

CABINET MEMBER FOR HEALTH AND WELLBEING

**Venue: Town Hall,
Moorgate Street,
Rotherham
S60 2RB**

Date: Monday, 10th October, 2011

Time: 11.30 a.m.

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested, in accordance with the Local Government Act 1972 (as amended March 2006).
2. To determine any item which the Chairman is of the opinion should be considered later in the agenda as a matter of urgency.
3. Minutes of meeting (Pages 1 - 5)
4. Tobacco Control (Pages 6 - 42)
5. Suicide Prevention Group/Plan (Pages 43 - 47)
6. Yorkshire Ambulance Service 'Looking to the Future' Public Consultation (Pages 48 - 54)
7. General Dental Committee - Professional Conduct Committee (Pages 55 - 92)

CABINET MEMBER FOR HEALTH AND WELLBEING
Monday, 12th September, 2011

Present:- Councillor Wyatt (in the Chair); Councillors Buckley and Pitchley.

An apology for absence was received from Councillor Burton.

K12. MINUTES OF PREVIOUS MEETING

Consideration was given to the minutes of the previous meeting held on 11th July, 2011.

Resolved:- That the minutes of the meeting held on 11th July, 2011, be approved as a correct record.

Arising from Minute No. D2 (KWILLT Project and Rotherham Conference) it was noted that the conference to be held on 19th September, 2011, was fully booked.

Arising from Minute No. D5 (Arrangements for the first Health and Wellbeing Board), it was noted that the first meeting was to be held on 21st September, 2011.

Arising from Minute No. D7 (Bereavement Services Forum), it was noted that a meeting was to be held on 20th September, 2011.

K13. CONFERENCE

Resolved:- That the Cabinet Member (or substitute) be authorised to attend the "Tackling Tobacco in your Community : A Compelling Business Case for Action" conference to be held in Manchester on 11th October, 2011.

K14. HEALTH SUMMIT

The Chairman reported that when the Cabinet had considered a report on Health Inequalities at its meeting held on 20th July, 2011 (Minute No. 34), it had recommended that a Health Summit be held in November with the key players concerned. In the meantime consultation take place to inform the process.

Rebecca Atchinson and Carol Weir, NHS Rotherham, had commenced the consultation at the Rotherham Show where they had spoken to approximately 426 people. This information, together with that of the Health and Wellbeing Board, would help ascertain whether the local level information married up with the statistical information and help to find out why some of the services provided were not as successful as hoped.

The work undertaken at the Rotherham Show was an initial exercise which would be followed by more indepth work at focus groups, Area Assemblies and communities of interest. They were asked if they thought that their health had improved. On the whole, participants thought it had got worse. When asked for the reasons why they thought that, the top 3 answers were:-

- unemployment
- less money to spend
- cost of weekly food shop

The 426 participants had been spread across the Borough, with a near 50-50 split of male and female, with representatives from ethnic minority groups.

Discussion ensued with the following issues raised:-

- The participants knew all the services existed but were not motivated to use them
- Send questionnaire electronically to all Elected Members
- Obesity was not mentioned as a problem although participants had raised the number of fast food outlets linked to the cost of fresh food and ability of some to cook
- The focus groups would give the opportunity for more indepth discussion
- Use the Rotherham Foundation Trust network to distribute the questionnaire
- Link in with the work taking place in A&E and Walk-in Centre on members of public presenting at the wrong place for their complaint
- Difficulty in understanding the difference between health and illness
- NHS and the council need to use different methods of engagement to obtain the views of hard to reach groups, particularly in disadvantaged areas

Resolved:- (1) That the work undertaken so far be noted.

(2) That the questionnaire be circulated electronically to all Members of the Council.

(3) That the Cabinet Member contact the local press with a view to the questionnaire being included on their web site.

K15. HEALTH TRAINER SERVICE

Carl Hickman, NHS Rotherham, gave a verbal report on the Rotherham Health Trainer Service which had been recognised in 2010 as 1 of the top 10 services in the country for helping patients plan and achieve their healthy lifestyle goals and deliver some of the highest health outcomes.

The Service was commissioned through the NHS providing the client a free, confidential, 1:1 service which dealt with behaviour and lifestyle change. It was for anyone who wanted to manage their weight, improve their diet, reduce stress/depression, increase their energy levels, do more physical activity, drink sensibly, lift low mood or stop smoking.

It was currently based within 29 GP surgeries in Rotherham. Customers received support from a Trainer for up to 1 hour, 6-8 times. It was not supposed to be a crutch but to build self-advocacy using self-motivation, promote behavioural change and move them along the route; they were set small achievable goals for them to go away and make those changes themselves.

At present the Service was commissioned until March, 2012. The current cost of intervention per client for 6-8 sessions was £107.

Initially every GP practice in the Borough was contacted with regard to providing the Service from their premises but some had failed to respond. It was felt that further analysis of the use of this service, including Super Output Area analysis, would assist in future targeting campaigns.

Resolved:- That the report be noted.

K16. FOOD STANDARDS AGENCY AUDIT

The Director of Housing and Neighbourhood Services submitted an update on the progress made with regard to the recommendations from the Food Standards Agency's audit in May, 2010. It also detailed the preparations undertaken for a potential follow-up audit.

The audit assessed the local arrangements that were in place for food premises inspections and internal monitoring with regard to food hygiene law enforcement with particular emphasis on officer competency in assessing food safety management systems. The scope also included an assessment of the overall organisation, management and internal monitoring of food law enforcement activities. The FSA produced a final report and the Food, Health and Safety Team undertook a programme of work to implement the recommendations made.

Details on the progress made against recommendations were set out in the report submitted.

The Food, Health and Safety Team and the Performance and Quality Team had commenced a number of activities in preparation for the potential follow-up audit including:-

- Establishment of a core group to undertake a range of quality assurance activities and peer-to-peer audits against policies, procedures and FSA Audit Checklist
- The Performance and Quality Team had undertaken a range of independent quality assurance activities and spot checks
- Staff briefing sessions
- Discussions at regular team meetings and 1:1 sessions
- Review of the website information and improvements made

The Audit report and recommendations therein had not resulted in any additional resource implications for the Authority.

Failure of the authority to implement the recommendations may result in the Authority failing in its statutory duties in relation to the official control of food safety. The FSA may also consider it necessary to take further action against

the Authority should it be considered to be failing to deliver its obligations.

The report also set out a strategic overview of the Food Hygiene Service which included the following statistics for 2010/11:-

- 5 premises had been closed
- 66 Hygiene Improvement Notices served
- 146 food samples taken
- 899 cases of infectious disease notifications; 382 notifications received up to 31st July, 2011
- 6 Food Alerts received from the Food Standards Agency

Resolved:- (1) That the progress made to meet the Food Standards Agency's recommendations and the work undertaken to prepare for a potential follow-up audit be noted.

(2) That information be submitted with regard to a strategic overview of the Food Hygiene Service.

K17. FOOD HYGIENE RATING SYSTEM

The Director of Housing and Neighbourhood Services reported that the Food Standards Agency now ran a National Food Hygiene Rating Scheme which had been adopted by 150 Councils up to June, 2011. The report highlighted the differences between the "Scores on the Doors" scheme currently operated by Rotherham and the actions needed to migrate to the national scheme.

The FSA had developed a national 6 tier scheme similar to the 1 currently operating in Rotherham. It extended the premises included in the "Scores on the Doors" which currently was only for caterers. The FSA scheme included establishments that supplied food direct to consumers including retailers. Certain exemptions were proposed, for example, primary producers, packers, importers, manufacturers, exporters etc. and groups such as childminders which were operating from private addresses and 'low risk' establishments such as chemists and newsagents selling pre-wrapped confectionery.

The Food Hygiene Rating System broadened the higher rated scores which would impact on the better premises in Rotherham and alter the descriptors published on the web. This would mean that some premises would alter their star rating. The descriptors of the premises would alter to very good, good, generally satisfactory, improvement necessary, major improvement necessary and urgent improvement needed.

If Rotherham adopted the Scheme, the FSA required participating local authorities to sign a formal agreement based on the 'Brand Standard'. Migration to the new system could be undertaken in a staged gradual approach or via a critical mass approach which was the favoured approach.

The change would be communicated to the businesses in a number of ways for which there was FSA funding. The Authority successfully bid for funding from the FSA with the other 3 South Yorkshire authorities, the total amount being £131,488. The cost of running the new scheme would be less than running "Scores on the Doors" as there was no annual cost (currently £3,220 per annum).

The suggested launch time across the four authorities was March, 2012.

Resolved:- (1) That the update regarding implementation by the Food Standards Agency of a national 6 tier Food Hygiene Rating Scheme (FHRS) and the "Brand Standard" be noted.

(2) That migration to FHRS be approved subject to the funding bid being accepted.

(3) That the Authority continue to support the Scores on the Doors Scheme until the contract with Transparency Data expires in February, 2012.

K18. STRATEGIC COMMISSIONING PRIORITIES FOR CHILDREN AND YOUNG PEOPLE'S SERVICES

This item was withdrawn.

K19. DATE AND TIME OF FUTURE MEETINGS

Resolved:- That meetings be held on the following dates in 2011/12 commencing at 11.30 a.m. in the Town Hall:-

- 10th October, 2011
- 7th November
- 5th December
- 16th January, 2012
- 13th February
- 12th March
- 16th April



Tobacco Bulletin

July 2011

Welcome to the Tobacco Bulletin. These bulletins will summarise the latest tobacco control activity within Rotherham, national and international news related to tobacco and smoking, and outline any relevant training and development opportunities.

Please pass this on to other colleagues who would be interested. If you know anybody who would like to be added to the distribution list for future editions please contact:

Alison.iliff@rotherham.nhs.uk

Smoking, drinking and drug use among young people in England 2010

The NHS information centre has published their annual report on young people's smoking, drinking and drug use. The key findings related to smoking are:

- In 2010, 27 per cent of pupils had smoked at least once, compared with 44 per cent in 2001.
- In 2010, 5 per cent of pupils smoked regularly. As in previous years, girls were more likely than boys to be regular smokers (6 per cent and 4 per cent respectively).
- 35 per cent of pupils thought it was acceptable for someone their age to try smoking to see what it was like
- There is strong evidence that pupils' smoking habits are influenced by the smoking behaviour of their families and friends. Almost all smokers (99%) said they knew at least one person who smoked, compared with 81% of non-smokers. Around three-fifths (62%) of pupils lived in households where no one else smoked, and they were less likely to be smokers than those who lived with other smokers, particularly those who lived with several other smokers. Among pupils who said that no one they lived with smoked, 94% did not smoke, compared with 69% of those who lived with three or more smokers.
- Pupils who smoked were most likely to get cigarettes by being given them by other people (69%), most usually friends (58%). Pupils who smoked were also likely to buy cigarettes from shops (45%) or other people (41%).
- Most pupils who ask someone else to buy cigarettes from a shop are successful, at least some of the time; 90% of those who had tried in the last year had been bought cigarettes at least once.

You can access the summary and full reports [here](#).

Tobacconomics

Action for Smoking and Health (ASH) have published Tobacconomics, a report that examines the spurious economic arguments put forward by tobacco companies to counter tobacco control

measures. The report gives examples of how these arguments are developed and debunks the claims that support them. You can access the Tobacconomics report [here](#).

Forthcoming Tobacco Control meetings:

Rotherham Tobacco Control Alliance: Thursday 20 October 2011 at 2.00pm

Smoking in Pregnancy Group: Friday 16 September 2011 at 11.00am

All meetings are held at Oak House, Bramley. Limited observers are welcome; if you would like to attend a future meeting please contact Alison.iliff@rotherham.nhs.uk

Training, Conferences and Events

For Rotherham Stop Smoking Service training events please see the training dates at the end of the bulletin

8 September 2011: Tackling Tobacco – A Case Study for Action, The Royal York Hotel, York. This event aims to provide senior policy makers, commissioners and practitioners from across the wider public health system with an opportunity to consider how, by working together through the new health and social care arrangements, they can plan and deliver systematic interventions to achieve key public health outcomes. It will introduce delegates to the latest evidence on the impact of smoking legislation, and to the various elements of the new Tobacco Control Plan. For further information contact mindingthegap@wakefield.gov.uk

7 October 2011: Smoking Cessation and the Cancer Patient, The Royal Marsden Education and Conference Centre, London. The conference will focus on the impact of smoking on cancer treatment and on supporting cancer patients and their families to stop smoking. Charge: £50. <http://www.royalmarsden.nhs.uk/education/education-conference-centre/study-days-conferences/2011-smoking-cessation-cancer-patient>

12-13 October 2011: Tobacco and Alcohol: Learning from Each Other, Parc Thistle Hotel in Cardiff. ASH Wales's 2011 conference will be held jointly with Alcohol Concern Cymru providing the opportunity to learn from each other and find new ways of working. Papers and ideas for presentations are welcomed; deadline for submission of abstracts is 1 May 2011. <http://www.ashwales.org.uk/ash-wales-events/i/9/>

In the news

From the UK

Doctors are urging mothers-to-be to give up cigarettes after new research linked smoking in pregnancy to babies suffering birth defects such as clubfoot, missing limbs and deformed limbs.

Those who smoke while expecting a baby increase the risk of their child being born with a serious malformation by as much as 50%, the study found. The disclosure led to calls for new measures to reduce what the authors called "staggeringly high" levels of smoking among pregnant women.

- News story: <http://www.guardian.co.uk/society/2011/jul/12/birth-defects-linked-smoking-pregnancy?INTCMP=SRCH>
- Press release: <http://www.ucl.ac.uk/news/news-articles/1107/1102201101-birth-defects-smoking-pregnancy>
- Full text: <http://humupd.oxfordjournals.org/content/early/2011/07/09/humupd.dmr022.full?sid=463f8c00-6ec6-4723-9827-d099e19a46ad>

Imperial Tobacco goes to court over display ban. A cigarette company has asked appeal judges to block rules intended to ban the open display of tobacco products in shops. Imperial Tobacco claimed that the Scottish Parliament had no legal right to restrict the open sale of its products. It was appealing against an earlier ruling that none of its challenges were "well founded".

<http://www.bbc.co.uk/news/uk-scotland-13605366>

Motivational text messages sent to smokers' mobile phones can double their chances of giving up tobacco, a study has found. The "txt2stop" trial tested the effects of inspirational text messages designed to encourage quitting on almost 3,000 smokers. Participants were twice as likely to banish their habit as another group sent texts unrelated to smoking.

<http://www.guardian.co.uk/healthcare-network/2011/jun/30/motivational-text-messages-help-smokers-quit?INTCMP=SRCH>

More than 80% of chewing tobacco products sold in England do not comply with legislation. The Race Equality Foundation together with the Action on Smoking and Health (ASH) foundation found that only 15% of such products are sold with relevant health warnings or adequate labelling. Many chewing tobacco products do not even state if they contain tobacco.

<http://www.bbc.co.uk/news/health-13413053>

From overseas

If you light up a cigarette, it will snuff out your chances to land a job with health-insurance giant Humana in Arizona. The health insurer said Wednesday that it will no longer hire workers in Arizona who smoke or use other tobacco products, part of a trend of employers who are cracking down on tobacco use among workers. To enforce the tobacco ban Humana will test new employees for nicotine use during a pre-employment urine drug screen. Although existing Humana-employed smokers aren't required to halt tobacco use, they will be encouraged to do so. Those employees will be offered free stop-smoking help. Employees who enrol in the smoking-cessation plans also are offered discounted medical insurance. http://www.usatoday.com/money/industries/health/2011-06-30-smokers-jobs-humana_n.htm

Australia's government has introduced a bill to parliament that would prevent tobacco companies from displaying their distinctive colours, brand designs and logos on cigarette packs. Tobacco companies argue that the move illegally diminishes the value of their trademarks. They are funding a nationwide advertising campaign that brands Australia a nanny state and warns that alcohol will be the government's next target.

<http://www.guardian.co.uk/world/2011/jul/06/australia-plain-packaging-cigarettes?INTCMP=SRCH>

<http://www.bbc.co.uk/news/business-13923095>

Nicotine treatment 'could control obesity' Scientists have identified a group of neurons in the brain responsible for smokers' lack of appetite. In an article in the journal Science, Yale University researchers describe experiments on mice which found nicotine activates neurons to send signals the body has had enough to eat. However they are not the same neurons which trigger a craving for tobacco. <http://www.bbc.co.uk/news/health-13711975>

And finally

The Telegraph takes a look at some vintage tobacco advertisements.

<http://www.telegraph.co.uk/health/healthpicturegalleries/8620411/Vintage-tobacco-advertising-how-cigarette-adverts-have-changed-over-the-years.html>

STOP SMOKING SERVICE TRAINING DATES & VENUES 2011

Please note: an application form for level 2 (intermediate) training is given after completion of level 1 (brief intervention) and must be returned before confirmation of a place on level 2 training is given. For more information on the courses please contact the Stop Smoking Service on 01709 422444.

| BRIEF INTERVENTION – Half Day (no more than 14 people) | | | |
|---|--|--------------------|--------------|
| | Date | Time | Venue |
| October | Wednesday 5 th October 2011 | 9.00 am – 12.30 pm | RCHC, room 2 |

| INTERMEDIATE INTERVENTION – 2 Days (no more than 14 people) | | | |
|--|--|-------------------|-------------------|
| | Date | Time | Venue |
| October | (Mon/Tue) 10 th & 11 th October 2011 | 9.00 am – 4.30 pm | RCHC, rooms 1 & 2 |

| UPDATE – Half Day (no more than 14 people) | | | |
|---|--------------------------------------|-------------------|-------------------|
| | Date | Time | Venue |
| December | (Mon) 12 th December 2011 | 1.30 pm – 4.30 pm | RCHC, rooms 1 & 2 |

| PEER SUPPORT | | | |
|---------------------|-------------------------------------|-----------------------|-------------------|
| | Date | Time | Venue |
| October IAN | (Tue) 18 th October 2011 | 12 – 2 pm or 2 – 4 pm | RCHC, rooms 1 & 2 |
| December | (Tue) 6 th December 2011 | 12 – 2 pm or 2 – 4 pm | RCHC, rooms 1 & 2 |

| RAISING AWARENESS | | | |
|--------------------------|-----------------------|--------------------|--------------|
| | Date | Time | Venue |
| August | (Mon) 15 August 2011 | 9.30 am – 10.30 am | RCHC, Room 5 |
| October | (Tue) 18 October 2011 | 9.30 am – 10.30 am | RCHC, Room 1 |

Tobacco Bulletin

September 2011

Welcome to the Tobacco Bulletin. These bulletins will summarise the latest tobacco control activity within Rotherham, national and international news related to tobacco and smoking, and outline any relevant training and development opportunities.

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Tobacco vending machines

Sales of tobacco from vending machines will be illegal after Saturday 1st October 2011. The legislation has been introduced primarily to reduce access to tobacco products for those aged under 18. Whist vending machines only accounted for 1% of cigarette sales, 11% of children who smoked regularly obtained their cigarettes from the machines. From Saturday machines must be inoperable and not display tobacco products. There is a recognition that removing all machines may take longer. It is believed that a number of pubs and bars that currently have vending machines will be provided with tobacco displays for behind the counter. As they would be classed as small retailers this would allow continued display of tobacco products until April 2015, although it should still restrict access to under-18s. .

No Smoking Day campaign merges with the British Heart Foundation (BHF)

As a result of national funding cuts to voluntary organisations, the No Smoking Day charity is becoming part of BHF to ensure its ongoing stability. The campaign for No Smoking Day 2012 (14 March 2012) will keep the existing branding and the theme will be launched in November.

Tackling Tobacco: A Case Study for Action

Minding the Gap organised this conference to raise awareness of the need for a comprehensive tobacco control strategy and to bring local policy makers and public health staff together to discuss how tobacco control will fit into health and wellbeing strategies and its impact on health inequalities. Presentations covered illicit tobacco, upcoming legislative changes (vending machines and point of sale display bans), and using the new health structures to further tobacco control activity.

Statistics on Smoking, England 2011

The Information Centre has published its annual reports on smoking and NHS Stop Smoking Services.

Key facts – smoking in England

- In England in 2009, 21 per cent of adults reported cigarette smoking, the same as in 2007 and 2008 and lower than 39 per cent in 1980. Prevalence continues to be higher among men than women with 22 per cent of men and 20 per cent of women reporting cigarette smoking.
- In England in 2010, over a quarter of secondary school pupils (27 per cent), had tried smoking at least once and 5 per cent were regular smokers (smoking at least one cigarette a week). Girls were more likely to smoke than boys; 9 per cent of girls had smoked in the last week compared with 6 per cent of boys
- In 2010, £17.7 billion was estimated to be spent on tobacco in the UK. The proportion of total household expenditure on tobacco has decreased since 1980, to 1.9 per cent in 2010. In 2010, tobacco was 33 per cent less affordable than in 1980.
- In 2009, an average number of 13.1 cigarettes were smoked each day by current smokers. This includes an average of 13.9 cigarettes for men and 12.4 for women.
- Among adults aged 35 and over, there were approximately 1.5 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking. The annual number of admissions has been rising steadily since 1996/97, when the number of such admissions was 1.1 million. Around 457,800 hospital admissions were estimated to be attributable to smoking. This accounts for 5 per cent of all hospital admissions in this age group.

[http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking/statistics-on-smoking-england-2011-\[ns\]](http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking/statistics-on-smoking-england-2011-[ns])

Key facts – NHS Stop Smoking Services

- 787,527 people set a quit date through NHS Stop Smoking Services. This is a 4 per cent increase (29,990) from 2009/10 when 757,537 people set a quit date.
- At the 4 week follow-up 383,548 people had successfully quit (based on self-report), 49 per cent of those who set a quit date. This is a 3 per cent increase (9,594) on that reported in 2009/10 when 373,954 people successfully quit.
- More women than men set a quit date (411,392 women compared with 376,135 men) and more women than men successfully quit (195,685 compared with 187,863), although the success rate of giving up smoking was slightly higher among men than women (50 per cent and 48 per cent respectively).
- Of those who set a quit date, success rates generally increased with age from 32 per cent for those aged under 18, to 56 per cent in those aged 60 and over.
- Among all clients who set a quit date, the majority (63 per cent) received Nicotine Replacement Therapy (NRT) only. A further 26 per cent received Varenicline (Champix) only, 1 per cent received Bupropion only and 1 per cent received both NRT and Varenicline. Of those who used Varenicline only, 59 per cent successfully quit, compared with nearly half (52 per cent) who received Bupropion only and 45 per cent of those who used NRT only. Half (50 per cent) of those who did not receive any pharmacotherapy successfully quit.
- Total expenditure on NHS Stop Smoking Services was £84.3 million, nearly half a million more than in 2009/10 when it was £83.9 million and almost £60 million more than in 2001/02 when the cost was £24.7 million. The cost per quitter was £220, a decrease of 2 per cent from £224 in 2009/10. These figures do not include expenditure on pharmacotherapies.

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-england-april-2010-march-2011>

The Independent

In early September *The Independent* published a series of articles on the tobacco industry. A few are linked below, from which you can explore their other relevant coverage.

- The tobacco industry is covertly using third-party companies to lobby against smoking restrictions and to gain access to health documents held by public organisations.
<http://www.independent.co.uk/news/uk/politics/smoke-and-mirrors-how-the-tobacco-industry-hides-behind-lobbyists-2348402.html>
- Ever since the link between smoking and lung cancer was established more than 50 years ago, the tobacco industry has displayed extraordinary tenacity when it comes to denying the scientific evidence showing that smoking kills.
<http://www.independent.co.uk/news/science/hairsplitting-brazen-denials-and-six-decades-of-dirty-tricks-2347262.html>
- The next big battle for the tobacco industry – some might say the final battle – will be waged around the issue of legislation that forces their cancer-causing products into plain cigarette packets that are free of company logos and branding.
<http://www.independent.co.uk/opinion/commentators/steve-connor-big-tobaccos-big-fear-is-a-brandfree-packaging-law-2347834.html>

Forthcoming Tobacco Control meetings:

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Smoking in Pregnancy Group: Friday 18 November 2011 at 12.00noon

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Training, Conferences and Events

For Rotherham Stop Smoking Service training events please see the training dates at the end of the bulletin

7 October 2011: Smoking Cessation and the Cancer Patient, The Royal Marsden Education and Conference Centre, London. The conference will focus on the impact of smoking on cancer treatment and on supporting cancer patients and their families to stop smoking. Charge: £50.

<http://www.royalmarsden.nhs.uk/education/education-conference-centre/study-days-conferences/2011-smoking-cessation-cancer-patient>

11 October 2011: Tackling tobacco in your community: A compelling business case for action, Manchester City Council, Town Hall, Manchester. This conference provides the opportunity for council members and officers to find out more about the case for a comprehensive approach to reducing tobacco use. It will have a focus on the importance of political leadership for this agenda with local and national politicians leading a range of discussion session. LGA member rate £75 plus

VAT, non-member rate £175 plus VAT (Councillors attend free of charge if accompanying an officer and booking at the same time). Places for NHS, community and voluntary organisations are available at a reduced rate – please enquire at info@local.gov.uk. <http://www.lga.gov.uk/lga/events/display-event.do?id=19338729>

12-13 October 2011: Tobacco and Alcohol: Learning from Each Other, Parc Thistle Hotel in Cardiff. ASH Wales's 2011 conference will be held jointly with Alcohol Concern Cymru providing the opportunity to learn from each other and find new ways of working. <http://www.ashwales.org.uk/ash-wales-events/i/9/>

7 November 2011: National No Smoking Day 2012 Yorkshire and Humber campaign launch, The Met Hotel, Leeds. Presentations will include the exciting new campaign theme, tips and advice on how to run a great event and how to use No Smoking Day for your public health work. Places are free of charge – please book at <http://www.nosmokingday.org.uk/organisers/getinvolved.php?status=launches2012>

2 December 2011: Stop Smoking Live! Business Design Centre, Islington, London. With a combination of seminars, exhibition stands from key suppliers, organisations active in the field, and services keen to recruit and share their expertise, Stop Smoking Live! will be an informative and educational day for everyone in the smoking cessation field. £20 per delegate or three delegates for £40. http://www.stopsmokinglive.org/ssl2011_index.php.php

20-24 March 2011: 15th World Conference on Tobacco or Health, Singapore. The conference will include a series of plenaries, symposiums, panel discussions covering a comprehensive array of tobacco control topics including Emerging Tobacco Products, End Game Strategies, Tools for Action, the Ins and Outs of the Tobacco Industry and more.

In the news

From the UK

The government's "nudge unit" wants to encourage the use of smokeless nicotine cigarettes, banned in many countries around the world, in an attempt to reduce the numbers killed in the UK by smoking diseases each year.

- <http://www.guardian.co.uk/society/2011/sep/14/smokeless-nicotine-cigarettes-government?INTCMP=SRCH>
- http://www.cabinetoffice.gov.uk/sites/default/files/resources/Behaviour-Change-Insight-Team-Annual-Update_acc.pdf

Women who start smoking increase their risk of a heart attack by more than men who take up the habit, according to a review of more than 30 years of research. A study of 2.4 million people, published in the Lancet, showed a 25% difference in increased risk. The reasons are unclear, say researchers.

- [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)60781-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60781-2/abstract)
- <http://www.bbc.co.uk/news/health-14474308>

- <http://www.guardian.co.uk/society/2011/aug/11/heart-disease-risk-women-smokers?INTCMP=SRCH>

A Scottish university is battling a tobacco giant's attempt to gain access to its research into the smoking habits of thousands of teenagers. Philip Morris International (PMI), which makes Marlboro cigarettes, has submitted Freedom of Information (FoI) requests to Stirling University.

- <http://www.bbc.co.uk/news/uk-scotland-tayside-central-14744240>
- <http://www.guardian.co.uk/society/2011/sep/01/cigarette-university-smoking-research-information?INTCMP=SRCH>

Teenagers who watch films showing actors smoking are more likely to take it up, new UK research suggests. Experts who made the link by questioning 5,000 15-year-olds say their findings should prompt a change in film certification so that under-18s are no longer exposed to such images.

- <http://www.bbc.co.uk/news/health-14971560>
- <http://www.guardian.co.uk/film/2011/sep/22/close-up-smoking?INTCMP=SRCH>
- <http://www.guardian.co.uk/commentisfree/libertycentral/2011/sep/21/films-smoking-18-certificate?INTCMP=SRCH>

Forcing cigarette manufacturers to introduce plain packaging, following Australia's lead, will not prevent young people smoking.

- <http://www.guardian.co.uk/society/joepublic/2011/sep/20/plain-packaging-wont-stop-youths-smoking?INTCMP=SRCH>

From overseas

The World Anti-Doping Agency believes smokeless tobacco is being used in various sports to enhance performance.

- <http://www.guardian.co.uk/sport/blog/2011/sep/21/doping-nicotine-drugs-wada-sport?INTCMP=SRCH>

Five tobacco companies have sued the US Food and Drug Administration (FDA) over a new law that would force them to place graphic health warnings on their cigarette packets. The firms argue the plan violates their constitutional right to free speech, as it requires firms to promote the government's anti-smoking message.

- <http://www.bbc.co.uk/news/world-us-canada-14553228>

People who smoke soon after getting up in the morning are more likely to develop cancer than those who light up later in the day, say US researchers. A study of 7,610 smokers, published in the journal *Cancer*, said the effect was independent of other smoking habits. Smoking in the first 30 minutes after waking nearly doubled the, already high, risk of lung cancer.

- <http://www.bbc.co.uk/news/health-14411744>

In Malawi and beyond, child workers as young as five are being exposed to the toxic dangers of tobacco harvesting

- <http://www.guardian.co.uk/global-development/2011/sep/14/malawi-child-labour-tobacco-industry?INTCMP=SRCH>

And finally

An orang-utan in Malaysia called Shirley - famous for smoking cigarettes thrown by visitors into her enclosure - is being helped to kick the habit. Wildlife officials say she is undergoing "cold turkey" at Malacca zoo after being removed from her zoo in southern Johor state last week. Shirley is expected to be sent to a wildlife centre on Borneo island once her rehabilitation is complete.

- <http://www.bbc.co.uk/news/world-asia-pacific-14880804>

STOP SMOKING SERVICE TRAINING DATES & VENUES 2011

Please note: an application form for level 2 (intermediate) training is given after completion of level 1 (brief intervention) and must be returned before confirmation of a place on level 2 training is given. For more information on the courses please contact the Stop Smoking Service on 01709 422444.

| BRIEF INTERVENTION – Half Day (no more than 14 people) | | | |
|---|--|--------------------|--------------|
| | Date | Time | Venue |
| October | Wednesday 5 th October 2011 | 9.00 am – 12.30 pm | RCHC, room 2 |

| INTERMEDIATE INTERVENTION – 2 Days (no more than 14 people) | | | |
|--|--|-------------------|-------------------|
| | Date | Time | Venue |
| October | (Mon/Tue) 10 th & 11 th October 2011 | 9.00 am – 4.30 pm | RCHC, rooms 1 & 2 |

| UPDATE – Half Day (no more than 14 people) | | | |
|---|--------------------------------------|-------------------|-------------------|
| | Date | Time | Venue |
| December | (Mon) 12 th December 2011 | 1.30 pm – 4.30 pm | RCHC, rooms 1 & 2 |

| PEER SUPPORT | | | |
|---------------------|-------------------------------------|-----------------------|-------------------|
| | Date | Time | Venue |
| October IAN | (Tue) 18 th October 2011 | 12 – 2 pm or 2 – 4 pm | RCHC, rooms 1 & 2 |
| December | (Tue) 6 th December 2011 | 12 – 2 pm or 2 – 4 pm | RCHC, rooms 1 & 2 |

| RAISING AWARENESS | | | |
|--------------------------|-----------------------|--------------------|--------------|
| | Date | Time | Venue |
| October | (Tue) 18 October 2011 | 9.30 am – 10.30 am | RCHC, Room 1 |

THE CASE FOR ACTION on TOBACCO USE & SMOKING

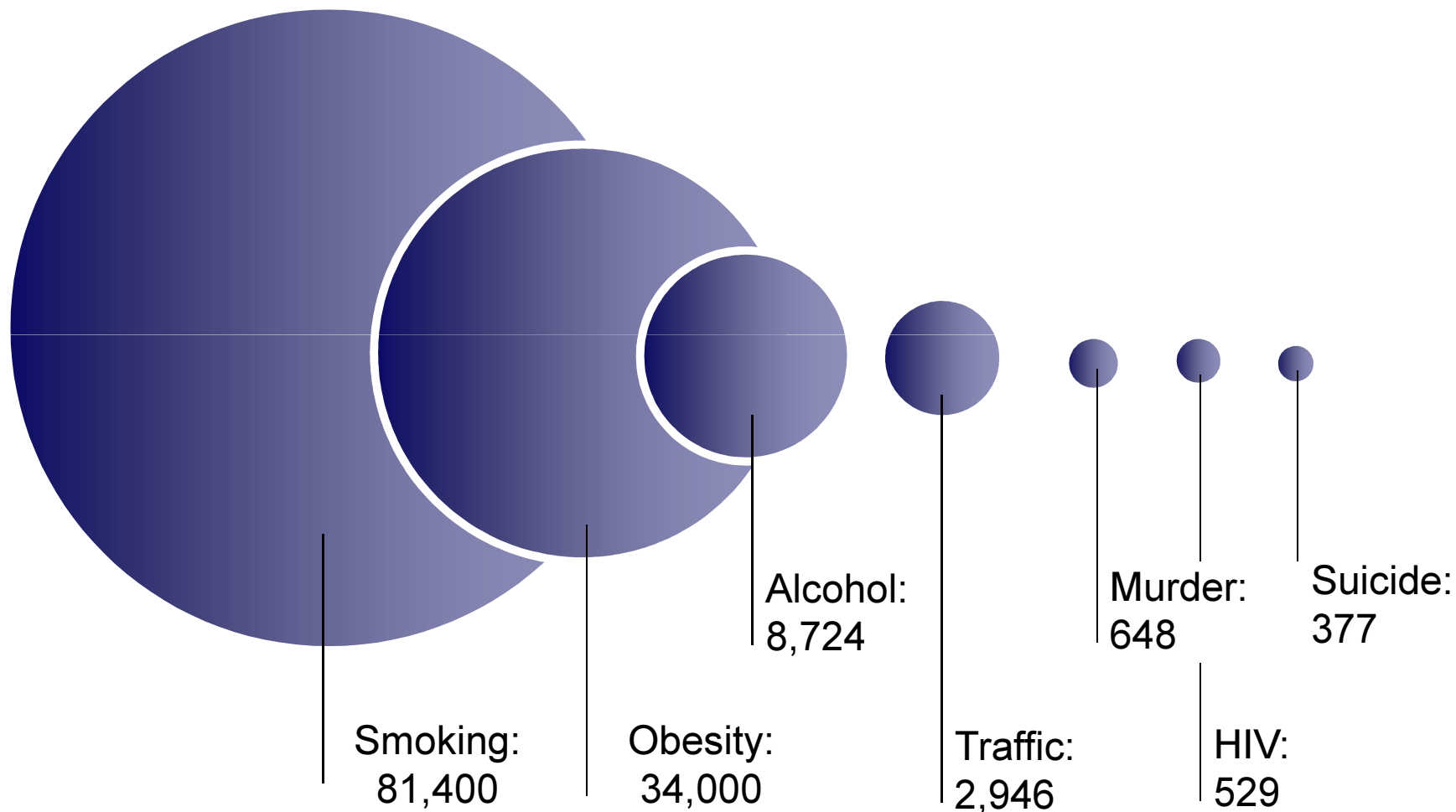
Harms caused by tobacco use & an overview of local tobacco policies to aid
commissioning

Health and Wellbeing Delegated Powers meeting
10 October 2011



1. Scale of the challenge

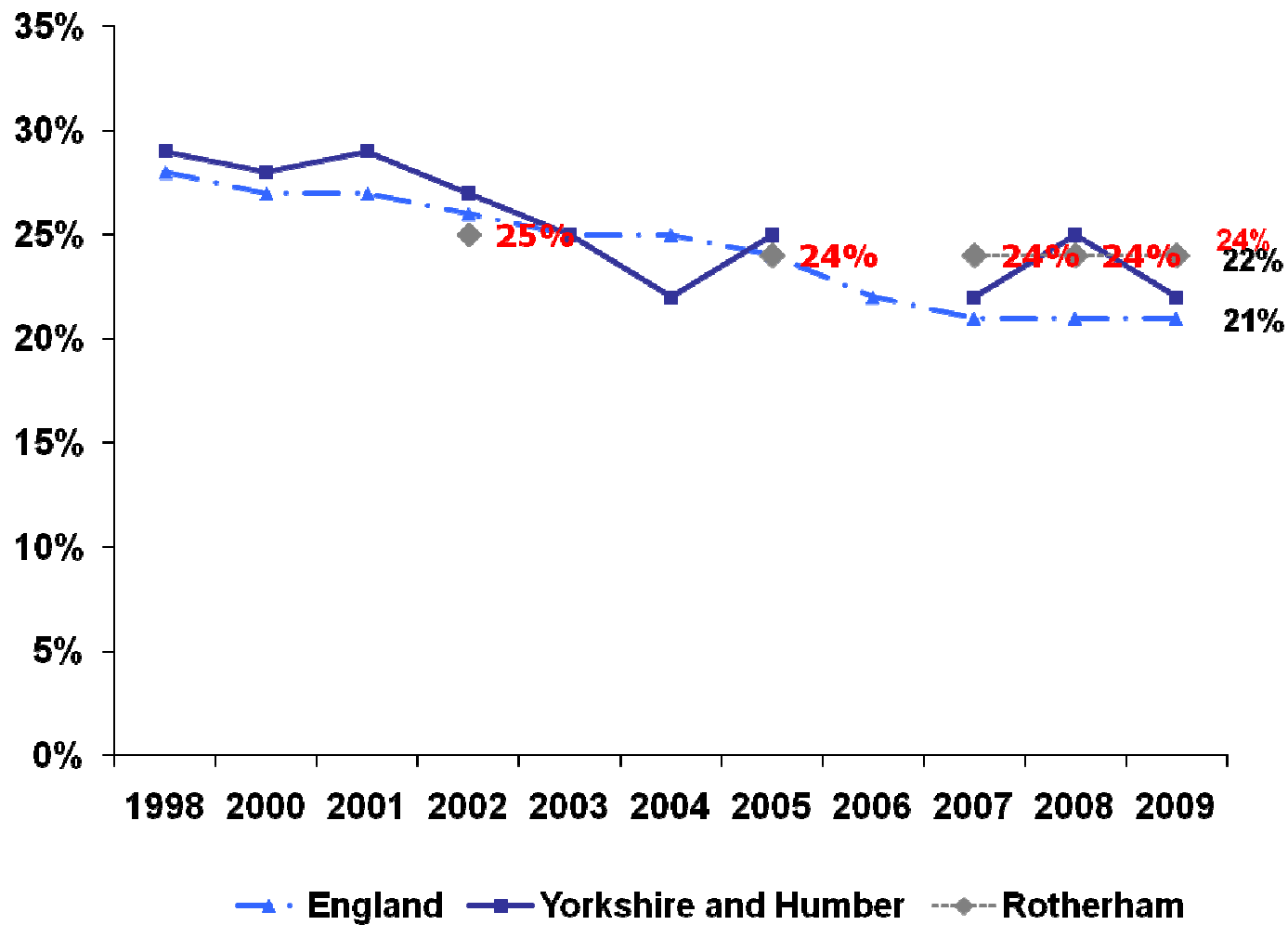
Each year smoking causes the greatest number of preventable deaths



References:

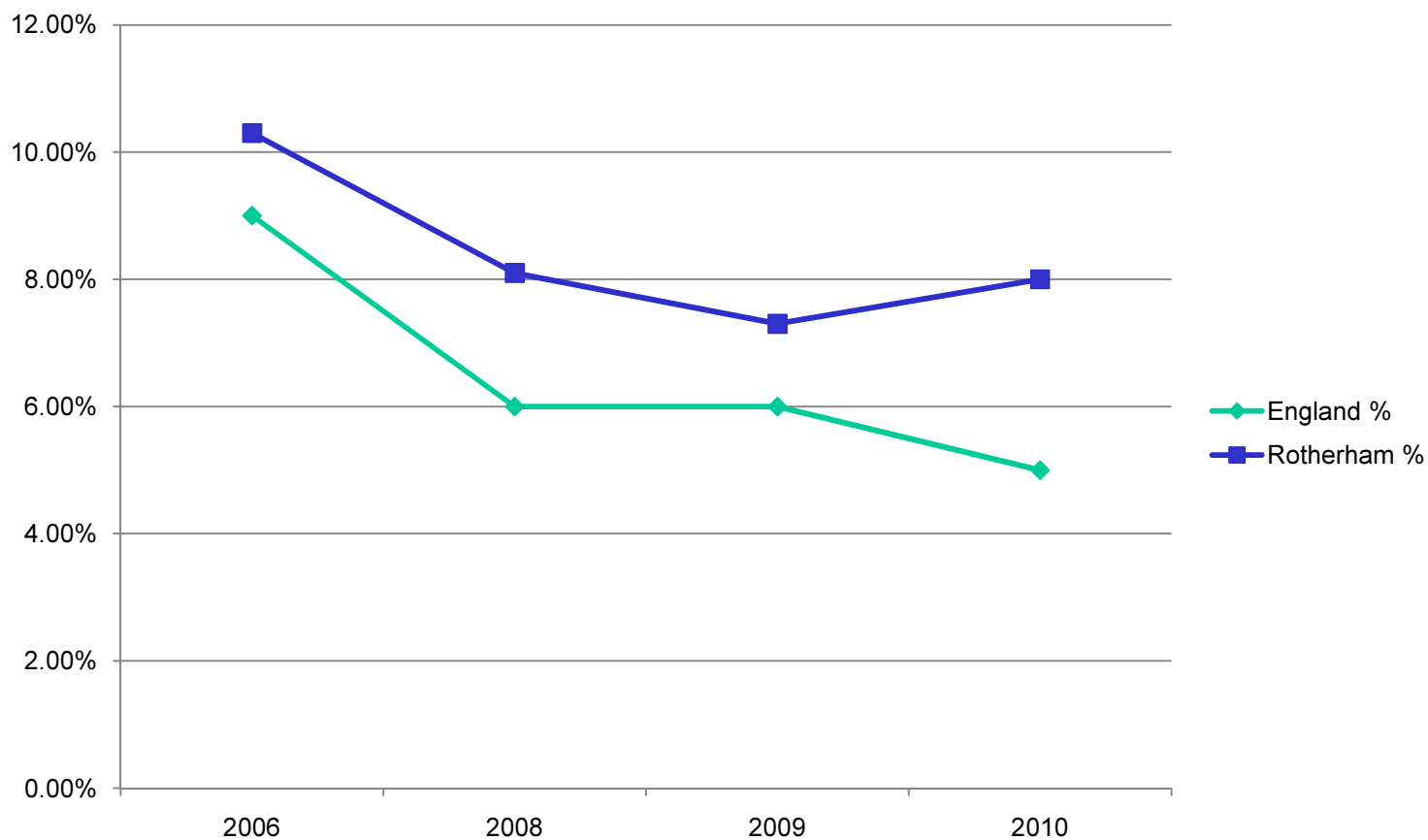
1. ASH Factsheet, Smoking Statistics: illness & death, June 2011 (http://www.ash.org.uk/files/documents/ASH_107.pdf) NB area represents value

The decline in smoking rates has stalled



References:
1. Integrated Household Survey 2010 (mid-point estimate for locality given small sample size and large confidence interval)

National children's rates of smoking (age 11 – 15)

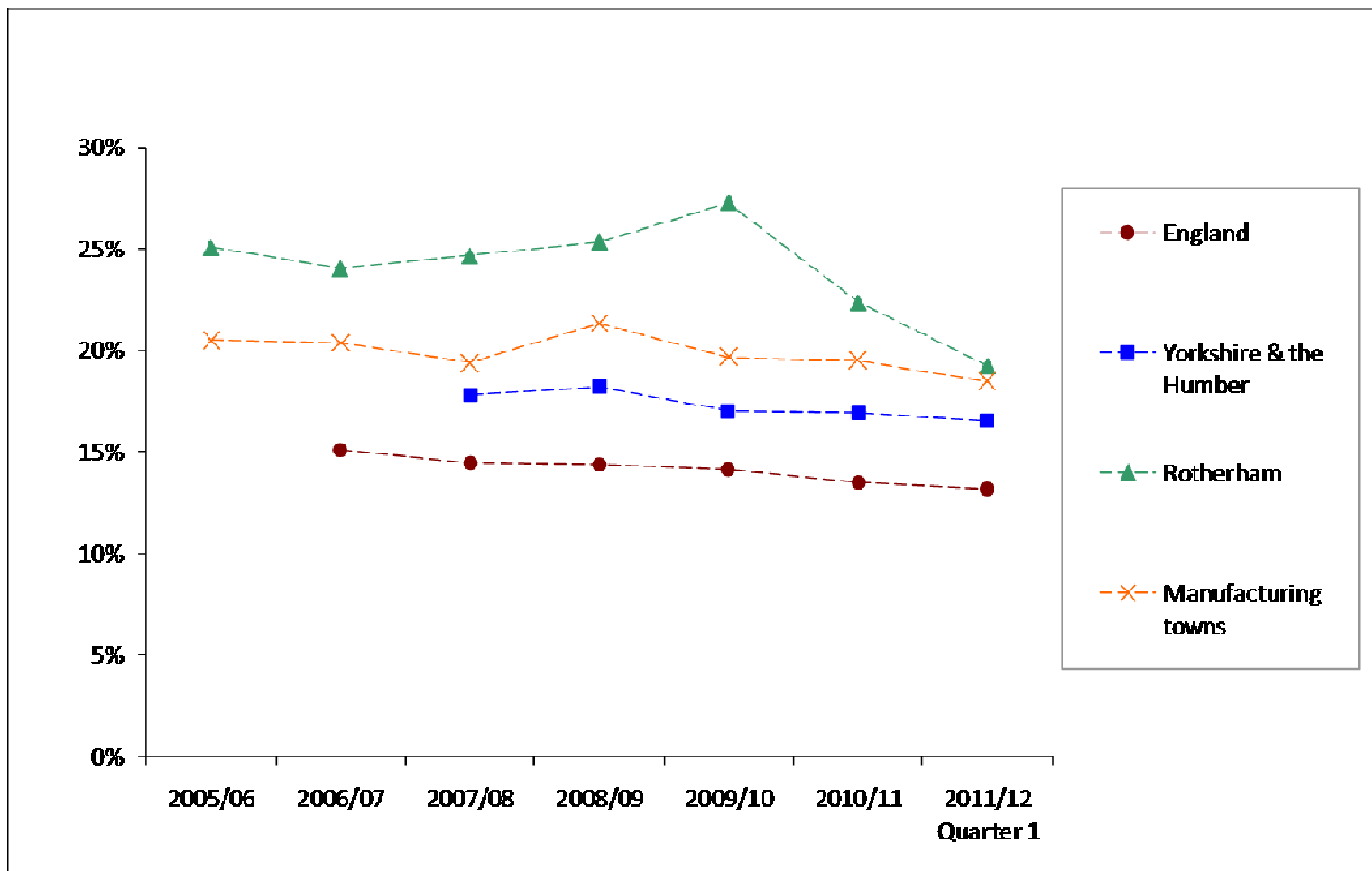


References:

1. Smoking, drinking and drug use among young people in England in 2009. National Centre for Social Research, 2010: NHS Information Centre for Health and Social Care.

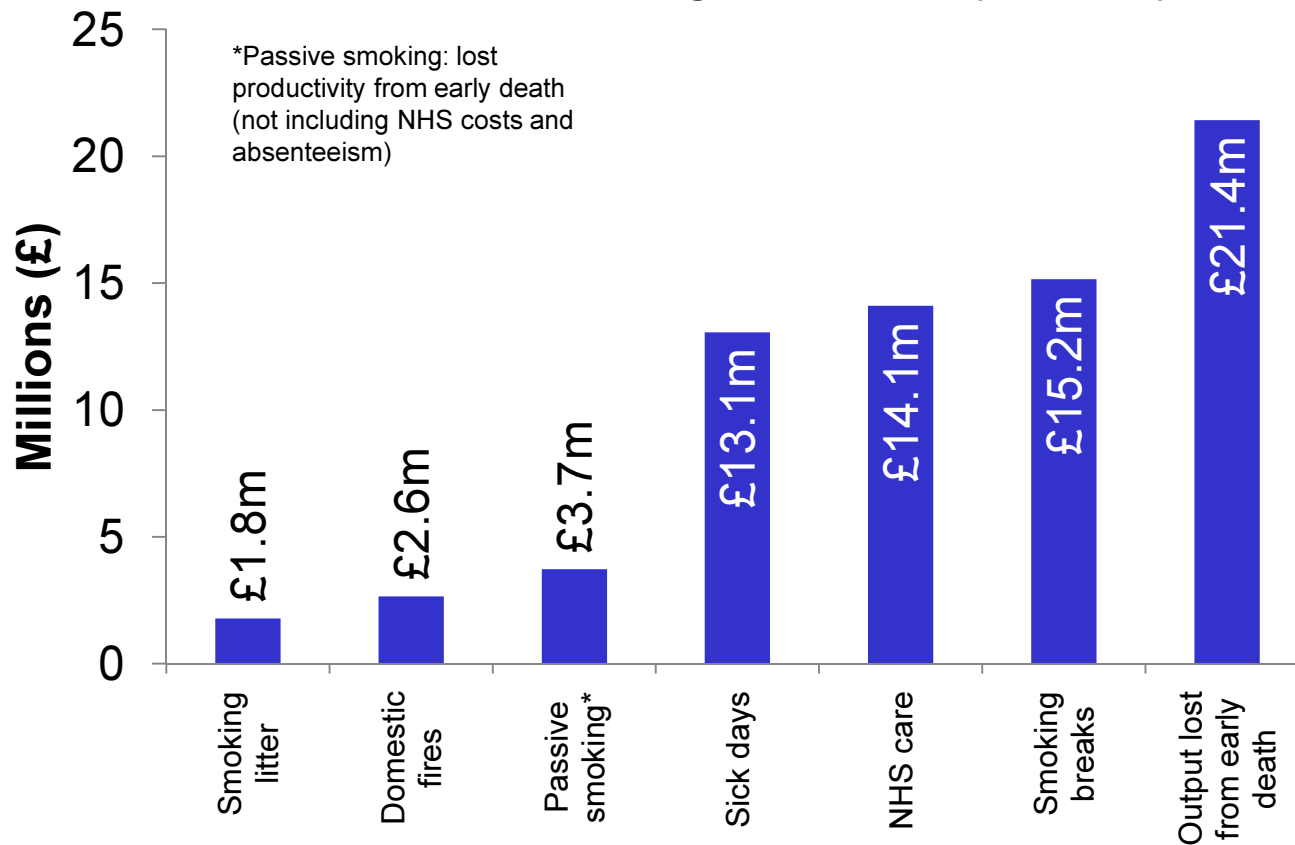
Smoking in pregnancy

Smoking at delivery rates



Smoking costs the local economy millions every year (£71.9m in Rotherham)

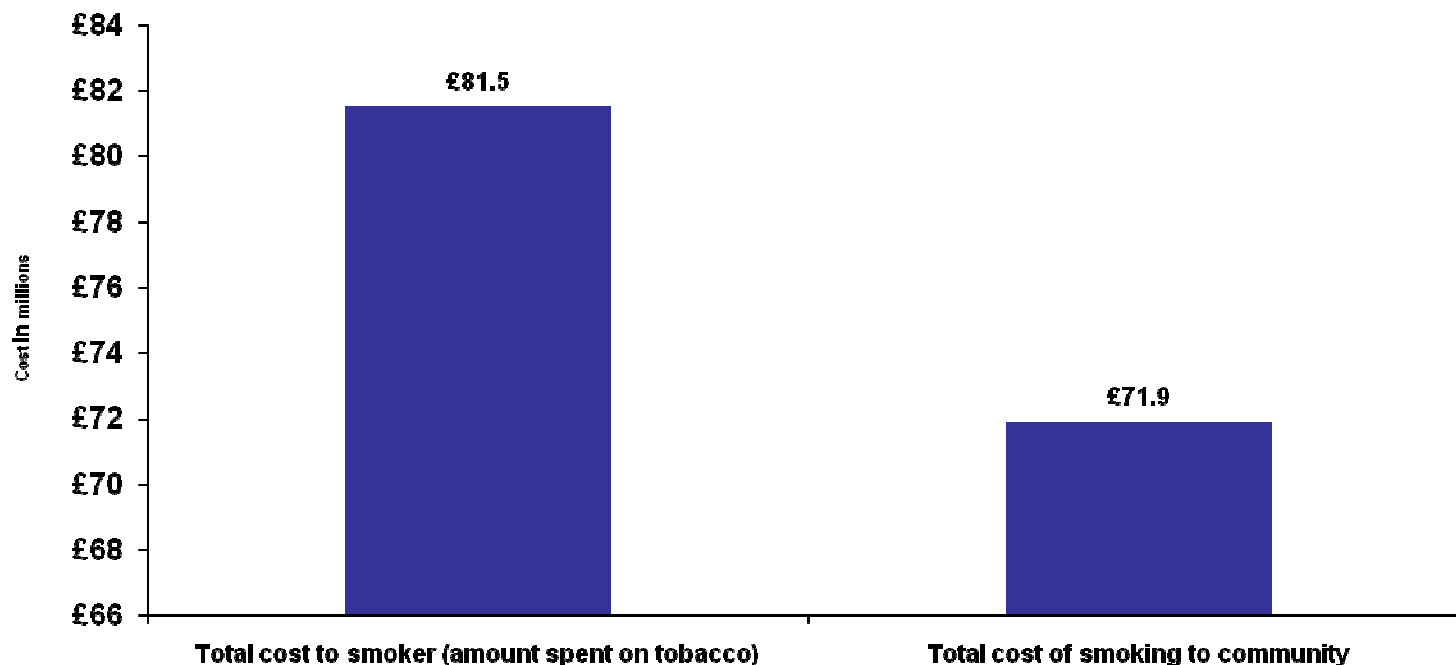
Estimated cost of smoking in Rotherham (£ millions)



References:
1. Cough Up, Policy Exchange, 2010 2. 'Reckoner' spreadsheet

The annual cost of smoking to smokers (compared to additional costs to our community)

Annual estimated costs of smoking to the individual and society



- Each year, smokers in Rotherham spend approx. £81.5m on tobacco products.
- This contributes roughly £62.1m in duty to the Exchequer.
- This means that there is an annual funding shortfall of £9.8m in this area.

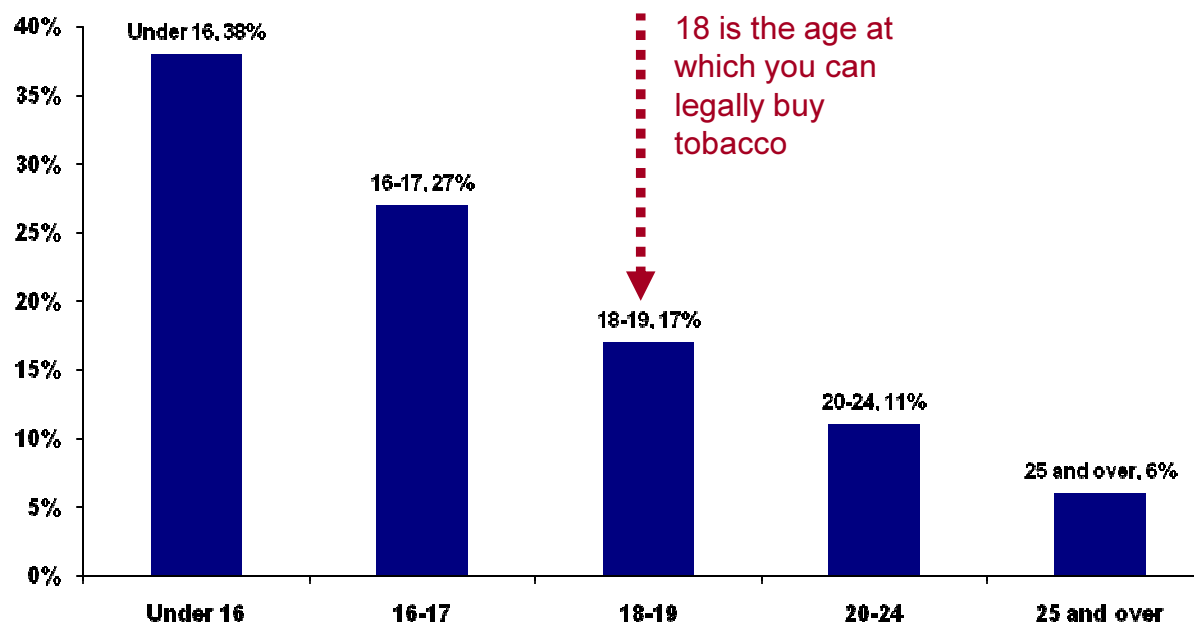
References:

1. Cough Up, Policy Exchange, 2010, 2. HMRC, 3. 'Reckoner' spreadsheet for calculated estimated local costs (ASH, 2011)

2. Smoking attitudes & behaviours

Children not adults start smoking

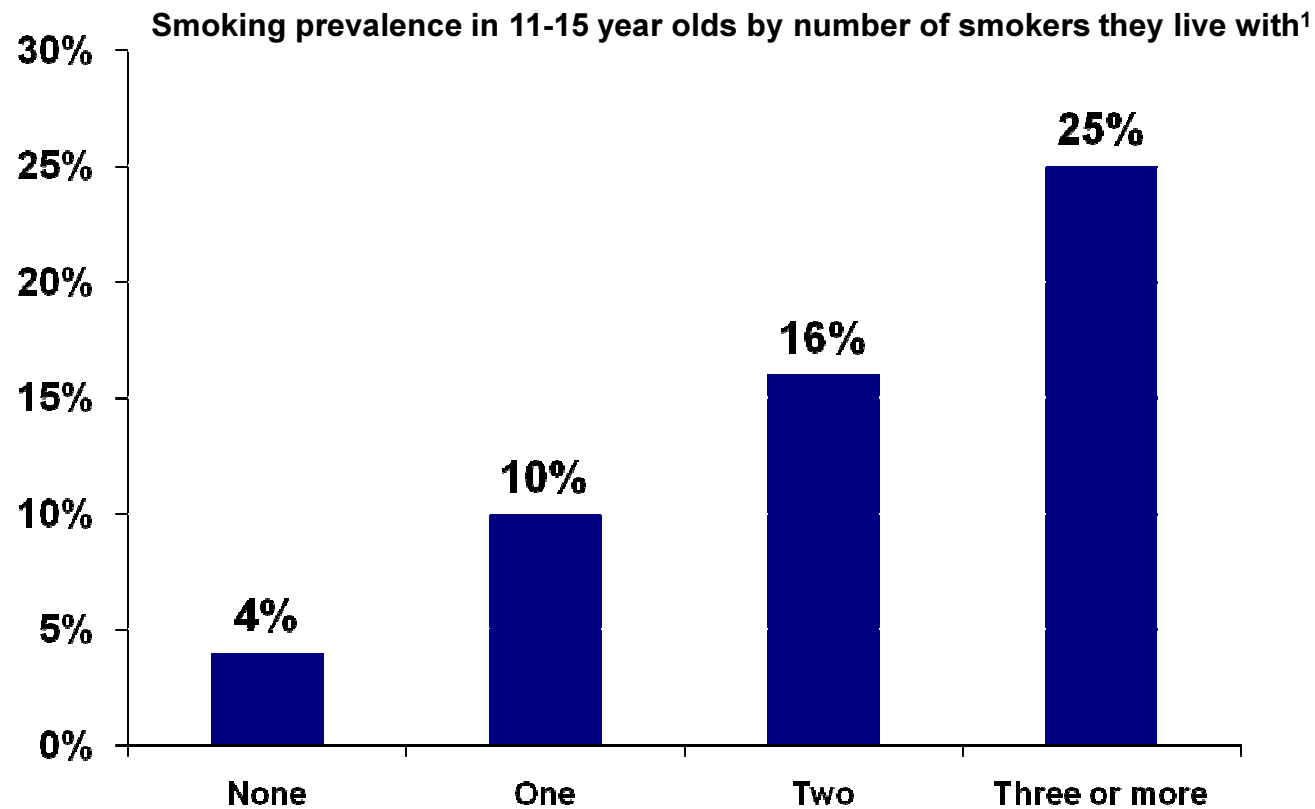
Age smokers start smoking: 90% of smokers started before the age of 19



References:
1. Smoking Attitudes & Behaviours, ONS 2011

Children are three times as likely to start smoking if their parents smoke¹

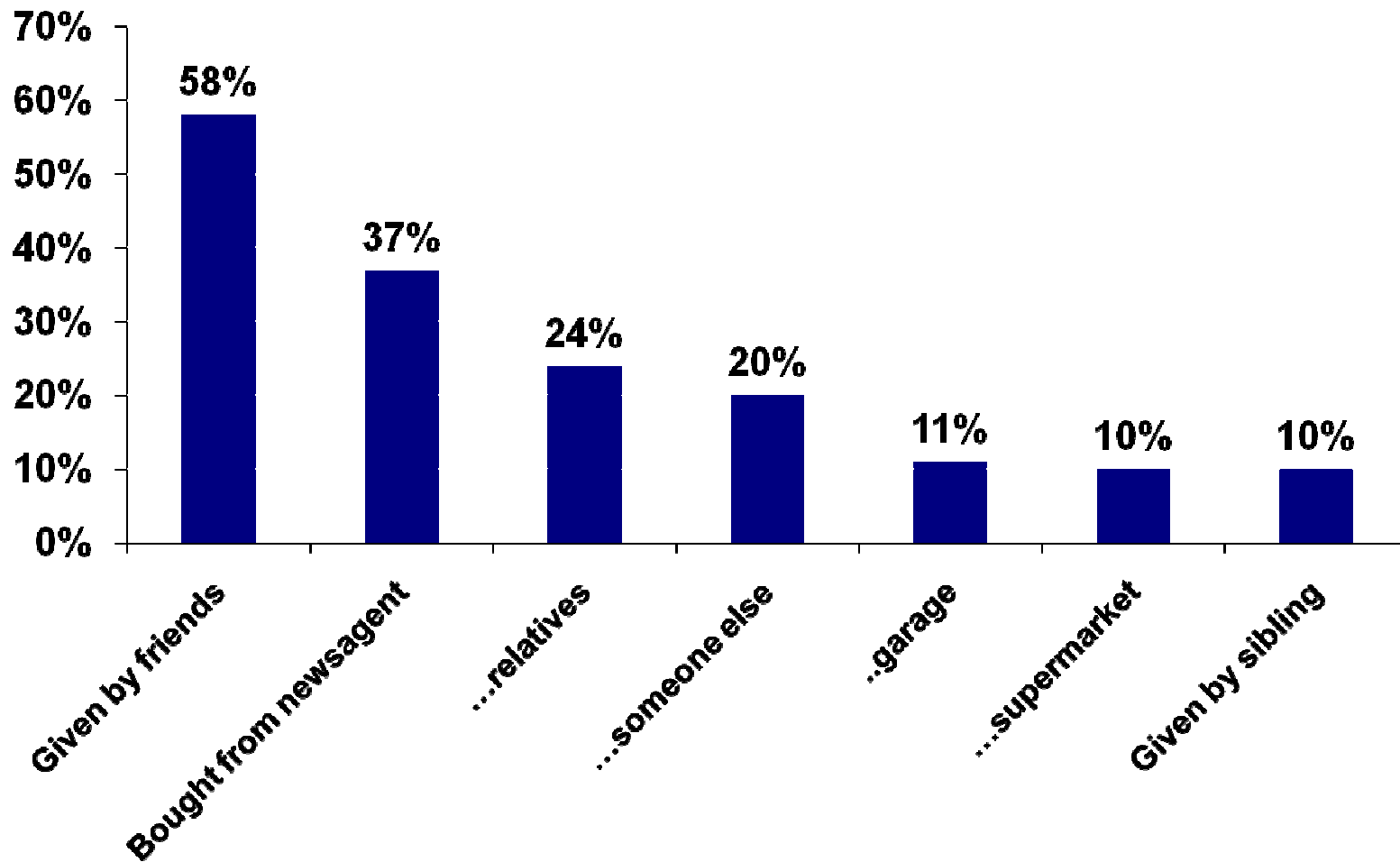
99% of 16 year old regular smokers live in a household with at least one other smoker¹



References:
1. Smoking, drinking and drug use among young people in England in 2010, ONS

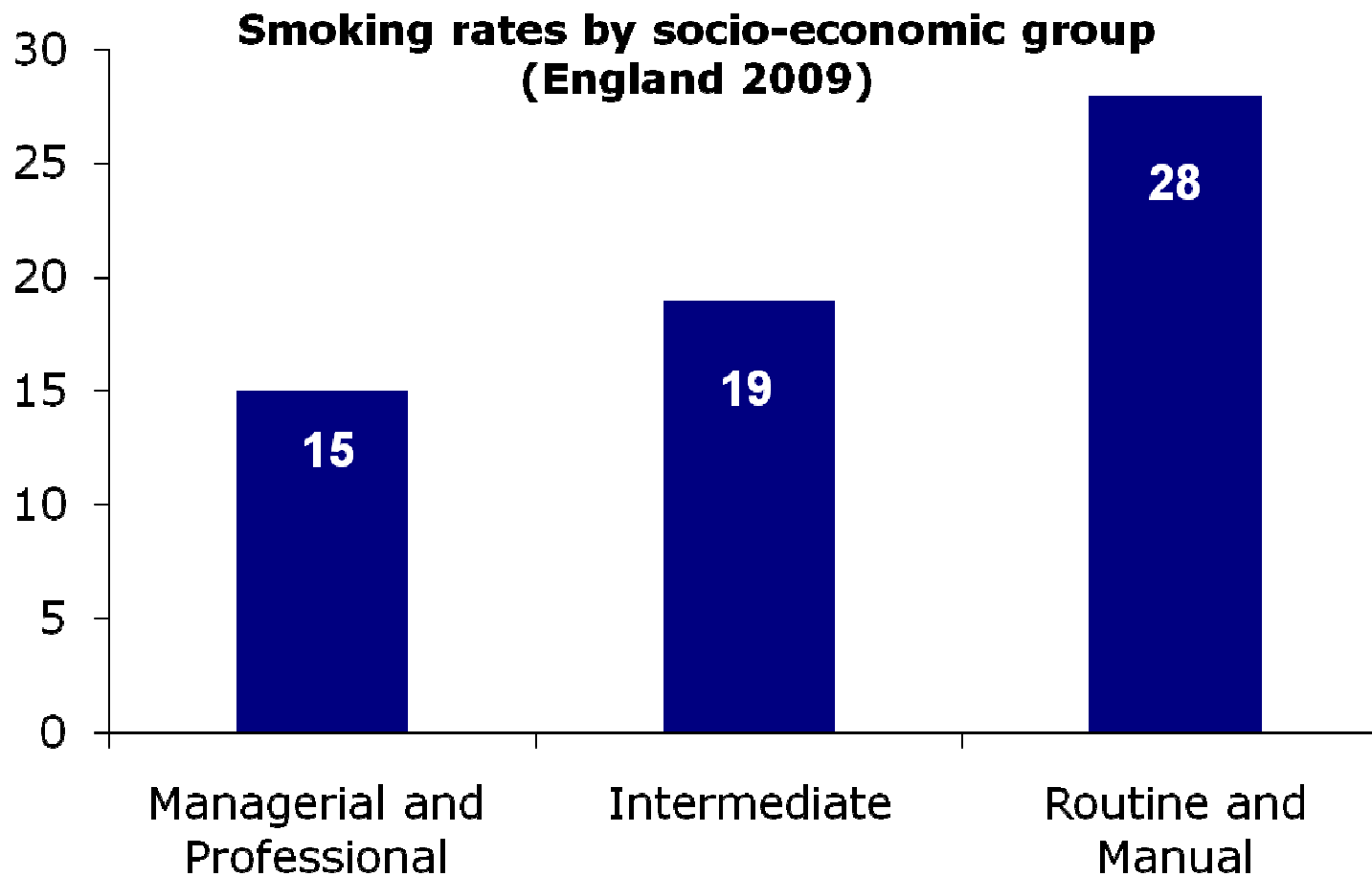
The majority of children who smoke get their cigarettes from a 'friend'

Usual sources of cigarettes for 11-15 year olds in England



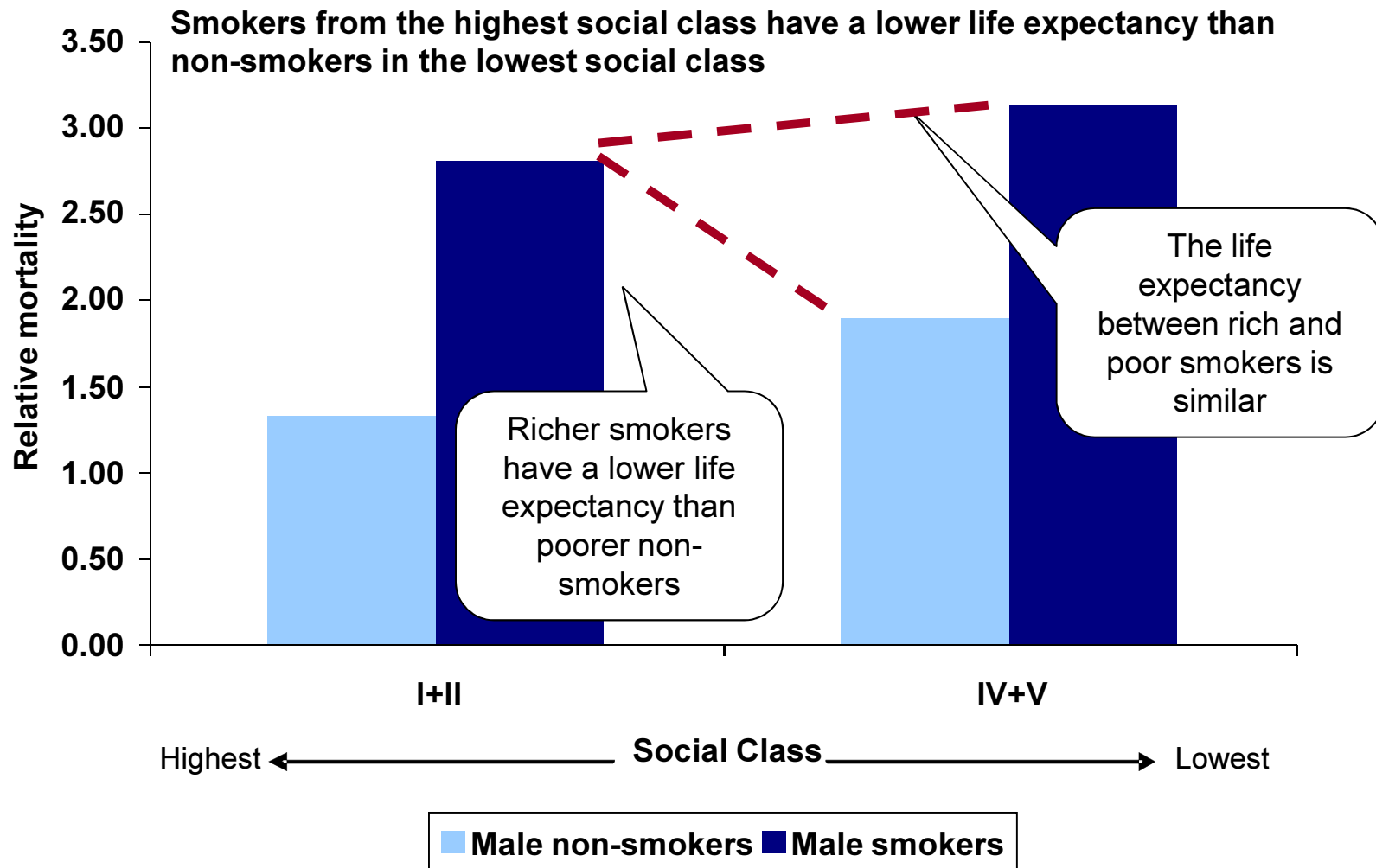
References:
1. Smoking, drinking and drug use among young people in England in 2006

The poorer you are the more likely you are to smoke



References:
1. General Lifestyle Survey, ONS, 2010

Smoking is one of the greatest causes of health inequalities



References:
1. Gruer L et al. BMJ 2009;338;bmj.b480 (Relative mortality assessed at 2nd 14 year follow-up between male smokers & non-smokers of highest & lowest social class)

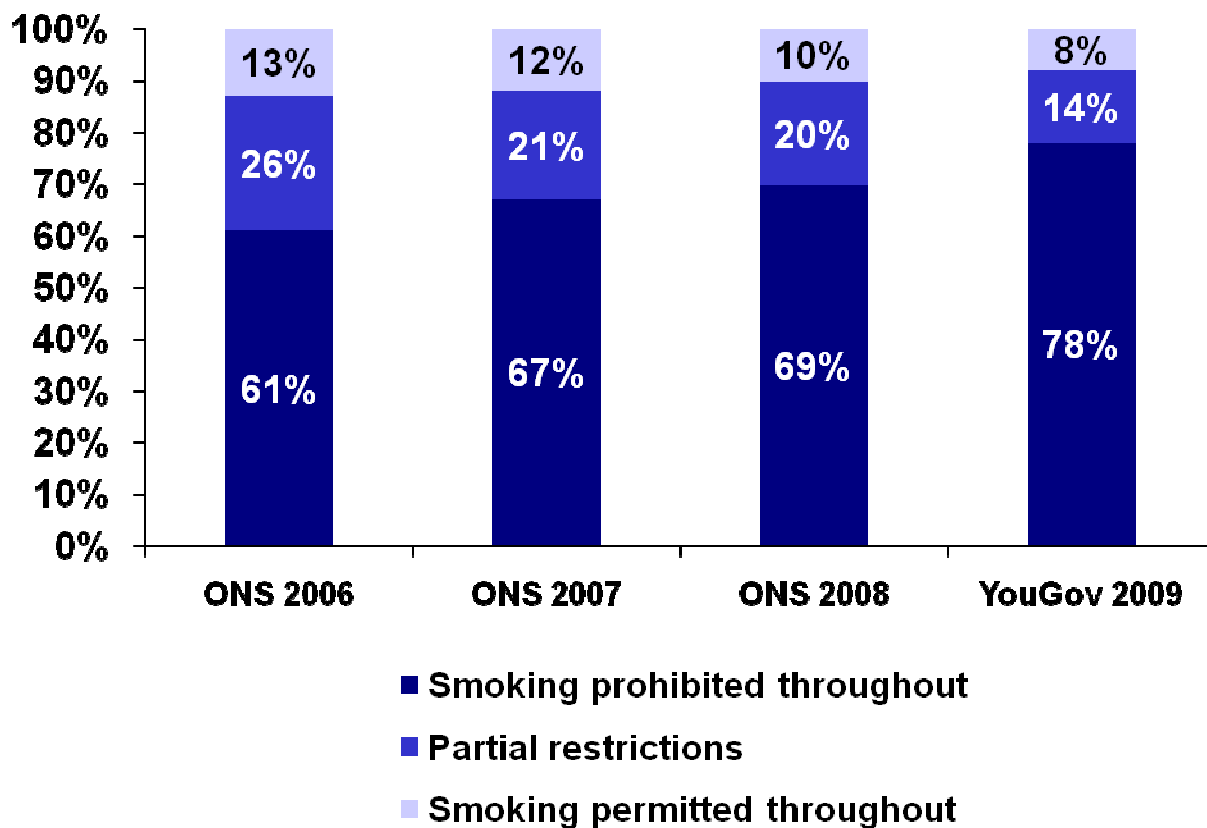
Poorer smokers are as likely to want to quit and try to quit but half as likely to succeed



References:
1. West R, Smoking Toolkit, UCL www.smokinginengland.org

Smokefree environments enjoy increasing public support

Percentage of adults reporting that their homes are smokefree



3. Tobacco control and local authority role

The World Bank has developed a '6 strand' strategy for reducing tobacco use

1. stopping the promotion of tobacco;
2. making tobacco less affordable;
3. effective regulation of tobacco products;
4. helping tobacco users to quit;
5. reducing exposure to secondhand smoke;
and
6. effective communications for tobacco control.

References:

1. World Bank, '6-Strand' Tobacco Control Strategy (found at <http://web.worldbank.org>)

Significant & growing role for Local Authorities

LA responsibilities include enforcement on:




-  Age-of-sale
-  'Smokefree' places
-  Smuggled & counterfeit tobacco
-  Advertising ban

From 2013, Local Authorities will take on responsibility to commission services to motivate & support smokers to quit their habit.

Working together for better health

- 1. Local Government, inc. Police & Fire Brigade**
- 2. Local Health Services**
- 3. Organisations that work across neighbouring localities within a region**
- 4. Employers**
- 5. Voluntary sector organisations**
- 6. Smokers**
(particularly, groups with high rates of smoking
e.g. routine & manual smokers)

Benefits of working across local boundaries

-  Marketing & mass media – to ensure ‘health messages’ are supportive, clear & do not conflict
-  Tackling smuggling – criminal gangs don’t pay heed to local government boundaries
-  Surveys, research & data collection – cost savings can be had from collectively commissioning research & surveys, & sharing the results

Challenges for Rotherham

- Smoking prevalence not declining (although data may not be reliable)
- Smoking in pregnancy is declining, but is still much higher than the national and regional average
- Understanding the apparent increase in young smokers and implementing further programmes to tackle youth smoking
- Cheap and illicit tobacco – continuing availability undermines other tobacco control activity

Key messages

- 1. Local Authorities have a key & important role to play;** the NHS alone cannot reduce smoking rates
- 2. Smoking is the single biggest preventable cause of health inequalities;** reducing rates will bring general improvements in health & cost savings in other areas
- 3. To reduce smoking we need to increase the number of quit attempts & the success of each attempt;** we should target the poorest smokers to narrow the gap in life expectancy between the richest & poorest and *improve the health of the poorest, fastest*

| |
|---|
| ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER |
|---|

| | | |
|----|---------------------|---|
| 1. | Meeting: | Health & Wellbeing Cabinet Member Delegated Powers Meeting |
| 2. | Date: | 10th October 2011 |
| 3. | Title: | Suicide Prevention Strategy |
| 4. | Directorate: | Public Health, NHR |

5. Summary

To update Cabinet Members on the national and local suicide prevention plans and make recommendations as to how to drive this work forward. Suicide is one of the proposed indicators in the Public Health Indicators framework which is out for consultation.

Suicide is a major issue for the whole of society, affecting not only immediate family and friends but the wider society. Nationally the figure for suicide in 2009, including undetermined intent was 4,399.

The figures for Rotherham are in the table below;

**Deaths from Intentional Self Harm and Event of Undetermined Intent*
(ICD-10: X60-X84, Y10-Y34 excl Y33.9)
Rotherham Residents by Gender and Year 2005-2010 (Year of
Registration)**

| Gender | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Males | 23 | 19 | 22 | 21 | 9 | 4 |
| Females | 3 | 2 | 7 | 3 | 3 | 2 |
| Total | 26 | 21 | 29 | 24 | 12 | 6 |

**Rotherham Residents by Gender and Age Group
2005-2010 combined**

| Gender | 0-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-74 | 75-84 | 85+ |
|---------------|-------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|------------|
| Males | 3 | 9 | 9 | 8 | 13 | 14 | 9 | 5 | 10 | 6 | 4 | 3 | 5 |
| Females | 0 | 1 | 0 | 2 | 3 | 0 | 0 | 7 | 0 | 2 | 2 | 3 | 0 |

Most of the people who die by suicide in Rotherham are men, which is a similar trend found nationally.

Rotherham Residents by Age Group - 2005-2010 combined

| Total | 0-19 | 20-29 | 30-39 | 40-49 | 50-59 | 60-69 | 70+ | Total |
|--------------|-------------|--------------|--------------|--------------|--------------|--------------|------------|--------------|
| Deaths | 3 | 19 | 26 | 23 | 22 | 10 | 15 | 118 |
| Percent | 2.5% | 16.1% | 22.0% | 19.5% | 18.6% | 8.5% | 12.7% | 100% |

In terms of the most common age group in England this is spread across the age groups of 20-64 (peaking at ages 35-49) and similar for Rotherham, although based on small numbers it is difficult to judge as the peak group can vary year to year.

The reduction in suicide since 2008 may be explained by the multi partnership public health work which is about building emotional resilience and supporting vulnerable and at risk people. These public health interventions include:

- Mental Health First Aid Training for Adults and Young People which has targeted a variety of frontline workers including Job Centre Plus, Housing, Health, Social Care, Voluntary sector projects, BME Community Leaders and Projects, Fire Service, Connexions
- Mental Health in the Workplace Project ('Mind Your Own Business') including training for managers to identify and support employees with poor mental health
- Public Health work of the Rotherham Primary Care Mental Health Service- for example Stress Control Classes
- Rotherham Occupational Health Advice Service- retaining people in work, improving employability/rehabilitation, improving health and wellbeing and maximising people's income
- Directory of mental health services
- Domestic Abuse Training for frontline workers to identify high risk victims
- Multi Agency Risk Assessment Conferences for high risk victims of domestic abuse
- Prevention work at Suicide Hotspot

There is strong evidence to support the continuation of this public health work. Suicide prevention is most effective when it is combined as wider work addressing the social and other determinants of poor health and wellbeing.

In addition Rotherham's Mental Health provider RDaSH conducts internal reviews when there is a suicide and the person is in contact with their service and looks at lessons that can be learnt. RDaSH assess their buildings in relation to their clients for the purposes of reducing risk.

GP Practices are informed by NHSR of a suicide and then conduct their own internal review to look at lessons which can be learnt.

Hanging accounted for 9 (89%) of Rotherham suicides in the period from July 2008 - 2009 and 1 (11%) suicide via Suffocation. 50% of the suicides took place in the deceased's own home. The other suicides were predominantly in homes known to

the individual or wooded areas. The majority of people who take their own life are not in contact with mental health services. This is why more is needed than a single approach to suicide prevention.

Responsibility

In the consultation document, *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health*, it was suggested that suicide prevention public health activities should be the responsibility of Local Authorities working with and being supported by Health and Well-being Boards.

The Department of Health is currently consulting on its new suicide prevention strategy for England to reduce the suicide rate and improve support for those affected by suicide. The document brings together knowledge about groups at higher risk of suicide, effective interventions and resources available. Consultation responses will inform the final strategy due to be published early in 2012. NHSR is keen for there to be a local response to this prevention strategy and has forwarded it to partner organisations

6. Recommendations

These are some of the recommendations for action at a local level:

- **Suicide prevention requires a multi agency approach and the Government has stated that much of the planning and work to prevent suicides will be carried out locally. This could be carried out via a Suicide Prevention Group.**
- **Assessment against and implementation of the National Institute of Health and Clinical Excellence clinical guidelines on the long term management of self harm in the NHS due November 2011.**

7. Proposals and Details

All Primary Care Trusts have a responsibility to carry out suicide audits. In Rotherham there are systems in place so that the Clinical Audit Team within NHS Rotherham is informed of a suspicious death by the Coroner's Office as soon as possible. The Clinical Audit Team then work with the GP Practice Managers to complete a nationally agreed dataset. The dataset is designed to provide background information for district level analysis of suicide trends. NHS Rotherham Clinical Audit staff will also liaise with mental health services in Rotherham to establish whether the person has been accessing services. Rotherham, Doncaster and South Humber Mental Health Trust conduct their own audit.

In light of the consultation about the current HM Government suicide prevention strategy, it is proposed we establish a suicide prevention group. This group would use local data from the suicide audit and from the Office of National Statistics to develop an action plan. Actions would include:

- Local scoping against the national strategy
- Reducing the risk amongst high risk groups
- Reduce access to means of suicide
- Taking action at any hotspots
- Providing better support to people bereaved by suicide
- Equip frontline staff to identify risk and manage risk in people who are suicidal for example Mental Health First Aid Training
- Looking at developing programmes which build the mental health resilience of individuals and communities

It is envisaged that the suicide audit results are discussed and interpreted at the prevention group in order to inform our local suicide prevention strategy.

With the introduction of the suicide prevention group the findings of the audit should be freely available to stakeholders thereby creating a more systematic approach to considering the suicide audit. Responses to the audit findings can then be discussed and actioned by partners.

8. **Finance**

Suicide is both a tragedy at an individual level but it is also a loss to society. It affects other people either directly or indirectly and can have devastating consequences economically and psychologically for those affected.

Years of life lost (YLL) is a measure of premature mortality. The concept of years of life lost is to estimate the length of time a person would have lived had they not died prematurely. By inherently including the age at which the death occurs, rather than just the fact of its occurrence, the calculation is an attempt to better quantify the burden, or impact, on society from the specified cause of mortality. Suicide represents a significant number of YLL, for example if someone dies at the age of thirty there is a considerable loss in the number of years regarding their economic and social contribution to society.

Suicide has a significant impact on family members and friends who will need to practical and emotional support to promote recovery and prevent long term emotional distress.

9. **Risks and Uncertainties**

Progress has been made in reducing the number of suicide rates nationally and locally but this is not a time for complacency. At this time of economic pressures on the general population we need to ensure that locally we are monitoring, reviewing and taking action to prevent an increase in suicide.

There is no single approach to suicide what is required is a coordinated approach across many partners organisations and sectors. With any cost analysis at a local level, it is difficult to ascertain the actual impact on resources. However, by promoting actions like supporting vulnerable people, increasing individual and community emotional resilience and equipping frontline workers to identify and

manage risk we can hopefully intervene before people get to a crisis point. There is strong evidence to support the continuation and strengthening of these public health interventions. The cost of interventions to support frontline staff and raise awareness is a relatively low cost.

10. **Policy and Performance Agenda Implications**

Draft PH Outcomes Paper
NICE Guidelines

11. **Background Papers and Consultation**

HM (2011) Consultation on preventing suicide in England

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128463.pdf

DH (2011) No Health without Mental Health

<http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm>

Officers:

Kate Tufnell- Head of Contracts & Service Improvement - Mental Health, Learning Disabilities & Specialised Services, NHSR

Ruth Fletcher-Brown- Public Health Specialist, NHSR

Have your say... help to shape the future of your local ambulance service

Yorkshire Ambulance Service is looking to apply for foundation trust status in 2012.

They have developed plans for how they would like to take the new organisation forward in the future. However, they want to be sure that you as a resident and colleague have a say in what they are proposing.

Between now and 4 December 2011 everyone across Yorkshire is invited to share their views about the plans, and help to shape the way that ambulance services are provided in the future.

They are also starting to recruit 'members' to the new organisation - who will be made up of staff and public across Yorkshire. Members will help to influence decisions that are made and ensure that they really benefit our local communities.

Have Your Say –join in the consultation and share your views.

Click on the link below, or visit the ambulance trust's website for more information about their future plans and how to become a member:
www.yas.nhs/ourfutureplans



Looking to the future

Our plans to become an NHS Foundation Trust





Yorkshire Ambulance Service **NHS**
NHS Trust

An Aspirant Foundation Trust

Looking to the future

Our plans to become an NHS Foundation Trust

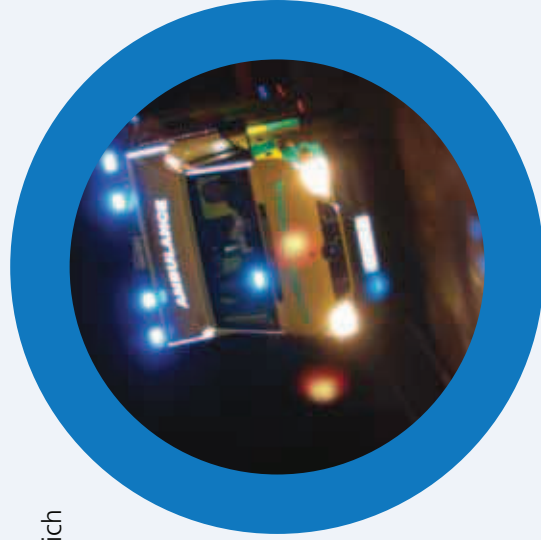


Summary consultation document

Our Services

Yorkshire Ambulance Service provides 24-hour emergency and healthcare services to more than five million people across Yorkshire, including:

- An accident and emergency ambulance service which responds to 999 calls. This includes our communications centre in Wakefield and York where staff arrange the most appropriate response to meet patients' needs, and our ambulance staff who go out to patients and provide immediate clinical care.
- A non-emergency patient transport service which takes patients who are eligible for the service to and from their hospital appointments.
- A private and events service which includes medical cover for football matches, race meetings, concerts, festivals and so on. We also provide ambulance transport for private hospitals, corporations and individuals.
- A GP out-of-hours service which handles calls to some primary care trusts across Yorkshire and beyond.
- Commercial first-aid training services in our local community, approved by the Health and Safety Executive.



Have Your Say...

We are looking to become an NHS foundation trust next year, which will bring with it several significant benefits.

We have developed plans for how we would like to take the new organisation forward in the future. However, we want to be sure that you have a say in what we are proposing.

Between now and 4 December 2011 we will be inviting everyone across Yorkshire to share their views about our plans, so that you can help shape the way that ambulance services are provided in the future.

We will also be starting to recruit 'members' who will be made up of staff, patients and public across Yorkshire, to help influence our decisions and make sure that they really benefit our local communities.

Have Your Say - visit our website for more information about our future plans and how to become a member: www.yas.nhs/ourfutureplans

What are foundation trusts?

NHS foundation trusts are membership organisations that are free from central government control. This means that we will have a lot more freedom to shape the way that we provide and develop services for our patients.

If foundation trusts make a profit from providing services they can invest this money back into their organisation. As a foundation trust we would also have more freedom to borrow money to fund projects to benefit our patients.

Like all other NHS organisations, NHS foundation trusts are still inspected each year by the Care Quality Commission to ensure that they are achieving national targets and standards. They are also controlled by an independent regulator called Monitor to ensure that the public's interest is protected.

Our plans and priorities for the future

We have identified the following plans and priorities as ways in which we can continue to improve our services:

Proposed public constituencies



111 number

People who call 999 sometimes don't need an emergency ambulance, but they don't know how else to get the help that they need. This is why we are planning to support a different option – a 111 number for calls that are less urgent than 999 calls, which would be introduced in 2013.



Major trauma

Major trauma is a serious or life-threatening physical injury which often happens after an accident. We are committed to working with all our partner NHS organisations to improve the ways that we identify major trauma as quickly as possible, increase our expert emergency clinical response, and make best use of major trauma centres.



Improving clinical outcomes

Over the next five years we are also going to be looking at how we can improve the lives of our patients who have had a stroke, a cardiac arrest or an ST elevation myocardial infarction, which is a type of heart attack.



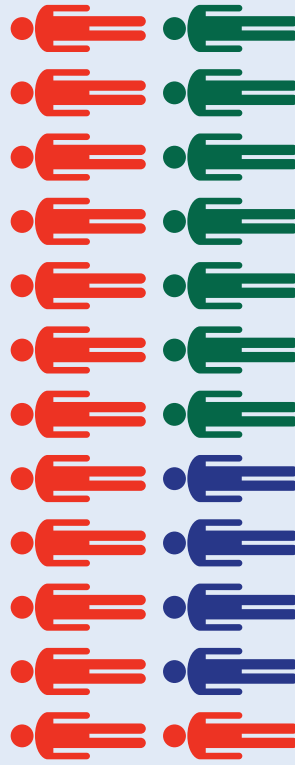
What will our members do?

Everyone who lives in the Yorkshire area and is over the age of 16 will be able to become a member or governor. Membership is free.

Our members will work with us to represent the views of their local communities or groups, and tell us about their needs. They will be represented by a Council of Governors (most governors will be elected and a few will be appointed) which will work with the Yorkshire Ambulance Service Board of Directors to influence how we develop and provide services in the future.

We understand that some people will want to be more involved than others and our membership scheme will allow you to do this.

Council of Governors



- **Thirteen public governors**
- **Four staff governors - three front-line/one support staff**
- **Seven appointed governors**

View the full consultation document online at:
www.yas.nhs.uk/ourfutureplans

Questions we would like you to consider

Do you support our plans for the future? Yes No

Comments:

Do you agree with the minimum age of 16 for membership? Yes No

Comments:

Do you agree that the minimum age of governors should be 16? Yes No

Comments:

Do you agree with the proposed public constituencies? Yes No

Comments:

Do you agree with the split between front-line and support staff? Yes No

Comments:

Do you agree with our proposals for how the Council of Governors will be made up? Yes No

Comments:

How do you think we should encourage people to become members and governors?

Comments:

Do you have any other comments? Yes No

Comments:

Your chance to become a member

I would like to become a member of the Trust.

Title: _____ First name: _____

Surname: _____

Address: _____

Postcode: _____ Date of birth: / /

Email _____

Home phone: _____

Mobile: _____

This information will remain confidential and will be held in accordance with the Data Protection Act (1998).

Thank you for applying to become a member of our Trust. We look forward to working with you in the future.

Your signature: _____ Date: _____

Detach this page and return in an envelope (no stamp needed) to:

Foundation Trust Consultation
FREEPOST XXXXXX
Yorkshire Ambulance Service NHS Trust
Springhill 2, Brindley Way
Wakefield 41 Business Park
Wakefield, West Yorkshire
WF2 0XQ

Alternatively, you can register your interest online at:
www.yas.nhs.uk/ourfutureplans and then go to the 'Get Involved' section.



**GENERAL DENTAL COUNCIL
PROFESSIONAL CONDUCT COMMITTEE**

June 2011

SIDDIQUI, Mohammed Shahid

Registration No: 73039

Mohammed Shahid Siddiqui registered as of 6 Reaper Crescent, High Green, SHEFFIELD, S35 3FH, BDS Birm 1997, was summoned to appear before the Professional Conduct Committee on the 13 June 2011 for inquiry into the following charge:

“That, being a registered dentist:

1. At all material times you practised as a dentist at Dalton Dental Care, 5 Rotherham Road, Dalton, Rotherham, S65 3ET.
2. You were the treating dentist for the patients as set out below and identified in Schedule A.
3. Your standard of care and treatment for the following patients fell far below that reasonably to be expected of a competent dental practitioner, in the following regards:

4. **Patient DJ**

Prescribing

- (a) You prescribed antibiotics on:
 - (i) 30th June 2003, for an abscess to LL4;
 - (ii) 10th February and 14th February 2004, for an abscess to UR2.
- (b) You failed to record:
 - (i) what steps, if any, you took to establish drainage of the abscesses;
 - (ii) your rationale for prescribing antibiotics.
- (c) Your prescriptions were inappropriate.

Radiographs

- (d) You failed to take any or any adequate pre-operative radiograph of LL4 prior to the provision of endodontic treatment on 4th July 2003.
- (e) You failed to take either an intra-operative or post-operative radiograph of UR2 in connection with the provision of endodontic treatment on 1st March 2004.

- (f) You failed to take any or any adequate radiographs prior to the crown preparation for:
 - (i) UL2, UR1, and UR2 on 1st October 2003;
 - (ii) UL4 on 1st March 2004;
 - (iii) UL3, and UR3 on 25th August 2005;
 - (iv) LL3 on 27th July 2006.

Periodontal Assessment and Treatment

- (g) A Basic Periodontal Examination (“BPE”) carried out on 30th June 2003, showed significant pocketing in all sextants.
- (h) You knew, or should have known, that the patient’s periodontal condition contra-indicated the provision of crown work subsequently carried out by you.
- (i) You failed to record adequately or at all, any information or advice given to DJ about her periodontal condition prior to 19th September 2007.

5. **Patient MR**

Prescribing

- (a) You prescribed antibiotics on:
 - (i) 14th May 2004, for an abscess at UL quadrant;
 - (ii) 10th November 2004, for an abscess at UL quadrant;
 - (iii) 23rd May 2005, for an abscess at UL4;
 - (iv) 7th April 2006, for a periodontal abscess.
- (b) You failed to record:
 - (i) what steps, if any, you took to establish drainage of the abscesses;
 - (ii) your rationale for prescribing antibiotics;
 - (iii) the location of the abscess diagnosed on 7th April 2006.
- (c) Your prescriptions were inappropriate.

Radiographs

- (d) You failed to provide a written justification for or report on radiographs taken on 8th January 2008.

Periodontal Assessment and Treatment

- (e) You knew, or should have known from a BPE carried out on 28th November 2002, that patient MR had advanced periodontal disease.
- (f) You failed to:
 - (i) provide patient MR with any or any sufficient information or advice, or record that appropriate advice had been given to the patient about his condition, prior to 5th September 2007;
 - (ii) adopt a planned approach to treatment of the patient's periodontal problems;
 - (iii) identify and provide prompt treatment for lesions apparent at:
 - (a) UL4 on 28th November 2002;
 - (b) UL5 on 23rd May 2005;
 - (c) UR5 on 8th January 2008.

6. **Patient SP**

Prescribing

- (a) You failed to record your rationale for prescribing Amoxicillin 500mg on 20th September 2007.
- (b) You inappropriately prescribed Amoxicillin on 20th and 28th September 2007.

Radiographs

- (c) You failed to take radiographs prior to fitting crowns at:
 - (i) LL6 on 2nd April 2003;
 - (ii) LR5 and LL6 on 5th March 2004.
- (d) You failed to take either intra-operative or post-operative radiographs in connection with the provision of endodontic treatment to:
 - (i) UR6 on 16th February 2004;

- (ii) UL3 on 12th March 2004.
- (e) You failed to provide a written justification for or report on radiographs taken on 29th September 2007.

Treatment

- (f) Between 24th March 2003 and 2nd April 2003, you failed to provide restorations to cavities present at UR7 and LR4.
- (g) You failed to record your justification for not providing restorations to UR7 and LR4 on 2nd April 2003.
- (h) You failed to provide appropriate management and treatment for UL3 in that:
 - (i) between 5th March 2004 and 4th October 2006, you provided repeated restorations to UL3;
 - (ii) on 7th September 2006, you placed a Porcelain Jacket Crown (PJC) on UL3;
 - (iii) you knew or should have known that a PJC was inappropriate treatment for UL3 in circumstances in which that tooth was:
 - (a) root-filled;
 - (b) had very little clinical crown;
 - (c) had no post;

and where no radiograph had been taken since 12 March 2004.

- (i) Between 19th October 2004 and 13th September 2007 you failed to diagnose and/or appropriately treat a cavity involving the pulp in the LR7, either by endodontic treatment or extraction.
- (j) You failed to diagnose a lesion at UL2 on 13th September 2007.
- (k) On 20th September 2007, you extracted UL2 and UR1.
- (l) You failed to add UL2 and UR1 to an existing upper denture.
- (m) You failed to advise SP of the temporary nature of the glass ionomer restoration placed at UR7 on 22nd May 2008;

7. **Patient HS**

Prescribing

- (a) On 12th October 2006, you inappropriately prescribed Amoxicillin 500mg and Ibuprofen 600mg.
- (b) You failed to record your rationale for prescribing antibiotics and analgesics on 12th October 2006.
- (c) On 20th November 2007, you diagnosed a suspected abscess at UL3 and prescribed Amoxicillin 500mg.
- (d) You failed to record:
 - (i) what steps, if any, you took to establish drainage of the suspected abscess;
 - (ii) your rationale for prescribing antibiotics.
- (e) Your prescription on 20th November 2007 was inappropriate.
- (f) You failed to provide any follow-up to your diagnosis and prescription on 20th November 2007.

Periodontal Assessment and Treatment

- (g) You knew or should have known from a BPE carried out on 3rd October 2006, that HS had periodontal disease.
- (h) Between 3rd October 2006 and 19th September 2007, you failed to:
 - (i) provide HS with any or any sufficient information or advice, or
 - (ii) record that appropriate advice had been given to the patient about her condition;
 - (iii) treat HS' periodontal condition.

8. **Patient JR**

Prescribing

- (a) On 19th May 2008 you diagnosed an abscess at LR5 and prescribed Amoxicillin 500mg.
- (b) You failed to record what steps, if any, you took to:

- (i) establish drainage of the abscess; or
 - (ii) extract LR5.
- (c) You failed to record your rationale for prescribing antibiotics.
- (d) Your prescription was inappropriate.

Radiographs

- (e) You failed to take any intra-operative or post-operative radiographs in connection with endodontic treatment provided to UL5 on 11th July 2003.

Treatment

- (f) Between 11th July 2003 and 3rd April 2008, your treatment of UL5 was inadequate in that:
- (i) the root filling placed on 11th July 2003 fell short of the apex;
 - (ii) you failed on repeated occasions between 11th July 2003 and 3rd April 2008 to:
 - (a) identify the inadequacy of the restoration of UL5;
 - (b) provide appropriate management and treatment of UL5.
- (g) On 3rd September 2007, you failed to provide treatment that you knew or should have known was required to LR5.
- (h) On 13th October 2007, you placed an inadequate restoration to LR5.
- (i) You failed to identify the inadequacy of the restoration to LR5 at an examination on 3rd April 2008.
- (j) On 14th May 2008, you carried out, or attempted to carry out endodontic treatment to LR5. Your treatment was inadequate in that you:
- (i) failed to properly root-fill the canal;
 - (ii) dressed the tooth with ledermix;
 - (iii) failed to arrange for further treatment to the tooth.

9. **Patient NH**

Prescribing

- (a) On 23rd April 2004, you diagnosed a periodontal abscess and prescribed Amoxicillin 250mg.

- (b) You failed to record:
 - (i) the location of the abscess;
 - (ii) your rationale for prescribing antibiotics.
- (c) On 31st May 2006, 7th February 2007, 4th September 2007, and 8th November 2007, you diagnosed an abscess at UL6 and prescribed 500mg Amoxicillin.
- (d) You failed to:
 - (i) investigate, properly or at all, the cause of the abscesses;
 - (ii) provide appropriate treatment;
 - (iii) record your rationale for prescribing antibiotics.
- (e) On 31st October 2006, you diagnosed an abscess at UL4 and prescribed 500mg Amoxicillin.
- (f) You failed to record:
 - (i) what steps, if any, you took to establish drainage of the abscess;
 - (ii) your rationale for treating with antibiotics.
- (g) Your prescription on 31st October 2006 was inappropriate.
- (h) You failed to provide a follow-up appointment.

Periodontal assessment and treatment

- (i) Between 23rd April 2004 and 11th September 2007, you failed to provide NH with any or any sufficient information or advice, or record that such information and advice had been given to the patient about his periodontal condition.

Treatment

- (j) Between 6th May 2004 and 15th September 2006, you failed to provide restorations to cavities at UR4 and UL4.
- (k) The restoration placed by you at UL4 on 15th September 2006 was inadequate.
- (l) On 13th February 2007, you took a radiograph of UL6 and UL4.
- (m) You knew, or should have known that the radiograph showed:
 - (i) considerable bone loss at UL6;

- (ii) an inadequate filling at UL4.
- (n) You failed to plan or provide appropriate treatment for either UL6 or UL4.
- (o) On 29th May 2008, you fitted a crown at UL4.
- (p) Prior to fitting the crown you failed to:
 - (i) take a pre-operative radiograph;
 - (ii) assess the condition of the apex.

10. **Patient GN**

Prescribing

- (a) On 10th August 2006, you prescribed Amoxicillin 500mg following endodontic treatment.
- (b) You failed to record your rationale for prescribing antibiotics.
- (c) On 15th October 2007, you extracted UL5 and prescribed Amoxicillin 500mg "*if abscess occurs*";
- (d) Your prescription on 15th October 2007 was inappropriate;

Radiographs

- (e) You failed to take any intra-operative or post-operative radiographs in connection with the provision of endodontic treatment to UL5 on 10th August 2006.
- (f) You failed to take a radiograph prior to preparing and fitting a crown to UL5 on 30th August 2007.

Periodontal assessment and treatment

- (g) Between 18th February 2004 and 12th July 2007, you failed to provide GN with any or any sufficient information or advice about his periodontal condition, or record that such information and advice had been given.

Treatment

- (h) On 8th December 2005, you took a radiograph of the UL quadrant which showed a lesion below the crown at UL5.
- (i) You failed to treat UL5 until 10th August 2006.

- (j) You failed to record your justification for not providing a restoration to UL5 prior to 10th August 2006.

11. **Patient PC**

Radiographs

- (a) You failed to take a radiograph prior to preparing UR6 for a crown on 3rd October 2007.

Treatment

- (b) You failed to take any or any adequate steps to ascertain the cause of sensitivity to UR6 prior to preparing the tooth for a crown on 3rd October 2007.
- (c) On 15th October 2007, having failed to complete endodontic treatment to UR6, you:
 - (i) placed a ledermix dressing and amalgam restoration;
 - (ii) failed to:
 - (a) make any further attempt to root fill the tooth;
 - (b) offer to make a referral;
 - (c) advise the patient that the tooth would require extraction.

12. **Patient SJ**

Prescribing

- (a) On 9th May 2007, you diagnosed an abscess at LL5 and prescribed Amoxicillin 500mg.
- (b) You failed to:
 - (i) investigate properly or at all the cause of the abscess;
 - (ii) record what steps, if any, you took to establish drainage of the abscess;
 - (iii) record your rationale for prescribing antibiotics;
 - (iv) arrange a follow-up appointment.
- (c) on 12th September 2007, you diagnosed an abscess at LL4 and LL5 and prescribed Amoxicillin 500mg.

- (d) You failed to:
 - (i) record your rationale for prescribing antibiotics;
 - (ii) arrange a follow-up appointment.

Radiographs

- (e) You failed to take a radiograph prior to preparing LR6 for a crown on 9th February 2004.
- (f) You failed to provide a written justification and report upon radiographs taken on 18th September 2007 and 24th September 2007.

Treatment

- (g) On 24th July 2003, you placed a restoration at UR5 which you knew or should have known was clinically inadequate.
- (h) You failed to make arrangements to correct the restoration at UR5.
- (i) You failed to provide either “bite” or “try-in” appointments for dentures fitted on 1st June 2006 and 26th July 2006.
- (j) On 14th July 2007 you placed inadequate restorations at LL4 and LL7.
- (k) At subsequent examinations on 14th August 2007, 18th September 2007 and 24th September 2007, you failed to diagnose the need to replace the restorations at LL4 and LL7.
- (l) The treatment provided by you to LL5 and LL7 was inadequate.

13. **Patient KT**

Prescribing

- (a) On 26th October 2006, you diagnosed an abscess at UL6 and prescribed Amoxicillin 500mg.
- (b) You failed to record:
 - (i) what steps, if any, you took to establish drainage;
 - (ii) your rationale for prescribing antibiotics.
- (c) On 29th November 2006, you diagnosed an abscess and prescribed Amoxicillin 500mg.

- (d) Your prescription on 29th November 2006 was inappropriate.
- (e) You failed to record:
 - (i) the location of the abscess;
 - (ii) your rationale for prescribing antibiotics;
- (f) On 5th December 2006, you diagnosed an abscess at UL6 and prescribed Amoxicillin 500mg;
- (g) Your prescription on 5th December 2006 was inappropriate.
- (h) You failed to record:
 - (i) what steps, if any, you took to establish drainage;
 - (ii) the nature of the abscess;
 - (iii) your rationale for prescribing antibiotics.
- (i) On 11th December 2006, you diagnosed an abscess and prescribed Erythromycin 500mg.
- (j) You failed to investigate properly or at all the cause of KT's abscess.
- (k) Your prescription on 11th December 2006 was inappropriate.
- (l) You failed to record:
 - (i) what steps, if any, you took to establish drainage;
 - (ii) the nature of the abscess;
 - (iii) your rationale for prescribing antibiotics.
- (m) On 24th April 2007, you diagnosed a periodontal abscess in the UL quadrant and prescribed Amoxicillin 500mg.
- (n) You failed to record your rationale for prescribing antibiotics.
- (o) On 11th May 2007, you diagnosed an abscess at UL6 and UL7 and prescribed Amoxicillin 500mg.
- (p) Your prescription on 11th May 2007 was inappropriate.
- (q) You failed to:
 - (i) investigate properly or at all the cause of KT's abscess;
 - (ii) record your rationale for prescribing antibiotics.

- (r) On 24th May 2007, you prescribed Amoxicillin 500mg.
- (s) Your prescription on 24th May 2007 was inappropriate.
- (t) You failed to record your rationale for prescribing antibiotics.

Periodontal Assessment and Treatment

- (u) You knew, or should have known from a BPE carried out on 26th October 2006 and 2nd May 2007, that KT had periodontal disease.
- (v) Between 26th October 2006 and 24th May 2007, you failed to:
 - (i) provide KT with any or any sufficient information or advice, or record that appropriate advice had been given to the patient about her condition;
 - (ii) adequately treat KT's periodontal condition.

14. **Patient AL**

Prescribing

- (a) You failed to record your rationale for prescribing Erythromycin 250mg on 4th July 2005.
- (b) On 24th October 2005 you diagnosed an abscess at LL5 and LL6 and prescribed Amoxicillin 500mg.
- (c) You failed to:
 - (i) investigate properly or at all the cause of the abscess;
 - (ii) provide appropriate treatment through either drainage or extraction.
- (d) Your prescription of antibiotics on 24th October 2005 was inappropriate.
- (e) On 1st November 2005, AL attended with facial swelling and you prescribed Metronidazole 400mg.
- (f) You had previously noted (on 4th July 2005) that AL was allergic to Metronidazole.
- (g) You failed to investigate properly or at all the cause of AL's abscess.
- (h) Your prescription of Metronidazole was inappropriate.
- (i) On 12th February 2008, you diagnosed an abscess at LL5 and prescribed Amoxicillin 500mg.

- (j) You knew or should have known that LL5 required extraction.
- (k) You failed to record your rationale for:
 - (i) not extracting LL5;
 - (ii) your prescription of antibiotics.
- (l) Your prescription of antibiotics on 12th February 2008 was inappropriate.
- (m) On 18th February 2008, you extracted LL5 and prescribed Amoxicillin 500mg.
- (n) You failed to record your rationale for prescribing antibiotics.
- (o) Your prescription of antibiotics on 18th February 2008 was inappropriate.
- p) On 30th June 2008, you diagnosed a buccal abscess at LR6 and prescribed Amoxicillin 500mg.
- (q) You failed to record:
 - (i) what steps, if any, you took to establish drainage;
 - (ii) your rationale for prescribing antibiotics.
- (r) On 8th July 2008, you diagnosed a buccal abscess at LR6 and prescribed Metronidazole 400mg.
- (s) You failed to:
 - (i) take any or any sufficient steps to establish drainage;
 - (ii) record your rationale for prescribing antibiotics.
- (t) Your prescription of Metronidazole was inappropriate;
- (u) On 11th July 2008, you inappropriately prescribed Erythromycin 500mg.

Radiographs

- (v) You failed to take a radiograph prior to preparing LL5 for a crown on 7th July 2004 and 6th January 2005.

Treatment

- (w) On 19th January 2004 you failed to:

- (i) carry out any or any sufficient investigations to assist your diagnosis of an abscess at LL5;
- (ii) formulate a treatment plan for LL5.
- (x) On 29th June 2005, you took a bitewing radiograph which showed:
 - (i) a distal filling at UL5 that required restoration;
 - (ii) an unsatisfactory restoration at UL4;
 - (iii) an inadequate crown at LL5.
- (y) You failed to provide the necessary treatment to render the patient dentally fit.
- (z) On 8th November 2005, 18th November 2005 and 24th January 2006, you took radiographs which showed that the crown at LL5 was inadequate.
- (aa) You failed to provide the necessary treatment to render the patient dentally fit.

15. **Patient BB**

Prescribing

- (a) On 8th January 2008, you diagnosed an abscess at UR7 and prescribed Amoxicillin 500mg.
- (b) You failed to record:
 - (i) what steps you took, if any, to establish drainage;
 - (ii) your rationale for prescribing antibiotics.
- (c) Your prescription was inappropriate;
- (d) On 14th January 2008, you extracted UR7 and inappropriately prescribed Amoxicillin 500mg.
- (e) On 23rd and 28th July 2008 you diagnosed an abscess at LL6 and prescribed Amoxicillin 500mg on each occasion.
- (f) You failed on each occasion to record:
 - (i) what steps you took, if any, to establish drainage;
 - (ii) your rationale for prescribing antibiotics.
- (g) Your prescriptions on 23rd and 28th July 2008 were inappropriate.

Radiographs

- (h) On 14th January 2008 you took a radiograph which showed that treatment was required to UR7 and UR5.
- (i) You failed to record a written justification for and report on the radiograph.

16. **Patient WS**

Prescribing

- (a) On 16th January 2008, you diagnosed a periodontal abscess at UL5 and prescribed Amoxicillin 500mg.
- (b) You failed to record:
 - (i) what steps you took, if any, to establish drainage;
 - (ii) your rationale for prescribing antibiotics.
- (c) Your prescription was inappropriate.
- (d) On 18th February 2008, you diagnosed an abscess, extracted UL5 and prescribed Amoxicillin 500mg.
- (e) You failed to record your rationale for prescribing antibiotics.
- (f) Your prescription on 18th February 2008 was inappropriate.
- (g) On 13th May 2008, you extracted LR6 and prescribed Amoxicillin 500mg and Ibuprofen.
- (h) You failed to record your rationale for your prescription.
- (i) Your prescription on 13th May 2008 was inappropriate.

17. **Patient GE**

Prescribing

- (a) On 3rd January 2008, you diagnosed an abscess at UL5 and prescribed Amoxicillin 500mg.
- (b) You failed to carry out any or any adequate investigation into the cause of the abscess.
- (c) You failed to record:
 - (i) what steps you took, if any, to establish drainage;

- (ii) the location of the abscess;
 - (iii) your rationale for prescribing antibiotics.
- (d) Your prescription was inappropriate.

18. **Patient MA**

Prescribing

- (a) On 8th August 2007, you diagnosed an abscess at LL6 and prescribed Amoxicillin 500mg;
- (b) You failed to record:
 - (i) what steps you took, if any, to establish drainage;
 - (ii) your rationale for prescribing antibiotics.
- (c) Your prescription was inappropriate.
- (d) On 31st August 2007, you prescribed Amoxicillin 500mg for a “dry socket”.
- (e) You failed to record your rationale for prescribing antibiotics.
- (f) Your prescription on 31st August 2007 was inappropriate.
- (g) On 15th January 2008, you diagnosed a periodontal abscess at LL7 and prescribed Amoxicillin 500mg.
- (h) You failed to record:
 - (i) what steps you took, if any, to establish drainage;
 - (ii) your rationale for prescribing antibiotics.
- (i) Your prescription on 15th January 2008 was inappropriate.

Periodontal Assessment and Treatment

- (j) You knew, or should have known from a BPE carried out on 8th August 2007 that MA had periodontal disease.
- (k) Between 8th August 2007 and 15th January 2008, you failed to:
 - (i) provide MA with any or any sufficient information or advice, or record that appropriate advice had been given to the patient about her condition;

- (ii) adequately treat MA's periodontal condition.

19. **Patient KB**

Prescribing

- (a) On 7th September 2007, you diagnosed an abscess at UR8 and prescribed Amoxicillin 500mg.
- (b) You failed to record:
 - (i) what steps you took, if any, to establish drainage;
 - (ii) your rationale for prescribing antibiotics.
- (c) Your prescription was inappropriate.

Periodontal Assessment and Treatment

- (d) On 13th September 2007, you failed to provide KB with any or any adequate oral hygiene instruction, or record that such instruction had been given.

Practice Management / Cross Infection Controls

20. Between 2nd September 2008 and 14th May 2009, you failed to maintain adequate standards of cross-infection control at your practice in that:

- (a) you failed to use a new pair of gloves for each patient treated;
- (b) you re-used single use items, including endodontic instruments;
- (c) you failed to ensure that waste was appropriately managed in that:
 - (i) you failed to ensure the segregation of clinical and non-clinical waste;
 - (ii) you failed to ensure that clinical waste was appropriately packaged;
 - (iii) you failed to ensure the prompt collection and disposal of the sharps;
 - (iv) you maintained no or no sufficient records of waste collection;
- (d) you failed to ensure that instruments were properly cleaned and sterilised after use;
- (e) you failed to ensure that instruments were stored appropriately;
- (f) you failed to ensure that furniture and floor coverings complied with accepted standards for clinical practice;

- (g) you permitted the decontamination room to be used as a “kitchen” area;
 - (h) you failed to ensure the maintenance of basic standards of cleanliness in either your surgery or the decontamination room;
 - (i) you failed to provide sufficient training to staff on cross-infection control issues.
21. Your acts and omissions as set out at paragraph 20 above presented:
- (a) a breach of your duty of care to your patients;
 - (b) a breach of your duty of care to your staff;
 - (c) a risk to public safety.
22. In your general approach to:
- (a) the assessment of your patients’ clinical needs;
 - (b) the provision and planning of treatment;
 - (c) your practice management;
- you:
- (i) were motivated by financial self-interest;
 - (ii) allowed financial / UDA targets to adversely affect the quality of care that you provided for your patients.
23. Your conduct, as set out at paragraph 22 above was:
- (a) inappropriate;
 - (b) inadequate;
 - (c) unprofessional;
 - (d) not in your patients’ best interests.

AND by reason of the facts alleged your fitness to practise is impaired by reason of your misconduct.”

On the 22 June 2011 the Chairman made the following statement regarding the finding of facts:

“Mr Siddiqui,

The Committee has taken into account all the evidence presented to it. It has accepted the advice of the Legal Adviser. In accordance with that advice it has considered each head of charge separately.

I will now announce the Committee's findings in relation to each head of charge:

1. Admitted and found proved
2. Admitted and found proved
3. Admitted and found proved
- 4.
4. (a) (i) Admitted and found proved
4. (a) (ii) Admitted and found proved
4. (b)
4. (b) (i) Admitted and found proved
4. (b) (ii) Admitted and found proved
4. (c) Admitted and found proved
4. (d) Admitted as amended and found proved
4. (e) Admitted and found proved
4. (f) (i) Admitted as amended and found proved
4. (f) (ii) Admitted as amended and found proved
4. (f) (iii) Admitted as amended and found proved
4. (f) (iv) Admitted as amended and found proved
4. (g) Admitted and found proved
4. (h) Admitted and found proved
4. (i) Admitted as amended and found proved
- 5.
5. (a) (i) Admitted as amended and found proved
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5. (a) (iv) Admitted and found proved
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- 5. (e) Admitted and found proved
- 5. (f) (i) Admitted as amended and found proved
- 5. (f) (ii) Admitted and found proved
- 5. (f) (iii) Admitted and found proved
- 5. (f) (iii) (a) Admitted and found proved
- 5. (f) (iii) (b) Admitted and found proved
- 5. (f) (iii) (c) Admitted and found proved
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- 6. (a) Admitted and found proved
- 6. (b) Admitted and found proved
- 6. (c) (i) Admitted and found proved
- 6. (c) (ii) Admitted and found proved
- 6. (d) (i) Admitted and found proved
- 6. (d) (ii) Admitted and found proved
- 6. (e) Admitted and found proved
- 6. (f) Admitted and found proved
- 6. (g) Admitted and found proved
- 6. (h) (i) Admitted and found proved
- 6. (h) (ii) Admitted and found proved
- 6. (h) (iii) (a) Admitted and found proved
- 6. (h) (iii) (b) Admitted and found proved
- 6. (h) (iii) (c) Admitted and found proved
- 6. (i) Admitted and found proved
- 6. (j) Admitted and found proved
- 6. (k) Admitted and found proved
- 6. (l) Admitted and found proved
- 6. (m) Admitted and found proved
- 7.
- 7. (a) Admitted as amended and found proved
- 7. (b) Admitted and found proved
- 7. (c) Admitted and found proved
- 7. (d) (i) Admitted and found proved
- 7. (d) (ii) Admitted and found proved
- 7. (e) Admitted and found proved
- 7. (f) Admitted and found proved

- 7. (g) Admitted and found proved
- 7. (h) (i) Admitted and found proved
- 7. (h) (ii) Admitted and found proved
- 7. (h) (iii) Admitted and found proved
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- 8. (a) Admitted and found proved
- 8. (b) (i) Admitted and found proved
- 8. (b) (ii) Admitted and found proved
- 8. (c) Admitted and found proved
- 8. (d) Admitted and found proved
- 8. (e) Admitted and found proved

- 8. (f) (i) Admitted and found proved
- 8. (f) (ii) (a) Admitted and found proved
- 8. (f) (ii) (b) Admitted and found proved
- 8. (g) Admitted and found proved
- 8. (h) Admitted and found proved
- 8. (i) Admitted and found proved
- 8. (j) (i) Admitted and found proved
- 8. (j) (ii) Admitted and found proved
- 8. (j) (iii) Admitted and found proved
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- 9. (a) Admitted and found proved
- 9. (b) (i) Admitted and found proved
- 9. (b) (ii) Admitted and found proved
- 9. (c) Admitted as amended and found proved
- 9. (d) (i) Admitted and found proved
- 9. (d) (ii) Admitted and found proved
- 9. (d) (iii) Admitted and found proved
- 9. (e) Admitted and found proved
- 9. (f) (i) Admitted and found proved
- 9. (f) (ii) Admitted and found proved
- 9. (g) Admitted and found proved
- 9. (h) Admitted as amended and found proved
- 9. (i) Admitted as amended and found proved

- 9. (j) Admitted and found proved
- 9. (k) Admitted and found proved
- 9. (l) Admitted and found proved
- 9. (m) (i) Admitted and found proved
- 9. (m) (ii) Admitted and found proved
- 9. (n) Admitted and found proved
- 9. (o) Admitted and found proved
- 9. (p) (i) Admitted and found proved
- 9. (p) (ii) Admitted and found proved
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- 10. (a) Admitted and found proved
- 10. (b) Admitted and found proved
- 10. (c) Admitted and found proved
- 10. (d) Admitted and found proved
- 10. (e) Admitted and found proved
- 10. (f) Admitted and found proved
- 10. (g) Admitted as amended and found proved
- 10. (h) Admitted and found proved
- 10. (i) Admitted and found proved
- 10. (j) Admitted and found proved
- 11.
- 11. (a) Admitted and found proved
- 11. (b) Admitted as amended and found proved
- 11. (c) (i) Admitted and found proved
- 11. (c) (ii) Admitted and found proved
- 11. (c) (ii) (a) Admitted and found proved
- 11. (c) (ii) (b) Withdrawn
- 11. (c) (ii) (c) Withdrawn
- 12.
- 12. (a) Admitted and found proved
- 12. (b) (i) Admitted as amended and found proved
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- 17. (a) Admitted and found proved
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- 17. (c) (i) Admitted and found proved
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- 18. (k) (i) Admitted as amended and found proved
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- 22. (c) (i) Admitted and found proved
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- 23. (c) Admitted and found proved
- 23. (d) Admitted and found proved

We have found all the allegations proved in the light of the full admissions by you and the evidence of the General Dental Council (GDC). We found all the GDC witnesses to be credible and reliable. There was compelling evidence to support all the heads of charge.

Despite your admissions there were some factual disputes between you and the GDC's witnesses concerning the allegations. In all cases where there were such disputes the Committee preferred the evidence of the GDC witnesses. The Committee believes you have not been entirely frank in your explanations of your actions. By way of examples;

- You adamantly maintained that you used your air rotor (high speed) drill with water, when it was appropriate to do so. However, four of your five dental nurses who gave evidence stated that you never used water. Tellingly, one of them commented that she only realised that "*water came out of drills*" when she moved to another practice. Another nurse commented that she wasn't even shown how to fill up the water bottle.
- You told us that during the negotiations on the 2009 contract your representative, Mr Watson, "steam rolled" you into pressing for the continuation of a contract based on 18,355 Units of Dental Activity (UDAs). Mr Heyes, whose evidence the Committee preferred, told us that you yourself had fought hard for a contract based on 18,355 UDAs, for which you would be the sole practitioner, and that you were incensed at the PCT's resistance to this.
- You suggested that your high provision of antibiotic prescriptions had been largely appropriate and that fault lay only in your record keeping. The Committee considered that your high provision of antibiotic prescribing was in fact an aspect of your reactive dentistry.

The Committee was invited by Mr Fortune, on your behalf, to give an indication of any particular areas of concern it may have at this stage on the basis of the evidence heard so far. The following comments are intended to assist with the remainder of the process but the Committee would like to make it clear that it retains an open mind about the issue of impairment and any other matters falling under stage two of the process.

The Committee has given considerable consideration to your motivation in relation to your actions as outlined in the allegations. You have admitted head of charge 22 and that you were motivated by financial self interest.

The Committee entirely agrees with the unchallenged expert evidence of Mr Scott who stated “ *the inescapable conclusion to my analysis is that Mr Siddiqui had maintained his very large PDS contract by providing ad hoc treatment to his patients at the cost of proper and clinically necessary care. It is inconceivable that Mr Siddiqui was not aware of the problems - he chose however to justify his behaviour in terms of the unyielding pressures of gaining his contracted UDAs.*”

The Committee would like to add that although it considers your prolonged practice of reactive dentistry arose from financial self interest, it is also concerned about the impact this has had upon your ongoing clinical skills and judgement.

We move to Stage Two.”

On the 28 June 2011 the Chairman announced the determination as follows:

“Mr Siddiqui,

The Committee has considered very carefully all the evidence it has heard and read in this matter, as well as the submissions which have been made on your behalf by Mr Fortune, and those from Ms Norton on behalf of the General Dental Council (GDC). It has accepted the advice given to it by the Legal Adviser.

The factual background to the heads of charge can be summarised as follows. You opened Dalton Dental Care in August 2002 as a sole practitioner. Dalton was described to the Committee as being a deprived area of Rotherham whose residents had a high level of unmet dental needs. You offered predominantly NHS services and, by the financial year 2003/2004, your turnover was in excess of £460,000.

In late 2004 you applied to the Rotherham Primary Care Trust (PCT) to switch from a General Dental Services (GDS) contract to a Personal Dental Services (PDS) contract. You entered the PDS Pilot Scheme from mid January 2005 until 31 March 2006. You then transferred to a new PDS contract with the PCT on 1 April 2006. The value of your new contract was approximately £500,000 and was based on the value of your financial claims made during the reference period in 2004. In order to receive this sum of remuneration you were required to complete a target of 18,355 Units of Dental Activity (UDAs).

The contract value and the number of UDAs were significantly higher than those of any other dentist in the area. The PCT had concerns about your ability to meet the UDA target as a sole practitioner but they understood that, under the rules then in place, they were obliged to award this contract to you because of your turnover during the reference period.

The PCT very quickly raised their concerns about your ability to maintain an appropriate standard of care to your patients, in light of the high UDA target and as a single handed practitioner. The PCT envisaged that you would take appropriate steps to recruit an associate.

Thereafter, your practice featured regularly in the Dental Practice Board’s “quarterly exception reports” and from August 2006 until May 2009 it was under close scrutiny by the PCT and the Dental Reference Service (DRS). During this period you were made fully aware of the authorities’ growing concerns about your clinical practice, your record keeping, and your practice management, including cross infection control. You were also made aware of the PCT’s ongoing expectation that you would employ an associate. Despite your assurances in this regard, you did little to achieve this until November 2007 when you

started placing advertisements in the British Dental Journal. You received a number of applicants but it was not until September 2008 that you employed Mrs Gowda, who worked only part time and left in February 2009.

During the same period a series of practice inspections revealed a developing problem with cleanliness and cross infection control. An unannounced visit by representatives of the PCT in May 2009 found that you were cutting corners and falling well below expected standards, thereby putting both your staff and patients at risk. As a result your practice was closed with your agreement on 15 May 2009. You were suspended by the PCT for 6 months on 18 May 2009 and removed from its Performers List in November 2009. You were also suspended by the Interim Orders Committee of the GDC on 12 June 2009 for period of 18 months. This order was subsequently varied on 26 May 2010 when conditions were placed on your registration.

The 23 Heads of Charge all relate to your practice at Dalton Dental Care.

Heads of Charge 3 to 19 inclusive relate to the deficient clinical treatment you gave to 16 of your patients. The deficiencies include failures, on many occasions, to:

- Take pre-operative, intra-operative and post-operative radiographs, when clinically required
- Record or explain treatment plans and options to patients
- Provide complete diagnoses
- Appropriately manage periodontal disease and other oral conditions, such as lesions
- Prepare and place restorations properly
- Make a proper diagnosis before prescribing antibiotics and
- Maintain an appropriate standard of record keeping.

The Committee further found, under heads of charge 20 and 21, that between 2nd September 2008 and 14th May 2009 you failed to maintain adequate standards of cross infection control at your practice, thereby breaching your duty of care to your patients and staff and risking public safety, in that you:

- Failed to use a new pair of gloves for each patient treated
- Re-used single use items, including endodontic instruments
- Failed to ensure that clinical and non- clinical waste was properly managed and disposed of
- Failed to maintain records of waste collection
- Failed to ensure the prompt collection and disposal of the sharps
- Failed to ensure that instruments were properly cleaned and sterilised after use and were stored properly
- Failed to ensure that the furniture and floor coverings were maintained to the required standards
- Permitted the decontamination room to be used as a kitchen area
- Failed to ensure the maintenance of basic standards of cleanliness in either your surgery or decontamination room
- Failed to provide sufficient training to your staff on cross infection control issues.

Finally, under heads of charge 22 and 23, it has been found that in your clinical care of patients and your practice management you were motivated by financial self interest and this adversely affected the quality of the care you provided. Your conduct was inappropriate, inadequate, unprofessional and not in your patients' best interests.

Misconduct

The Committee has had regard to the following GDC guidance documents which were in place at the time of these events;

- *Maintaining Standards (1997-2005)*
- *Standards for Dental Professionals (May 2005 to date)*
- *Guidance on Principles of Management Responsibility (2008 to date)*

The requirements set out in "Maintaining Standards" and "Standards for Dental Professionals" are very similar; only extracts from the current GDC guidance document are set out below.

The Committee considered that you have failed to comply with the following sections and paragraphs of *Standards for Dental Professionals*;

1. Put patients' interests first and act to protect them

1.1 *Put patients' interests before your own or those of any colleague, organisation or business.*

1.4 *Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.*

1.7 *If you believe that patients might be at risk because of your health, behaviour or professional performance, or that of a colleague, or because of any aspect of the clinical environment, you should take action. You can get advice from appropriate colleagues, a professional organisation or your defence organisation. If at any time you are not sure how to continue, contact us.*

2. Respect patients' dignity and choices

2.4 *Listen to patients and give them the information they need, in a way they can use, so that they can make decisions.*

This will include:

- *communicating effectively with patients;*
- *explaining options (including risks and benefits); and*
- *giving full information on proposed treatment and possible costs.*

4. Co-operate with other members of the dental team and other healthcare colleagues in the interests of patients

4.3 *Communicate effectively and share your knowledge and skills with other team members and colleagues as necessary in the interests of patients. In all dealings with other team members and colleagues, make the interests of patients your first priority. Follow our guidance 'Principles of Dental Team Working'.*

5 . Maintain your professional knowledge and competence

- 5.1 *Recognise that your qualification for registration was the first stage in your professional education. Develop and update your knowledge and skills throughout your working life.*
- 5.2 *Continuously review your knowledge, skills and professional performance. Reflect on them, and identify and understand your limits as well as your strengths.*
- 5.3 *Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.*
- 5.4 *Find out about laws and regulations which affect your work, premises, equipment and business, and follow them.*

6. Be trustworthy

- 6.1 *Justify the trust that your patients, the public and your colleagues have in you by always acting honestly and fairly.*
- 6.2 *Apply these principles to clinical and professional relationships, and any business or educational activities you are involved in.*

The Committee considered that you also failed to comply with the following section and paragraph of *Guidance on Principles of Management Responsibility*;

1. Your own behaviour

- 1.7 *Make sure that you do not put the interests of patients at risk by allowing financial or other targets to have a negative influence on the quality of care provided by the people you direct or manage.*

The Committee considers that your acts and omissions represent extremely serious breaches of the standards expected. Your conduct fell very far below that which is expected of a general dental practitioner. This is not a case involving mere negligence or isolated incidents. On the contrary, the Committee is satisfied from the evidence that for a number of years you knowingly practised “*reactive dentistry*”, by which the Committee means that you provided *ad hoc* treatment rather than planned courses of treatment arising from oral health assessments. You regularly saw as many as 45 or 50 patients in a day, too often treating the symptoms but not the causes of their problems. The Committee finds that this conduct was particularly reprehensible because you were well aware of what constituted proper treatment. It agrees with the evidence of Julian Scott who stated that it was “inconceivable” that you were not aware that your treatment was sub-standard. You had every chance to change your ways but chose not to. You deliberately pursued this practice in order to maximise your very high income, until you were stopped in May 2009.

In your evidence to the Committee you stated that you were driven to practise in this manner by your UDA target and your fear of losing your contract. The Committee does not accept this. It is clear from the evidence that the PCT would have agreed to a reduction in your UDA target if you had wanted it, and that it was you who was determined to continue the contract without amendment in order to maintain your income. Your problems were entirely self imposed.

Your failings in relation to your practice management were also a direct result of your pursuing your financial self interest. You cut corners when purchasing and using equipment with significant adverse effects on your cross infection control. You employed a succession of trainee dental nurses at the lowest possible wage and failed to train them properly in relation to cross infection control and other matters. Despite having the means and space to do so, you failed until September 2008 to install a second surgery and recruit an associate.

In the light of the matters set out above, the Committee has no hesitation in finding that the facts admitted and found proved amount to misconduct.

Impairment

The Committee then went on to consider whether your fitness to practise is currently impaired by reason of your misconduct.

It has taken into account in particular the documents in your bundle (D5) and your Continuing Professional Development (CPD). It has also taken into account the evidence of Mr Heyes, Mr Renshaw, Mr Fulford, Ms Rocky, Ms Young and your own evidence and demeanour at this hearing, concerning the developments since 2009.

Since you ceased practising in 2009 you have :

- Refurbished and recently sold Dalton Dental Care
- Undertaken numerous CPD and other courses
- Appointed and received advice and guidance from a mentor
- Worked as an associate dentist for Ms Patricia Young in her practice in Lampeter, Wales from January to April 2011.

The Committee was conscious that in considering impairment it must look to the future. It considered the way in which you behaved in the past and the context in which that conduct took place, whether your failings are easily remediable, whether they have been remedied, whether you have insight, and the likelihood of repetition.

The Committee considered that there are three principal areas of ongoing concern arising from your previous conduct. First, that you acted without integrity in placing your own interests before those of your patients. Secondly, that you practised sub-standard dentistry (and "reactive dentistry") for such a prolonged period that it has adversely affected your clinical skills and judgment. Thirdly, that you also failed to meet cross infection control standards in many significant ways.

As far as insight is concerned, the Committee considers that this has been slow in coming and remains patchy. It is clear that when you first ceased practising in Dalton you had little or no insight into what you had done wrong. The Committee were astounded to learn that in 2009 you sought a further contract with the PCT still with a target of 18,355 UDAs for you as a sole practitioner, despite knowing that this could not be achieved without compromising basic standards of dentistry. Since then you have clearly received a good deal of guidance, most particularly from your mentor, Mr Renshaw, from whom the Committee heard evidence. At the start of this hearing you made, through your counsel, full admissions of all the heads of charge. You gave evidence to the Committee and stated that you accepted responsibility for your conduct for which you apologised. Whilst the Committee gives you credit for these matters, it is concerned that when questioned you backtracked to some degree and sought

to justify your behaviour or minimise its culpability. By way of example, you maintained that you believed (at the time) that you were “*doing a good job*” for your patients in Dalton and that you could not reduce the number of UDAs in your contract. As previously indicated, the Committee considered that you were not fully frank in your evidence. You argued, for example, that you had sometimes used water with the air rotor, whereas there was clear evidence that you did not do so.

In relation to remediation, the Committee acknowledged that you spent a considerable amount of money refurbishing Dalton Dental Care and that Mr Fulford’s last inspection revealed that it now meets the appropriate standards for all aspects of cross infection control. You no longer have any interest in Dalton Dental Care. Further, the Committee heard that you are now an expert, upon and somewhat evangelical, about cross infection control procedures. In these circumstances the Committee is satisfied that you have remedied the problems you faced in relation to cross infection control issues.

In the Committee’s view you still have not fully accepted and remedied your poor clinical performance. Whilst the Committee has found that you knowingly provided poor treatment in Dalton, it notes that you say that in Lampeter you were trying to provide “*textbook dentistry*”. It is, therefore, worrying that Ms Young gave evidence (which the Committee accepts) of ongoing clinical concerns relating to the use of the air rotor without water, the inappropriate use of “*Ledermix*” as a liner and the inappropriate use of root planing. Whilst these matters may be remediable, they have not been remedied as yet and there is an ongoing risk of repetition in the future.

Finally, the Committee were of the clear view that your trustworthiness and judgment are of ongoing concern. As already stated, the Committee does not believe that your evidence was fully frank and realistic. Further, the evidence from Ms Young about your placement at her practice showed that it was fraught with problems. Whilst it does seem that this was not an ideal placement for you, it was, nevertheless, an opportunity for you to demonstrate your ability to behave appropriately and professionally. However, we heard that you upset your supervisor by conducting an audit without her permission, upset the nursing staff with personal remarks and lost your temper.

Your “attitudinal” failings are not easily remediable and the Committee is not satisfied that they have been fully remedied. Your mentor, Mr Renshaw, stated in his evidence that he was only just “*beginning to trust you*”, that it was still “*work in progress*” and that there was still a long way to go before you reached the required standards expected of a dental professional. In his view it would be unsafe to allow you to practise unrestricted at this stage and the Committee agrees with this.

Finally, the Committee reminded itself of the recent guidance from the High Court in the case of *CHRE v NMC and Grant* [2011], which stated that when considering impairment it must:

‘Not lose sight of the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession. The Committee should consider not only whether the practitioner continued to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the circumstances of the case.’

In all the above circumstances the Committee reached the clear view that your fitness to practise is impaired by your misconduct.

Sanction

The Committee next considered what sanction, if any, to impose. It had regard to the Guidance for the Professional Conduct Committee dated November 2009.

The Committee reminded itself that the sanction is not intended to be punitive. Its purpose is to protect the public, uphold public confidence in the profession and maintain appropriate standards. It must be a proportionate response balancing your interests with those of the public.

In her submissions, Ms Norton on behalf of the GDC argued that only two of the sanctions open to the Committee were potentially appropriate in this case, namely Conditions of Registration and Erasure. Mr Fortune on your behalf sought to persuade the Committee that conditions would be sufficient.

Nevertheless, the Committee first considered whether to conclude the case with or without a reprimand. It decided that in view of the seriousness of the facts admitted and found proved, such an outcome would not be proportionate and would not take into account protection of the public and maintenance of public confidence in the profession.

The Committee next considered whether it would be sufficient to impose conditions on your registration. It considered whether conditions could be sufficient to protect the public, uphold public confidence in the profession and maintain appropriate standards, and whether you have sufficient insight to meet such conditions.

As far as your clinical work is concerned, the Committee is satisfied that you are capable of learning how to practise to a good standard and it is willing to accept your indication that you want to do so. You told us yourself that it would not be appropriate for you to practise without supervision. We entirely agree but believe that with appropriate and lengthy supervision and support you could be able to establish good working practices.

What the Committee found very much more difficult was the issue of your lack of integrity and trustworthiness. Arguably, such issues are not easily remediable and you have demonstrated only partial insight into these problems. This caused the Committee great concern because trustworthiness is a vital and fundamental tenet of practice as a professional person. In particular, a practitioner who cannot be trusted always to put his patients' interests before his own will not be fit to practise without restriction.

The Committee gave very lengthy consideration to this aspect of your case and came very close to concluding that conditions could not provide sufficient protection for the public. If it had done so, the outcome may well have been an erasure order as both parties indicated that a period of suspension would not have been appropriate in this case.

However, eventually the Committee decided, just, that conditions could be sufficient. It was willing to accept Mr Renshaw's view that you have made some advance on your insight and general trustworthiness, although this is clearly "*work in progress*". It was also willing, as Mr Fortune invited us, to give you a final chance to demonstrate your trustworthiness. The

Committee noted too that the GDC did not submit that erasure was the only appropriate sanction in this case.

The GDC did submit that if conditions were imposed they would need to be stringent and lengthy. Your legal team and mentor did not suggest otherwise. Mr Renshaw, who told us that he drafted the conditions imposed on you by a First Tier Health Tribunal hearing in July 2010, gave his view that conditions should be in place for 3 years. Mr Fortune told us that he did not raise issue with any of the conditions currently in place.

The Committee has drafted the conditions set out below, all of which it considers to be necessary for the protection of the public. In drafting these conditions the Committee has borne in mind that they must be workable and it is entirely satisfied that they are. It recognises that they may not be easy to comply with but it believes they represent the minimum that is necessary in order to protect the public.

By way of explanation, the Committee would like you to understand that it is requiring you to work in a vocational training practice and then only when at least one other dentist is also working. This is for two main reasons; first, your evidence was that your clinical failings arose, in part, from your professional isolation and secondly, because the Committee is concerned that you have practised a poor standard of dentistry for so long that many bad practices have become ingrained. In the circumstances, the Committee considers it is vital you work only in a supportive, learning environment where excellent standards of practice are in place.

The Committee was well aware that any sanction must not only protect patients but also uphold public confidence in the profession and maintain appropriate standards. It concluded that the conditions set out below, taken as a whole, were the minimum necessary to achieve that end.

The Committee wishes to emphasise that it will be vital for you to comply with these conditions and to take this opportunity to demonstrate that you can and will practise in an entirely safe and trustworthy manner in the future. If there are any breaches of these conditions by you, or if you fail to meet the standards of conduct expected, it is this Committee's view that it is very unlikely that a reviewing committee would permit you to continue in practice at all.

The conditions will apply for 3 years and will appear in the Dentists Register as follows:

1. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer and any PCT on whose Dental Performers List he is included.
2. At any time that he is employed, or providing dental services, which require him to be registered with the GDC, he must place himself and remain under the supervision of a workplace supervisor appointed in consultation with the Postgraduate Dental Dean (or nominated deputy). The workplace supervisor shall work at the same practice as he and shall report to the GDC every 3 months on his fitness to practise.
3. He must restrict himself to working in a practice that has been approved by the Postgraduate Deanery as an NHS vocational training practice.

4. He must allow the GDC to exchange information with his employer, or any contracting body for which he provides dental services.
5. He must advise the GDC of the full contact details of a professional colleague (not working at the same practice) who would be prepared to keep his conditions under review and to report every 6 months to the GDC on his fitness to practise. He must advise the GDC of the name of any new professional colleague if the nominated professional colleague changes, within two weeks of the change. The professional colleague must be a registered dental practitioner and his or her appointment shall be subject to the agreement of the GDC.
6. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.
7. He must inform the GDC if he applies for dental employment outside the UK.
8. He must work with the Postgraduate Dental Dean (or a nominated deputy) to formulate a Personal Development Plan, specifically designed to address professional ethics and the deficiencies in the following areas of his clinical practice:
 - a. Record keeping
 - b. Prescribing
 - c. Use of radiographs
 - d. Periodontal assessment and treatment
 - e. Treatment planning
 - f. Use of lining materials
9. He must meet with the Postgraduate Dental Dean (or a nominated deputy) on a regular basis to discuss his progress towards achieving the aims set out in his Personal Development Plan. The frequency of his meetings is to be set by the Postgraduate Dean or a nominated deputy.
10. He must allow the GDC to exchange information about the standard of his professional performance and his progress towards achieving the aims set out in his Personal Development Plan with the Postgraduate Dental Dean (or a nominated deputy) and any other person involved in his retraining and supervision.
11. At any time that he is employed, or providing dental services, which require him to be registered with the GDC, he must place himself and remain under the supervision of a remedial supervisor appointed in consultation with the Postgraduate Dental Dean (or a nominated deputy) and agreed by the GDC. The remedial supervisor will be expected to provide him with support and advice on his professional and career development, identify learning needs and appropriate courses, and assist in the preparation and implementation of his Personal Development Plan. The remedial supervisor will also be expected to assess samples of clinical records to ensure that he is now following best current clinical practice in

the areas where his practice was found to be deficient. The remedial supervisor may be the same person as the professional colleague referred to in condition 5 above.

12. He shall permit, at his own cost, his remedial supervisor, or another person nominated by that supervisor, to undertake annually an audit of not less than 50 sets of patient records, selected randomly, to assess the standard of his dentistry with particular reference to:
 - a. General standard of record keeping
 - b. Prescribing
 - c. Use of radiographs
 - d. Periodontal assessment and treatment
 - e. Treatment planning
 - f. Use of lining materialsand to report on the findings to the GDC.
13. He must engage in dental practice only at a practice he does not own, at premises where another dentist or dentists are working at the same time as he is working, and with whom each day he has made personal contact before he commences treatment of patients.
14. He must confine his practice to general dental practice posts.
15. He must not be responsible for the administration or management of any dental practice.
16. He shall only practise dentistry when assisted by a registered dental nurse.
17. He must not work as a locum or undertake any out-of-hours work or on-call duties.
18. He must agree to the appointment of a mentor, appointed in consultation with the Postgraduate Dental Dean (or a nominated deputy). For the avoidance of doubt this should be an experienced colleague who is able to offer guidance and support. His relationship with his mentor is confidential and the GDC does not therefore expect the mentor to provide reports.
19. He must keep his professional commitments under review and limit his dental practice in accordance with his workplace supervisor's advice.
20. He must inform immediately the following parties that his registration is subject to the conditions, listed at 1 to 19, above:
 - Any organisation or person employing or contracting with him to undertake dental work
 - Any prospective employer (at the time of application)
 - Any PCT in whose Dental Performers List he is included, or seeking inclusion (at the time of application)
21. He must permit the GDC to disclose the above conditions, 1 to 20, to any person requesting information about his registration status.

Before the end of the period of this order, this matter will be considered at another meeting of the Professional Conduct Committee which you will be expected to attend. The next Committee will expect to see evidence of your full compliance with the above conditions. It will expect to receive all the reports produced over the three year period from your remedial supervisor, your work place supervisor and the professional colleague relating to your progress, the standard of your dentistry, the audits referred to in condition 12 above, and your conduct and trustworthiness in general. It will also expect to receive a report from the Postgraduate Dental Dean (or a nominated deputy) on your progress towards meeting the targets set out in your Personal Development Plan. Additionally, you should present evidence of your Continuing Professional Development.

The Committee is minded to consider imposing these conditions on your registration with immediate effect, but before taking that decision it must first seek submissions from both parties.

Having heard submissions from both parties, the Committee is satisfied that it is necessary for the protection of the public, is otherwise in the public interest and is in your own interest that the conditional registration order should be imposed with immediate effect.

The interim order currently in place is hereby revoked.

That concludes the case.”