac defects at risk of developing infective endocarditis

Healthcare professionals should regard people with the following cardiac conditions as being at risk of developing infective endocarditis:

- acquired valvular heart disease with stenosis or regurgitation
- valve replacement
- structural congenital heart disease, including surgically corrected or palliated structural conditions, but excluding isolated atrial septal defect, fully repaired ventricular septal defect or fully repaired patent ductus arteriosus, and closure devices that are judged to be endothelialised
- previous infective endocarditis
- hypertrophic cardiomyopathy

Patient advice

Healthcare professionals should offer people at risk of infective endocarditis clear and consistent information about prevention, including:

- the benefits and risks of antibiotic prophylaxis, and an explanation of why antibiotic prophylaxis is no longer routinely recommended
- the importance of maintaining good oral health
- symptoms that may indicate infective endocarditis and when to seek expert advice
- the risks of undergoing invasive procedures, including non-medical procedures such as body piercing or tattooing

Prophylaxis against infective endocarditis

Antibiotic prophylaxis against infective endocarditis is not recommended:

- for people undergoing dental procedures
- for people undergoing non-dental procedures at the following sites:
 - upper and lower gastrointestinal tract
 - genitourinary tract; this includes urological, gynaecological and obstetric procedures, and childbirth
 - upper and lower respiratory tract; this includes ear, nose and throat procedures and bronchoscopy

Chlorhexidine mouthwash should not be offered as prophylaxis against infective endocarditis to people at risk of infective endocarditis undergoing dental procedures.

Infection

Any episodes of infection in people at risk of infective endocarditis should be investigated and treated promptly to reduce the risk of endocarditis developing.

If a person at risk of infective endocarditis is receiving antimicrobial therapy because they are undergoing a gastrointestinal or genitourinary procedure at a site where there is a suspected infection, the person should receive an antibiotic that covers organisms that cause infective endocarditis.*

Ministerial Visit to CDS Special Needs Unit Causeway Hospital

The Minister, Michael McGimpsey, visited and praised the specialist dental unit at Causeway Hospital on 19 March 2008.

This unit, staffed by members of the Community Dental Service (CDS), provides dental care for special needs patients such as those with a learning disability, physical disability or a compromising medical condition. During the visit the Minister was given a tour of the facilities and met with staff and patients.

Speaking during his visit, the Minister said:

This specialist unit is a shining example of how a multidisciplinary team working together can deliver a first class service to patients. I am pleased to see that the Trust have taken on one of the main recommendations from the Review of the Community Dental Service report and prioritized their dental services on providing care for special needs patients.

Over the past two years the service at Causeway Hospital has played an important role in addressing waiting time issues which were being experienced by learning disabled patients living in the EHSSB area. The dental service at Causeway hospital has assessed 81 patients from the EHSSB and provided care for 78 of these patients, thus significantly

reducing waiting times in the EHSSB area.

The Minister added:

I particularly want to thank the staff here at Causeway for the important role they played in helping to reduce waiting times for learning disabled patients from the Eastern Health and Social Services Board over the past two years.

The General Anaesthetic and Intravenous Sedation dental service at Causeway Hospital was established in 2004 and was developed to provide care to a wide group of patients with special needs including children and adults with disability, patients with extreme dental phobias and patients with complex medical needs. It is a complementary service to Antrim Area Hospital and the two services work closely together to ensure all patients have access to timely and locally responsive services.

In the four years since its inception the service has assessed more than 550 patients from the following programmes of care.

Programme of Care	Numbers
Learning Disabled	309
Child Phobia	127
Adult Phobia	82
Mental Health	19
Elderly	11
Physical Disability	7
Acute Sector	1

Initially the service at Causeway was responding to a backlog of unmet need and so utilization of General Anaesthetic was relatively higher. As the service has matured and reduced the backlog, the increase in usage of Intravenous Sedation has grown.

The service aims to provide all treatment for those patients who have been assessed by the staff. One of the quality service standards is that no patient should wait on average more than 90 days (13 weeks) between assessment and treatment. On average, over the four years of operation, the service has delivered against this 13 week target.*

Additional Specialist Registrar Posts

The Department has provided funding for two additional specialist registrar (SpR) training posts. The need for additional SpR posts was identified in the *Review of Consultant Staffing in the Hospital Dental Service in Northern Ireland* in 2004 which was overseen by the Hospital Services Subcommittee (HSSC) of CDAC. This workforce review identified the need for 4 new SpR posts; two of these posts were funded in 2004 (restorative dentistry and oral surgery) and the bid for additional 2 posts has now been met.

Irish Society for Disability and Oral Health Annual Conference

This year's conference, entitled **Brain Training Matters** is on 13th June 2008 in the Grand Opera House Belfast

Morning Session: Providing care for people with acquired brain injuries.

Afternoon Session: Training needs and opportunities in Special Care Dentistry. Including DCP's Lunch & Networking Group: How 'special' is dental nursing in special care dentistry?

Pre Conference Workshop

12 June 2008, School of Dentistry, Belfast

Treatment planning dilemmas in Special Care Dentistry

Pre Conference Dinner

12th June 2008

Evening Reception, Tour & Dinner Parliament Buildings, Stormont

For further information contact: Dr Ruth Gray, ISDH President dental@ruthgray.com

Application forms available to download on website www.isdh.ie

Irish Society for Disability and Oral Health

Founded in 2002 the ISDH aims to *promote, preserve and protect the oral health of people with disabilities*. Membership is open to all with an interest in oral health and all disciplines are welcome!

If you are interested in joining the society please contact Norman Campbell: n_a_campbell@hotmail.com

Additional Funding for Cross Infection Control

Additional, non-recurrent, funding of £1.5million was identified by the Department in February 2008 to help dental practices work towards the Departmental priorities for improving cross infection control as outlined in the QIS letter of 13 November 2007.

Unlike the £1.5 million allocated in November 2007, this additional £1.5 million required receipted invoices to be sent to the relevant Health and Social Services Board by 31 March 2008. Given the tight timescale, practitioners were therefore permitted to use their allowance against any of the four priority areas:

1. **Washer disinfectant and reverse osmosis water plant;**
2. **Surgery layout (including additional instrument storage);**
3. **Vacuum bench-top steam sterilizers (type B);**
4. **Additional sets of dental instruments.**

By the financial year end, the vast majority of this additional funding was spent within the required period against the stated criteria. The Department is committed to improving cross infection standards in general dental practice and in the past financial year has provided £3million specifically for cross infection control improvement, which on a pro-rata basis is more than other country in the UK. *

Miscellaneous Provisions Act

The Health (Miscellaneous Provisions) Act (Northern Ireland) 2008 received Royal Assent on 25 February 2008.

From a dental perspective the new act has several implications:

- **Local commissioning** The powers within the Act allow for local commissioning of dental services by Health and Social Services Boards and thus help to improve access to dental services. The Act also governs the terms and content of the new dental contract.
- **Suspension from the dental list** The Act extends the powers of the four HSSB's to allow suspension of a listed practitioner directly by a Board. Suspension could take place pending, for instance, referral to the Tribunal or the outcome of a court case or a hearing by a professional regulatory or licensing body. The act also extends the powers of the Boards to allow payment to suspend practitioners.
- **List management** The Act introduces the power for regulations to provide and set out the criteria for refusal or removal

of a practitioner from a Board's list. It also inserts provisions to provide for a Board to admit or retain a practitioner on its list as long as he or she agrees to be bound by specific conditions and extends the existing list system to embrace all practitioners including locums, deputies and employees.

- **Tribunal** The Act extends the functions of the Tribunal which is the principal health service disciplinary body for family health service practitioners. The Act introduces an additional ground under which the Tribunal may deal with a practitioner who has been referred to it, namely "unsuitability by reason of professional or personal conduct". It also extends the categories of person subject to the Tribunal's jurisdiction to include all practitioners assisting with the provision of services and those practitioners wishing to join a Board's list. At present the Tribunal may direct that a practitioner's name should be removed from the list of a Board (local disqualification) or should be excluded from all Board's lists (general disqualification). The Act removes the sanction of local disqualification, thus if a practitioner is not fit to deliver services

Adviser on Salaried Primary Care Dental Services

John Finnerty has been seconded, on a part-time basis, into the Department for a one year period as an adviser on salaried primary care dental services. The purpose of this secondment is to complete the work on the implementation of the recommendations of the Review of the CDS and to support the development of the salaried general dental service. John also works as the assistant Clinical Director of the Community Dental Service in the Northern Trust.

The priority will be to recommence the work on the implementation of the recommendations from the Review of the Community Dental Service and John has already made significant progress on this front.

We welcome John to the Department and wish him well in this post.

in one Board's area he or she should not be able to do so in another.

- **Retirement age** The Act repeals the power to make regulations as to specifying the retirement age of general dental and general medical practitioners. This is within the spirit of the EC Directive regarding discrimination on grounds of age in the field of employment. *

Review of Public Administration

The Minister published his proposals for health and social care reform on 18 February 2008 for a 12 week consultation period.

The main elements of the new organizational model are:

- a streamlined Regional Health and Social Care Board focused on commissioning, performance management and improvement and financial management which both encourages and ensures access to quality services responsive to need;
- dynamic Local Commissioning Groups with the active involvement of GPs; professionals within social work, public health, nursing and Allied Health Professionals; other primary care practitioners; and community representatives;
- a smaller Department more sharply

- focused on its responsibilities for serving the devolved administration, bringing forward legislation, and determining & periodically reviewing policy, standards, priorities, and targets;
- the establishment of a common services organisation to provide a broader range of support functions for the health and social care service;
 - a new Regional Public Health Agency to create better inter-sectoral working to tackle health promotion and inequalities and help realise the shared goal of a better and healthier future for all our people, which would incorporate the functions of the existing Health Promotion Agency;
 - action to reinforce the independence of the Health and

- Social Services Councils and strengthen the regional aspects of patient, client and carer representation while maintaining a strong local focus; and
- increased democratisation through local government representation on key bodies and improved partnership with local government and other stakeholders in the commissioning and delivery of health and social care.

Although extremely ambitious, it is proposed that these new structures would be set up from April 2009.

We will update the profession on how this will impact on dentistry once the consultation period is over and there is greater clarity of where the various dental functions will sit.

School Screening

The Acting Chief Dental Officer issued a statement on the future policy on dental screening (inspection) in schools to the service on 4 March 2008. In summary, the policy advises that school screening should cease after the current programme of screening is completed for 2007/08 and Trusts have been asked to redeploy the resources used on screening into the other priority business areas outlined in the Community Dental Service corporate plan (September 2006).

While dental screening of school children is a long established function of the Community Dental Service (CDS), recent research undertaken by the University of Manchester cast much doubt on the efficacy of school dental screening. From the results of this research it was concluded that **School dental screening has a minimal impact on dental attendance and only a small proportion of screened positive children receive appropriate treatment. The programme fails to reduce inequalities in utilisation of dental services.**

Following on from the results of this research, the National Screening

Committee (NSC) recommended to the UK Chief Dental Officers that there is no evidence to support the continued population screening for dental disease among children aged 6-9 years. Moreover, the NSC advise that the resources used on screening be redeployed on interventions which are more effective in reducing inequalities in oral health.

In Northern Ireland the DHSSPS wanted to complete the 2007/2008 school dental screening exercise in order to inform progress against the dental PfA target before making a final decision on the future of the screening programme here.

We have now considered our policy position in relation to the future of school dental screening. Given the findings of the most recent research coupled with the advice from the NSC, and also taking into consideration the impact of positive consent on screening, it has been concluded that the programme of school dental screening does not meet the Departmental aims of improving the oral health for our population and reducing inequalities and, therefore, should cease once the screenings for the 2007/08 school year have been completed. Trusts

are asked to redeploy the resources used on screening into the other priority business areas outlined in the Community Dental Service corporate plan, issued by the DHSSPS in September 2006.

We would stress that this policy change does not relate to children in special schools who are considered to be a separate group.

The full policy statement is available on the Dental Branch Website at:

www.dhsspsni.gov.uk/index/dental/dental-whatsnew.htm *

DCP Registration - a reminder

The deadline for DCP registration is July 2008.

For more information go to gdc-uk.org and click:

- > Potential registrant
- > Regulating the dental team
- > Frequently asked questions about DCP registration