Dental Tribune

The World's Dental Newspaper · United Kingdom Edition

Published in London | October 2013 | Vol. 7 No 12

News in Brief

Bad teeth among athletes
Athletes at the London 2012 Olympic Games had 'striking' levels of bad teeth, say researchers. A team at University College London says many competitors had bad dental problems, with large amounts of carbohydrates and sugary energy drinks consumed regularly causing the damage. The study, published in the British Journal of Sports Medicine, looked at competitors visiting the dental clinic at the Games. Of the 302 athletes examined, 55 per cent had evidence of cavities, 45 per cent had tooth erosion and 76 per cent had gum disease. One in three said their oral health affected their quality of life and one in five said it affected training or athletic performance. Stress on the immune system from intense training may also leave athletes at risk of oral disease.

Cigarette health warnings
Barely a third (35 per cent) of teenagers in the South East are deterred from smoking by current cigarette packs, compared to nearly half (48 per cent) of teenagers in Australia, where packs are almost entirely covered by graphic warnings, a survey has revealed. The British Heart Foundation's (BHF) poll found that 75 per cent of teenagers in the South East think the UK should introduce standardised cigarette packs. It was also found that 59 per cent of teens in Australia think graphic images on packaging deter people their age from smoking. The European Parliament is set to vote on key legislation tomorrow (8 October 2013) that would see cigarette packs across the EU feature larger graphic health warnings on both sides of the box.

Guilty beautician
A beautician has pleaded guilty to unlawfully practising dentistry by carrying out tooth whitening treatment. Ms Elaine Taylor-Valles is the first person to be prosecuted by the General Dental Council (GDC) since the High Court upheld the view that tooth whitening is the practise of dentistry and should only be carried out by dentists, dental hygienists and dental therapists, working on the prescription of a dentist. Ms Taylor-Valles has been given a nine month conditional discharge and ordered to pay £350 towards the GDC's costs. During sentencing at Preston Magistrates' Court, District Judge Goodwin said: "I accept that Ms Taylor-Valles had done a teeth whitening course, however she did not ring the General Dental Council to confirm whether she was allowed to do tooth whitening." DT

Senior BDA executive tells boss to quit

BDA crisis deepens after angry GDPC meeting

The BDA's General Dental Practice Committee (GDPC) met on Oct 4. The meeting was dominated by an angry discussion about the disastrous financial impact on the BDA that the new membership structure has had

GDPC members received a presentation from Richard Shilling, the BDA's Financial Director, at which he stated: "We have to cut staff, services and other costs, in order to enable us to make the savings needed under our proposed recovery plan".

Whilst taking questions from Committee members, the Finance Director admitted that 25 whole time or equivalent posts have been put at risk of redundancy already, representing nearly 20% of the total BDA staff capacity across the UK, and management continue to invite further voluntary redundancies from across the staff. The Finance Director also admitted that the BDA may well need to look at a further round of redundancies, as part of a deeper cost-savings exercise.

Martin Fallowfield, Chair of the BDA's Principle Executive Committee (PEC), struggled to answer the many angry questions from Committee members about how such a wildly miscalculated new membership structure had been introduced without proper planning for the worst case scenario.

The BDA Finance Director told the meeting that there is currently a recurring shortfall in subscriptions of about £2.5m and a projected 'worst case' deficit of £3.4m. One GDPC member, who wished to remain anonymous, commented: "Simple maths tells me that the BDA needs to recruit about 8,500 new members at the 'Essential' level of BDA membership, in order to make up a £2.5m shortfall in this first year. And even that would still leave the organisation with no financial reserves unless savings are made from other areas.

"Surely this model should have been more carefully considered by the management team and by the Principle Executive Committee? I gather less than 10% of the membership was lost during the transition to this new structure. It is clear to me that this is not a problem with member loyalty, this is about management incompetence."

The BDA is now in the process of convening an Emergency General Meeting of the UK Council. Under the BDA's Articles of Association, the UK Council has the power to dismiss the Principle Executive Committee and to call new elections.

Speaking with a member of the Smile-on News team, one senior BDA executive has raised the question of the viability of some members of the PEC and the CEO's position and suggested that now may be the time for some to 'fall on their swords'.

Martin Fallowfield, Chair, BDA Principal Executive Committee, said: "The BDA's membership structure needed to change. It was not financially viable and it was not fair to members; some were paying for services they seldom required while others were heavily using services for which their membership fees did not pay.

"The new system is fair because it links services received to membership fee paid. Members choose the membership package that is appropriate for them and they pay for it. It also establishes a sustainable finan-

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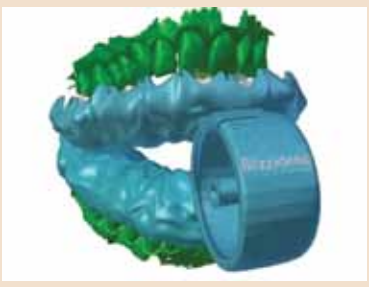
3D printed toothbrush cleans teeth in six seconds



A new 3D printed toothbrush tailor-made to fit a person's mouth is claimed to completely clean teeth in six seconds.

To make the 'Blizzident', dentists take a digital scan of a person's teeth and use that to determine the optimal placement of 600 bristles by simulating biting and chewing movements. The bristles resemble normal toothbrush bristles but are much finer and tapered to reach the gum line better.

The scan is used to create a computer aided design (CAD) model of the brush, which is converted into a 3D object using stereolithography, a method in which liquid plastic is cured into a shape with an ultraviolet laser. The bristles are then attached.

To use the Blizzident, a person bites down on it and grinds their teeth for about six seconds. The brush's makers say this is sufficient time to clean teeth completely, although independent studies have yet to verify this. DT

Anna Jefferson cleared over CQC cover up

Anna Jefferson, CQC's current Head of Media, has been cleared of wrong-doing in an internal enquiry.

As previously reported, a report revealed that the CQC 'covered up' knowledge of its failings over a series of baby deaths at a Cumbria hospital. Anna Jefferson, along with Cynthia Bower and Jill Finney, were blamed in a follow-up report. They were all said to be present at a meeting where deletion of a critical report was allegedly discussed.

Ms Jefferson is alleged to have said of the report: "Are you kidding me? This can never be in a public domain."

However, the CQC has now released a statement that says: "Anna Jefferson had not used 'any inappropriate phrases' as attributed to her by one witness quoted in the Grant Thornton report" and that "Anna Jefferson had not supported any instruction to delete and internal report prepared by a colleague – Louise Dineley."

It added: "The CQC regrets any distress Anna Jefferson has suffered as a consequence of this matter and is pleased to welcome Anna back to the organisation following a period of maternity leave. She is currently undertaking a course of postgraduate study with CQC's support." DT

Natural teeth last longer than dental implants

Patients should hang onto problem teeth as long as possible rather than getting dental implants, a new literature review suggests.

The review, published in the Journal of the American Dental Association, found that 15-year tooth loss rates range from 3.6 per cent to 13.4 per cent, whereas implant loss rates range from nought per cent to 33 per cent.

Some clinicians recommend dental implants as an alternative to treating severely diseased teeth, however the researchers note that even teeth classified as 'hopeless' may survive, especially if periodontal treatment address the underlying problem.

"The results of this systematic review show that implant survival rates do not exceed those of compromised but adequately treated and maintained teeth, supporting the notion that the decision to extract a tooth and place a dental implant should be made cautiously," the authors write.

It was found that more conical implants had higher stresses than did cylindrical and screw-shaped implants, and textured implants had better outcomes than those with machined surfaces. Implants were more likely to fail in patients with periodontitis-related tooth loss, in those who smoked, and in those with diabetes mellitus, a history of radiotherapy, or impaired bone quality.

"In light of the above review, the decision to retain properly treated and maintained teeth for as long as possible seems to provide an overall solution that can reduce the treatment risks over the long term," they conclude. DT

Tooth restores man's sight

A man has had his sight restored after one of his teeth was implanted in his eye.

More than two decades ago, former factory worker Ian Tibbetts began to lose his sight after suffering an industrial accident. According to the Independent, as he was removing a piece of scrap metal from an oven it struck him in the right eye, ripping his cornea in six places. By 1998 he had lost all sight in his right eye, followed a decade later by nearly all the remaining vision in his left.

Now thanks to an operation in which one of his teeth was implanted in his eye socket to act as a cradle for a false lens, his sight has been restored. The procedure, known as osteo-odonto-keratoprothesis (OOKP) was carried out by surgeon Professor Christopher Liu at the Sussex Eye Hospital in Brighton.

The two-stage surgery involves the removal of a piece of tooth and bone from the patient's mouth, and then stitched into the eye socket.

"The technical success rate is close to 100 per cent. The number of people who will see well for a very long time is two-thirds to three-quarters. If I am a bit more pessimistic I will say half to two-thirds. But for the majority of people it will work," says Professor Liu. DT

DENTAL TRIBUNE
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cial footing for the Association.

"The changes were made after years of research and engagement with members. The new membership packages respond to what dentists have told us they want.

"They are also flexible. Members can trade up to a higher package if they realise they need a higher level of service and we see them doing exactly that.

"With new members joining and current ones upgrading every day it is not possible to form a definitive picture of the profile of BDA membership yet, and the detailed analysis of members' usage of services prior to the implementation of the new structure suggests that there will be lots more movement before that picture does properly emerge.

"The implementation of a new business model brings challenges for any business and the BDA is no exception. The BDA's senior management team has looked at the out turn and thought carefully about what changes are needed to respond to members' decisions. It has moved quickly to implement a new financial model and is also consulting on changes to the deployment and headcount of its staff resource. Unfortunately, that will mean redundancies in some areas. Members can be assured that services will be protected.

"The changes were necessary and have been made after thorough research, careful consideration and dialogue with members. The BDA's elected representatives – including the Executive Board and Representative Body; the bodies superseded by the PEC in 2012, and latterly the PEC itself – endorsed the changes.

"Like any democratic organisation the BDA is a crucible for different opinions and interests and has formal decision-making mechanisms through which they are debated and reconciled. Inevitably, with an issue as important as the operation of the Association, views come to the fore.

"One of the mechanisms for the exchange of views is the BDA committees and councils representing dentists working in different dental crafts and the four UK countries and we are committed to ensuring these bodies are kept fully informed. Many of them are scheduled to meet during the autumn and are being updated as they do, but contrary to reports, no EGM of the UK Council has been scheduled." DT

Editorial comment

Hello and welcome to this month's issue of *Dental Tribune*.

This month profession and industry alike are gearing up for one of the biggest events in the dental calendar – BDTA Dental Showcase.

Held this year in Birmingham October 17-19th, visitors have a multitude of stands and lectures to choose from relating to all aspects of dentistry including running the practice, clinical topics and education.

I think we know one stand which may be extremely popular this year – that would be the BDA's stand (K04). With all the news, rumours and rhetoric that has been circulating the organisation since the announcement of the new three tier membership system and the seeming failure of that system to ignite the interest of the profession, no doubt many members and non-members alike will be flocking to speak with the team.

We will be based on Stand H01 – do come and say hello. DT

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page?

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CQC given more independence

The Care Quality Commission is to be given greater independence, Health Secretary Jeremy Hunt has announced.

Under the proposals, the Health Secretary will relinquish a range of powers to intervene in the operational decisions of the CQC. The CQC will no longer need to ask for Secretary of State approval to carry out an investigation into a hospital or care home, and the Secretary of State will no longer have the power to direct the CQC on the content of its annual report.

In addition, the newly created positions of Chief Inspector of Hospitals, General Practice and Adult Social Care, will be enshrined in law. They will lead CQC's inspections and regulate providers of health or social care services across the public, private and independent sectors.

Health Secretary Jeremy Hunt said: "The Chief Inspector must be the nation's whistleblower in chief. We will legislate in the Care Bill to give the CQC statutory independence, rather like the Bank of England has over interest rates. The welfare of patients is too important for political meddling and our new legislation will make sure Ministers always put patients first." DT

Dentist jailed for filming female staff

A dentist has been jailed in Germany for secretly filming his female staff while they were changing clothes.

The 52-year-old had installed a video camera in the changing room of his practice which was used by his female hygienists and receptionists. After staff discovered the camera, investigators found almost 7,500 video files on the defendant's computer going back six years, showing eight victims in their underwear or naked.

He has been convicted of 211 counts of violation of privacy using a recording device and jailed for two years and four months. DT

'Pressure wash' your teeth and gums

A dentist has invented a device that will replace the traditional toothbrush, toothpaste, floss and mouth rinse, and now he is trying to raise money to develop it.

The CLEARsmile device is a 'pressure wash' for teeth and gums that hits every angle simultaneously, says inventor Dr Igor Reizenson. He came up with the idea while working in the Veterans Hospital and seeing elderly bed-ridden patients unable to clean their teeth, and nurses not able to do it for them.

He also did community dentistry on mobile buses for under privileged children across the state of Georgia, US, and came to the conclusion that an oral hygiene device that is quick, easy and effective, is needed.

Dr Reizenson now needs to create a prototype and it was found that $750,000 is needed to be raised to do this. His campaign can be found at the crowd funding site indiegogo.com DT

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Interview: 'The patient should be told the truth'

Dental Tribune Online spoke with Prof Stephen Porter from the UCL Eastman Dental Institute about new risk factors and prevention strategies for oral cancer

Prof Stephen Porter, Director and Professor of Oral Medicine of UCL Eastman Dental Institute

Dental Tribune Online: A recent study on Turkish dental patients in central Anatolia has shown that only one in two people are aware of oral cancer. Are these results representative of most people's knowledge about the condition nowadays?

Prof Stephen Porter: It is not uncommon for individuals not to be aware that cancer can arise in the mouth. Indeed, there are studies indicating that even patients without cancer who attend clinics that specialise in mouth cancer are unaware of the possibility. This trend regarding a lack of awareness occurs across the globe, although it varies between countries.

With celebrities such as Michael Douglas struggling publicly with the disease, do you think awareness of malignant diseases of the mouth is increasing?

Undoubtedly, it will increase. When a celebrity announces that he or she has a particular disorder, there is often an upsurge of referrals by concerned individuals. In the UK, this was perhaps best illustrated when Freddie Mercury declared that he had HIV. There was a substantial rise in the number of persons seeking advice and/or testing for the disease in the aftermath.

A fair number of famous people have had oral cancer, including Sigmund Freud, Ulysses S. Grant and TV producer Aaron Spelling to name but a few. In the UK, journalist and first husband of TV cook Nigella Lawson John Diamond wrote a series of articles detailing the progress of his disease and its treatment that informed many of the impact this disease can have on an individual and his or her family.

Unfortunately, the Michael Douglas situation has perhaps confused the exact role of the human papillomavirus (HPV) in mouth cancer. Certainly, it can cause mouth cancer and it can be acquired through orogenital contact, but there is no evidence that such contact will lessen any subsequent risk of contracting mouth cancer.

Oral cancer figures are rising worldwide. What are the reasons for this, and does it fulfil the criteria for an epidemic, as it has been called in some media reports?

An epidemic is defined as new cases of a disease in a given human population over a particular period. It often has an emotive element to it. Oral cancer certainly is on the increase in the developed world, although the number of new cases is falling in some parts of the globe, notably parts of India.

The rise in some countries is gradual but sustained. Smoking tobacco and/or drinking alcohol are the two factors that traditionally have given rise to mouth cancer. In addition, individuals are now acquiring cancer-causing (oncogenic) types of HPV, probably via orogenital contact. This burst of infectious disease, or indeed sexually transmitted infection, is not a new phenomenon, but it has become much more manifest in the last 30 years. So, what is new is probably that oncogenic types of HPV are just more common in the sexually active population than in the past.

The exact risk that it carries is unclear but it has been suggested that the risk of HPV-related mouth and/or throat cancer climbs when someone has had more than nine different sexual partners.

What other factors besides smoking, drinking and HPV are currently being investigated, and what is their malignant potential?

People chew betel nut preparations (eg paan masal and gutka) in parts of India, Pakistan, Bangladesh and surrounding areas. These cause initial fibrosis of the oral tissue, termed "submucous fibrosis", which carries a high risk of causing oral cancer of possibly 30 per cent. Submucous fibrosis can arise even in young individuals and is irreversible, and thus patients are likely to have a lifelong risk of mouth cancer, even if they stop the causative habit. The nightmare scenario is that when examining a patient with submucous fibrosis the mouth opening can be so small that a clinician may be unable to see the cancer.

Mouth cancer can also arise in patients who have rare genetic disorders, such as Fanconi anaemia and dyskeratosis congenita, but the most common oral disorder that is considered to be potentially malignant is oral lichen planus. This is a global disorder that typically occurs in middle-aged and older women. It is a chronic immune disorder that may cause painless white patches that sometimes are accompanied by painful erosions or ulcers. It affects about one to two per cent of the population and is the most common disorder to affect the lining of the mouth (the oral mucosa).

It has been suggested that one-two per cent of patients with oral lichen planus will develop mouth cancer, but this risk is highly unpredictable because it does not appear to be consistently associated with the duration or type of treatment of the lichen planus, nor the age or sex of the patients, nor their alcohol or tobacco habits. The good news, perhaps, is that 98 to 99 per cent of patients with oral lichen planus will not contract mouth cancer.

Isolated white or red patches on the oral mucosa (sometimes termed "leukoplakia" and "erythroplakia") have malignant potential as well, but these are actually uncommon, particularly the latter, compared with oral lichen planus.

Besides new treatment concepts, prevention remains the most effective strategy against oral cancer. Why do so many dentists still appear to overlook obvious signs of the disease, and do current screening procedures have shortcomings?

The great majority of patients ultimately found to have mouth cancer will have been referred to a specialist service because a dentist or other dental professional will have noticed something abnormal. He or she might not have known what it was, but they did the correct thing by referring the patient to a specialist.

Screening for possible mouth cancer is straightforward. It is just a matter of examining the neck and mouth carefully. However sometimes dentists do not know what to look for, as they have probably never seen more than one type of oral cancer in their professional lives.

Similarly, mouth cancer is

more likely in socio-economically deprived groups than the wealthy. Socially disadvantaged people have a tendency not to attend health care providers, including dentists, on a regular basis nor to take up possible screening opportunities for common diseases and therefore have a variable awareness and practice of disease prevention strategies, whether concerning oral health or general health.

Clearly, the best option for screening would be opportunistic screening, where health care staff examine patients in risk groups for a particular disease, but this requires people to want to attend a clinic and to appreciate the possible benefits of such attendance for their health and well-being.

Is there any evidence that regular screenings could help prevent oral cancer?

There is no evidence that a particular frequency of dental examination will lessen the risk of mouth cancer. However, the more regularly a person is examined, the greater the chance that emerging malignant or potentially malignant disease will be detected and that any lesion present will be small.

However, overzealous review is likely to be wasteful and thus all patients should be advised that if they become aware of a change in their gingivae or oral mucosa that persists for more than three weeks and has no obvious local cause, or example a sharp tooth or filling, they should seek advice from their dentist.

In its 2008 policy statement, the FDI stresses the important role of dental professionals in the detection of oral cancer and patient education. To what extent are dental professionals fulfilling this role?

The majority of patients ultimately found to have oral cancer will have been identified by a dentist or other dental professional; thus, dental professionals are fulfilling this role to a great extent. However, dental professionals should also be able to provide advice about oral cancer prevention, for example tobacco and alcohol cessation, and information on where additional advice can be obtained, for example tobacco cessation services.

The current rule of thumb is that the more people smoke and the longer that habit the greater the risk of mouth cancer. The same applies to alcohol. There are some nuances as regards the type of tobacco or alcohol that may affect risk but these are really not of notable concern when communicating a disease prevention message. Of significance is that the risk of cancer developing if someone smokes and drinks is much higher than if someone smokes or drinks (i.e. there is a synergistic rather than additive effect).

Of course, many dentists will indicate that they have no experience of having seen oral cancer or having managed any patient who has previously had such disease. However, there are some simple rules. If a lesion is solitary, has been present for more than three weeks and has no local cause, the patient should be referred. Any lesion that strikes a dental professional as odd and/or destructive warrants referral.

Dentists should always keep an accurate and contemporaneous record of what is observed during clinical examination and be familiar with the contact details of local oral cancer specialists (typically oral and maxillofacial surgery or oral medicine).

Finally, the patient should be told the truth, ie that the dental professional has concerns that a lesion is possibly malignant or premalignant, and is thus referring the patient for further investigation. DT

Regular screening increases the chance of detecting oral lesions early

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Amit's corner

Amit Rai guides on guidelines

With all that was going on with the transition of PCTs to NHS England, the DH's 2013 update of HTM 01-05 has gone relatively unnoticed. Maybe this is because it was resentfully received on account of wrapped instruments now being able to be stored for six times longer than before, which in turn questions the previous 21- or 60-day guidelines along with the practice costs associated.

This got me thinking about guidelines. I'm not sure why, but people don't always like to follow guidance and direction. In fact a study has shown that when people are asked to plan a journey they don't tend to follow their own directions, because the scene, as it unfolds in real-time, presents various opportunities to reduce the journey time through taking short-cuts. Maybe it's because we think we know better or we are too pragmatic to be wasting our time on "reading" and would rather be "doing". Either way, when it comes to professional guidelines the risks of not following them could be more serious.

A guideline is considered to be a statement by which to determine a course of action, and clinical guidelines are published by a number of bodies, including the National Institute of Health and Clinical Excellence (NICE) who assert that *"good clinical guidelines aim to improve the quality of healthcare"*. Are guidelines mandatory to follow? Well, the case of JAC Richards v Swansea NHS Trust [2007] EWHC 487 (QB) demonstrates how the judiciary has held professional guidelines as the legal standard in which to find negligence.

In this particular case, the time taken to deliver a baby by emergency caesarean section exceeded that recommended in the NICE and Royal College of Gynaecologists and Obstetricians guidelines on caesarean section. As this delay was found to have led to the claimant's cerebral palsy Field J found the NHS Trust to be negligent. This reliance on guidelines represents a judicial shift away from the Bolam standard of a competent body of professional opinion because, unlike experts, guidelines are evidenced-based and objective. Guidelines can therefore be relied on as a tool to reduce clinical error and promote consistency in the provision of care.

Examples of guidelines within the dental sphere include NICE Guidance on the Extraction of Wisdom Teeth (2000) and FGDP Adult Antimicrobial Prescribing in Primary Dental Care for General Dental Practitioners (2012).

Use of clinical guidelines does however present concerns to the practise of dentistry including the growth of 'cookbook dentistry' where dentists are at risk of practicing prescriptively, even when it is justified to use clinical discretion in the patient's best interests. Fear of litigation could perhaps give rise to defensive dentistry. As inferred from Plato, the imposition of guidelines threaten the autonomy of our profession, which prides itself on being truly imprecise insofar that patients are unique and no disease manifests in the same way. Samanta et al contend that it is important that the courts use guidelines that are credible. This credibility could be determined on the basis of predefined standards, ie authorship by esteemed professional bodies and the guidelines themselves being systematically developed on the basis of evidence.

Guidelines are just that – guides. However, beware of likening them to futile instructions. This is because they are valued by the judiciary to help identify what is legally expected, offering a framework which can be used by the courts in order to assess the reasonableness of decisions in the arena of clinical negligence.

• References are available upon request. The views expressed are those of the author and do not necessarily reflect the views of, and should not be attributed to, any organisation or institute that he works for. DT

About the author

Amit Rai is a General Dental Practitioner, Dental Educator and Advisor with a Dento-Legal background

An app-ropriate way to save lives

Dental Tribune looks at the CPR app LIFESAVER

The Resuscitation Council (UK), the medical charity that produces official UK guidelines for CPR, has launched an app as a way to learn CPR in the 21st century. Together with production company UNIT9, the Resuscitation Council has created LIFESAVER, a free app that is available on your computer, smartphone or tablet.

An estimated 60,000 people each year in the UK have an out-of-hospital cardiac arrest and less than 10 per cent of these survive; this means that it's more likely that the person suffering the arrest will be known to the rescuer. The Resuscitation Council built this app as an attempt to let people learn CPR easily, have the confidence to do it, and ultimately, save lives. With almost everyone having access to a computer, smartphone or tablet and wanting to receive information in a quick condensed manner, this is the first effective way of learning CPR available to everyone.

LIFESAVER is an interactive short film that is played like a game. The user is put into the situation and asked questions about what you would do each step of the way; if you pick the wrong answer, you're told why it's wrong and what should be done instead. Playing the game is quite pressured - you're given a time limit to answer the questions so have to react quickly, just as you would if you were in a real-life situation. The interactivity really puts you in the situation and makes you feel as if you are experiencing it .

Being involved in the game provides a more vivid experience than practising on a dummy like traditional CPR classes.

There are three different scenarios to go through, giving you advice in what to learn in each situation. There is also the opportunity to hear expert advice on CPR and real-life accounts of cardiac arrest.

Viv Cummins talks about her experience when her husband had a cardiac arrest. Viv phoned the ambulance and the responder talked her through what to do. She'd done a CPR course a few months earlier and says it all came back to her – her panic went and she got into practical mode.

"I already knew it was too late at this point but I had to do what I could and got on with what I'd been trained to do. It was nothing like carrying it out on the mannequin in the training", she says.

Viv knows that she had done everything she could to try and save him. Her husband dying wasn't as a result of her not knowing what to do, and she says this has given her great comfort since his death.

LIFESAVER is available from both the Android and Apple app stores, and can be played online at www.life-saver.org.uk DT