

Kent, Surrey and Sussex Local Dental Network (LDN)

**Minutes of the 01st Meeting**

14:00 – 17:00 Thursday 20th April 2017

Boardroom, NHS York House, 18-20 Massetts Road, Horley, RH6 7DE

**Co-Chairs –** Brett Duane and Mark Johnstone

| **Present** | **Name** | **Job title / Organisation** |
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|  | Mark Johnstone (MJ) | Co-Chair of Kent, Surrey and Sussex LDN |
|  | Brett Duane (BD) | Co-Chair for Kent, Surrey and Sussex LDN |
|  | Annie Godden (AG) | Senior Contracts Manager, NHS England |
|  | Jenny Oliver (JO) | Consultant Dental Public Health, Public Health England |
|  | Stephen Lambert-Humble (SLH) | Dental Dean, Health Education England |
|  | Gemma Michael (GM) | Business Support Officer, NHS England |
|  | Sarah Davies (SD) | Kent Oral Health Promotion Chair |
|  | Andrew Elder (AE) | Kent, Surrey and Sussex Restorative MCN Chair |
|  | Barry Hayes (BH) | Kent Orthodontic MCN Chair |
|  | Elizabeth Lines (LL) | Kent Healthwatch Patient Representative |
|  | Richard Jones (RJ) | Sussex Orthodontic MCN Chair |
|  | Agi Tarnowski (AT) | West Sussex Local Dental Committee Representative |
|  | Tim Hogan (TH) | Chairman, Kent Local Dental Committee |
|  | Jackie Sowerbutts (JS) | Public Health Consultant (Oral Health) |
|  | Nish Suchak (NS) | East Sussex Local Dental Committee Representative |
|  | William Westwood (WW) | Surrey Local Dental Committee Representative |
|  | Paul Mellings (PM) | Dental Practice Advisor, South East Commissioning Hub |
| **Apologies:** | Nic Goodger | Kent Oral Surgery MCN Chair |
|  | Geoff Thomas | Sussex Healthwatch Patient Representative |
|  | Steve Innet | Chief Executive Kent Healthwatch |
|  | Julian Unter | Secretary, Kent Local Dental Committee |
|  | Huw Winstone | Dental Practice Advisor, NHS England |
|  | Snehal Dattani | Surrey Local Dental Committee Representative |

| **Agenda Item** |
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| **1. Welcome and Apologies**  Mark Johnstone introduced the first Kent, Surrey and Sussex (KSS) Local Dental Network meeting.  Introductions were made and apologies given as above. |
| **2. Matters arising not on the agenda**  None declared. |
| **3. Declarations of interest**  Completed forms should be sent to Linda White, Corporate Governance Team, 4W03, Quarry House, Leeds, LS2 7UE. |
| **4. Minutes of Kent & Medway and Surrey & Sussex Local Dental Network (LDN) and actions**  **Kent and Medway Amendments:**  Page **11**. Healthwatch update – Remove clean bill of health and change to nothing to report.  No further amendments and MJ signed off the minutes as a true and accurate record of the meeting.  **Kent and Medway Actions:**  Action **2**. JS to feedback to SLH of the requirement to send the LDN the project planning board for circulation. **Update** **–** JS needed some clarification over this action; GM stated she would go to the appropriate previous minutes for JS and send her the information.  **Action: GM to clarify the above action. Update – This action has been superseded.**  Action **4**. MR to feedback to Annie Godden that the LDN feels it should be involved with the dental referee in some way. **Update –** BD suggested that the dental referee is becoming outdated and should be updated by the DERS Manual. The LDN will agree this at a future meeting.  **Action: BD to work with the DERS Project Team to develop the DERS manual.**  Action **5**: MJ to write to BD as the Chair of the Dental Electronic Referral System (DERS) Project Board concerning the LDNs expectation on referrals from non-GDPs**. Update –** There is not the capacity to accept referrals from non-GDPs. In this respect the paper process will continue.  Action **6**: MJ to write to the Area Team to formally write his concerns concerning the transfer cases and patient protection. **Update –** BH told the group that Cherie Young confirmed that the PR Form is sufficient to use for these cases.  Action **7**: MJ to take back to the KSS Strategic Core Group to get clarification for the LDN to understand claw back and project processes. **Update –** This action to be discussed later in the KSS LDN, as the Strategic Core no longer exists.  Actions **9, 10 &11**: Health Needs Assessment. These actions have been completed; the outcome papers to be circulated are currently with the dental commissioning team. One of the documents is a response to the comments received and the other paper is regarding commissioning.  AG confirmed that the LOT location and sizes have been finalised. The intention was to go out for engagement, however due to upcoming general and local elections, there is now a period of purdah. This has been raised as an issue and advice is being sought on what engagement is permissible.  There is also a legal challenge that will need to be addressed before any engagement can go ahead. National advice is being sought over the timescales for the delay.  RJ asked AG for the potential final date when it is realistic to put in place procurement for the April 2018 contracts. AG responded by stating that national approval is being sought on whether an extension or not will be granted for these contracts. Realistically, engagement cannot be started until after June 2017. Notifications must then be given to each individual and then a 10-day window to submit a stage 1 bid is granted. The advertisement of the LOTS will then be advertised.  All other actions have been completed on the Kent and Medway LDN action log – 07/12/16.  **Surrey and Sussex Amendments:**  Page **1**. Snehal Sattani to be changed to Snehal Dattani.  Page **11**. BD told the group that a Dental Care Champions network has been set up. BS wants to change this wording and will provide new wording. Change to the Dental Care Champions network is being discussed.  **Action: BD to provide GM the wording for this paragraph.**  No further amendments and BD signed off the minutes as a true and accurate record of the meeting.  **Surrey and Sussex Actions:**  Action **3:** BD to draw up letter to send to those members who fail to attend two LDN meetings in a row. **Update –** Roll on action for BD  **Action: BD to draw up this letter.**  Action **4:** JC to obtain information from the appropriate clinicians of the set-up of the 3 Oral Surgery MCNs. A representative will be asked to sit on the LDN. **Update –** The MCNs will be discussed as per agenda.  Action **5**: SLH to get together a theme for the March Challenges Conference and ask for comments. Update – SLH the next Conference will be in September 2017.  **Action: SLH to send out a ‘Save the Date’ email and to provide AG a list of those on the attendance list.**  Action **21**: AG to send NS the template to fill for potential projects to be agreed by the LDN later. **Update –** AG confirmed that she had not yet done this.  There was discussion on the format of the template and a prioritisation tool that Anna Ireland produced for Thames Valley. The group agreed that it would be beneficial if a template could be formatted to suit the KSS LDN.  **Action: MJ, BD, AG, JO and JS to discuss this at their next catch up to put together a KSS template for potential projects to be considered by the LDN. The prioritisation tool and the template will then be shared with the KSS LDN committee members.**  All other actions have been completed on the Surrey and Sussex LDN action log – 08/12/16. |
| **5. Projects/Pilot**   1. **Anti-microbial resistance (AMR)**   The aim was to trial the released national toolkit with 60 foundation practices on prescribing habits. This data will educate dentists on how to carry out an audit and the techniques involved. It will also ensure they can identify their prescribing habits and if they are using best practice.  JS confirmed the real benefit of collecting this data is that there will now be some baseline information of what is happening in Kent, Surrey and Sussex.  The worst offender of prescribing Clarithromycin in the entire country is Kent and after this, it is Surrey and Sussex. This data was collected from NHS Prescriptions. The audit is to understand what practitioners are doing and how to improve antibiotic prescribing.  There is a need for specific funding for further analysis to get the best out of the project that the LDN needs to agree on. AG agreed that it would be ideal to have this as an ongoing project and whilst there may be funding in this financial year, there could not be a further commitment of £41,000. An option may be an online tool, although it would cost more to purchase in the first instance, it could allow this project to be ongoing. Other advantages are that reports are directed back to the practices and the tool is easier to use, as it is more user friendly.  All attendees agreed that this was a priority project.  **b) Antibiotic prophylaxis for cardiac patients**  JS informed the group that a lead pharmacist in Guildford and Waverly Clinical Commissioning Group (CCG) approached her on Surrey cardiac guidelines. The National Institute for Clinical Excellence (NICE) guidelines have changed very slightly. The lead wanted to know the possibility of starting a standard template letter passport created by Surrey Cardiac Network, with input from dentists to see what dental practitioners would like to know about specific high-risk cardiac patients before they write up a prescription for antibiotic prophylaxis.  Is this a feasible way forward?, at the moment dentists on the whole are following the NICE guidelines stating that they won’t prescribe and is then sent back to the General Practitioner (GP). The GP also states they do not want to prescribe; this is an issue, as it is not contributing to patient care. The lead pharmacist would like a formal tool to so that information can be given on why you need to prescribe certain medication.  The Cardiac Network would also like professional agreement that someone from the committee is willing to work with them to produce this letter.    The aim is get a reasoned letter from consultants to support their decisions based on clinical evidence of someone who is competent on the patient’s detailed condition.  TH responded by stating there is a risk to dentists following the new NICE guidelines and exposing them. There is an increased risk of a fatal endocarditis; AT also confirmed that she would be reluctant to take ownership of a patients cardiac problems. Both she and WW agreed that it should remain the concern of the cardiologist.  JS agreed that to respond with a letter expressing concerns concerning the legal responsibilities for the dentist that prescribes for something that previously would not have been in the NICE guidelines.  **Action: JS and TH to work on this letter and bring it back to the LDN before submission.** |
| **6. Managed Clinical Network (MCN) Chair Reports (including DCP Update)**  AE gave the group a PowerPoint presentation, highlights from this were:  AE had now been a consultant in Kent for the past 7 years. In his interview statement, he voiced how he would bring a high quality accessible restorative dental service to patients and practitioners.  His passion was to repatriate patients who needed to travel to London and to create extensive clinical networks. He has enjoyed developing the service into a 3b service supporting all orthodontic and maxillofacial colleagues.  All head and neck cancer patients now have pre-assessments, they have the relevant treatment before they go onto have surgery and radiotherapy. Patients also go on to have prosthetic rehabilitation.  All hypodontia patients who were travelling to London for joint orthodontic and restorative treatment now have consultations and rehabilitation locally.  More advance traumas are now managed in-house.  AE expressed frustration as he had hoped that by this stage to develop more of a local network and that the issue had been due to the delay of the national guidance. There is still no date for its release.  DERS has been successful; AE has worked closely with BD and David Ezra from Vantage. He confirmed it is a great tool and it is expected to go live in a couple of months. Some of the terminology was cumbersome but was taken from the commissioning guides.  AE expressed that he is very passionate about the next stage and the importance of enforcing triage and changing practices on how referrals are made and to potentially look at virtual consultations.  In regards to the MCN, there are terms of reference and a workplan. Until the issues regarding the Chair appointments are resolved, it will be difficult for the MCN to move forward.  Conversations need to had over the aging dental population. Most patients suffer with tooth service loss and they need complex treatment. There are patients who are denture intolerant. There are also practitioners taking on complex treatments then requiring the assistance of a specialist when there are problems with the outcome. AE thought this to be because younger dentists may be less clinically skilled than in previous times.  NHS England advice was needed on:   * Is there enough funding to provide all specialists enhanced treatment in Restorative dentistry? * The need to prioritise patients and treatment * Should all patients be eligible for specialist treatment i.e. if patient under a dental plan, should there still be eligibility? * Should a young patient eligible for complex treatment be able to access lifetime management? * Who should manage complex treatment failure of private treatments provided overseas?   AG responded these are not local decisions but national ones. Part of the delay for the national commissioning guides is all questions that have been asked in the working groups. NHS England will not publish a commissioning guide that sets out that patients can receive treatments that are not affordable to the NHS. One agreed conclusion that has been reached it that the NHS will only deal with the acute episode only from former treatment and stabilisation is the only course of treatment given to the patient.  1. **Restorative -** Commissioning Guide for Restorative Dentistry – The publication of this document has now been delayed for over a year from March 2016. AE believes that this has been for NHS England to make final revisions to the document created by the appointed committee of Restorative Dentistry experts and commissioners. Also to allow related guidance on dental implant provision to be completed. Until this document is published, it has been decided that work cannot commence on reconfiguring services.  **2. Restorative Managed Clinical Network (MCN) –**Terms of reference and work plans have been prepared in line with national guidance and recently. AE has continued to have informal contact with stakeholders including David Cheshire, Arijit Ray – Chaudhuri Consultants in Restorative Dentistry, in Chichester and Brighton respectively including meetings to advise on the Restorative DERS. An inaugural meeting of a Restorative Dentistry Managed Clinical Network has been awaiting the publication of the Commissioning Guide. The MCN then can start advising on patient pathways and the development of additional local endodontic, periodontics and prosthodontics services. Agreement on any remuneration and expenses for the MCN chair role is outstanding.  **3. Dental Electronic Referral System (DERS) –** AE had been meeting with Brett Duane and David Ezra to advice on Restorative Dentistry DERS since September 2015. A comprehensive Restorative Referral Form for Kent Surrey and Sussex has been developed and is ready to go live. Endodontic DERS forms in Kent and Sussex, and Prosthodontics in Sussex had to go live at short notice, due to the timeframe becoming more urgent further to notice being served by the Sussex Referral Management Centre.  Unfortunately, this has led to confusion with practitioners in Kent as they can see these forms and seemingly have been referring patients to London providers, as they have no local providers listed. It has been requested that a search be undertaken by Vantage to identify the number of patients.  AE had meetings in June and September 2016 with David Cheshire, Arijit Ray - Chaudhuri, Brian Miller and David Ezra to advise on how to incorporate likely future national commissioning guidance into the Restorative forms. Due to the complexity of restorative referrals this will still need some triaging. Brian Miller is triaging Sussex prosthodontic referrals; the triaging in other areas requires further discussion. The system will be a great improvement in information sharing and quality of referrals that will be important in allowing the development of managed clinical networks with different tiers of clinicians managing patients. AE hopes that developments will be made in order for it to be used for telemedicine.  **Orthodontics** – **Sussex MCN:** RJ explained that there is a lot of concern and a lack of clarity over the procurement process, confirming that the pre-qualifying stage is being extended due to the legal challenge and the general election.  In regards to the MCN structure, this had already been discussed and a way forward has been established.  Another concern was with the needs assessment, but this had again been discussed. The response paper is ready to be circulated and AG stated that the comments and feedback could also be circulated, however, the LOTS location and size will not be circulated until advice had been sought.  DERS is running smoothly but RJ remains unconvinced the quality of referrals have improved but that at least dentists have widely adopted the service so not getting lots of issues with paper referrals. In the future, he hoped an audit might be completed to assess the quality of the referrals. AG confirmed this would be an ideal workstream for the MCNs.  **Orthodontics** – **Kent MCN:** BH confirmed that the small issues with DERS have been resolved.  There are concerns with the delay with the procurement process.  One practitioner is to retire from a practice in Canterbury; his workload has been recycled to other practitioners.  **Oral Surgery –** An Oral Surgery update was not forthcoming as there was no representation at the meeting.  **Kent and Medway Oral Health Promotion –** SD confirmed there is lots of work promoting oral health in Kent and Medway.  There is some consideration whether to join Kent and Medway, Surrey and Sussex Oral Health Promotion Networks or to keep them separate. This will be discussed between SD and JS.  There is a change to the representation to the committee from Kent LDC. The committee is reviewing their role with the Local Authorities.  **Surrey and Sussex Oral Health Promotion (OHP) –** the first meeting was in December 2016 and was well attended, and included colleagues from Kent.  A future meeting is scheduled for the 06th June 2017.  There will be some change to Oral Health Promotion commissioning.  **Action: JS and SD to work together on the structure of the OHP MCN.**  **Special Care and Paediatrics** **–** MJ confirmed this meeting continues to be well attended.  There is lots of work involving DERS, General Anaesthesia (GA) specification and dental facilities. In the future, there will work on the hard to reach groups and bariatric dental services.  The bariatric specification is almost ready to publish. A consultation will be held before publication. This will be discussed at a separate meeting.  **Action: AG/BD and LL to speak regarding a public consultation.**  **DCP Champions group –** BD informed the group that a proposal has been made to set up a group of DCPs to consider different projects across Kent, Surrey and Sussex.  **Action: BD and SD to discuss this outside of the meeting.**  **Action: SLH to send JS the lesson learned paper from Tashfeen Kholasi.** |
| **7. Sustainability and Transformation Boards (STP) Update**  MJ expressed the importance of engaging with the STPs of which there are 4 relevant to KSS. East Surrey and Sussex, Surrey Heartlands, Frimley Heath and Kent and Medway.  Each STP will have a Chair and lead and will publish and consult their plans for each geographical area, which will align with the Five Year Forward View. However, there is no mention of dental in any of the plans. There are topics in which dentistry can be involved with, 7-day service, friends and family scheme, urgent and emergency network and electronic records.  The STPs have all been contacted and response has been varied. East Surrey and Sussex are interested to engage with dental, MJ will shortly meet with programme and urgent care leads. The other STPs have acknowledged emails and state they will be in contact soon. |
| **8**. **NHS England**  AG informed the group that Orthodontics in the South Region and Cumbria in the North as they are going out for procurement at the same time have developed a service specification in line with the commissioning guides. It is almost ready to go out for consultation.  Due to the extension to the Orthodontic procurement, has postponed the planned General Dental Service (GDS) procurement, as they cannot be run at the same time.  Approval has been received to extend community dental services and out of hours emergency dental contract to 2019. Work has started for this procurement. |
| **9. Health Education England (HEE)**  There is a clear date for the process for move to 1 Dean and 1 department by the end of September 2017.  With Continuing Professional Development (CPD), there is a big thrust for as much as possible to be multi-professional.  This will now be referred to as Workforce transformation and development and this fits in well with the audit process.  SLH voiced that there is a need for LPN, NHS England and the STPs to ask that HEE to ensure that there is a KSS facing "person" in HEE who are able to attend these important meetings.  **Action. BD/MJ to write a letter regarding the requirement of a dental dean to attend the LDN meeting.**  The next Challenges Conference is hoped to take place in September 2017. The Chairs of the LDN to contribute to the agenda and will liaise with GM in the next week about dates.  **Action: SLH to communicate with GM in regards to the next Challenges Conference**.  CPD Programme Process Dental Education Booking System has been moved to e-wisdom.  There is a framework for a new apprentice to deliver the oral health message to schools and care homes supported by the practice.  HEE will continue to support Fitness to Practice and overseas dentists.  HEE work areas - Mental Health, Urgent and Emergency Care, Children and Young People, End of Life care, Technical and Enhanced Learning and e Learning for Healthcare, Workforce transformation, public health, learning disabilities.  Mouth Care Matters now has 5 arms these are Care Homes and Home Supported Care, Hospitals, Mental Health including Dementia and dementia friendly dentistry, Learning Disabilities and Palliative Care. Closely linked with the Academic Health Sciences Network (AHSN). There will be a hospital presentation on 7 July 2017.  **Action: SLH will circulate details of this event to the committee.** |
| **10. Public Health England (PHE)**  JO and JS cover the South East in a Public Health England role. JO works on a 1 Work Time Equivalent (WTE) and JS on a 0.6 WTE.  JO informed the group at this point, PHE is agreeing an offer as a PHE South East Centre to the NHS Local Office, and the objectives are also in the process of being agreed.  BD expressed some concern over PHE capacity for KSS. JO responded by stating that she and JS have a number of stakeholder to support and after some personal development, teaching and training and national work, time allocation is given appropriately. At the current time, both JO and JS are covering previous role in the interim until these positions are filled. |
| **11. Local Authority update**  JS confirmed there is a huge task for the Local Authorities (LA) as there is variation on the contracts and identifying what this means.  There is some confusion about the location of funding, if funding has been transferred, the LAs have not seen it.  JS confirmed that oral health might be the last things on their minds. |
| **12. Local Dental Committee (LDC)**  NS voiced that in the local area, there is the move of Maxillofacial Surgery in East Grinstead taking away from Eastbourne and Hastings. There was no public consultation and the LDC is responding to this.  AG expressed that NHS England were not consulted until the decision had been made. Any patient needing an overnight bed will be treated at the Queen Victoria, as this was the only hospital with capacity. Outpatient and day cases will still be treated locally.  There are enough funds from the LDC to hold a study day; this could possibly be on anti-microbial resistance.  AT told the group the LDC is keen to engage with HEE to develop tasks with local medical committees to try to discuss improvements on common issues. Information Governance remains an important issue.  TH confirmed that the LDC has been heavily involved with the Orthodontic procurement.  Kent LDC is proud of their website as it is developing more as a go to resource and receiving thousands of hits. |
| **13. Healthwatch**  A series of issues have been raised through the Healthwatch Kent information and Engagement Team by five clients:  One person raised concerns in relation to accessing orthodontic services, appointments and the future location of these services following possible alterations to the service provision from 2018.  A second person had a negative experience with dental services in Sheerness and the issues raised have been escalated to Support Empower Advocate Promote (SEAP) and the General Dental Council (GDC).  A third person raised concerns over the safety of treatment received and the behaviour of an employee and this has been referred to both the Law Society and the GDC.  A fourth person raised issues about charges and the client was signposted to NHS England. Finally, a person recorded the good treatment received by another practice.  Despite the cuts in budget, LL informed the group that the Dental Leaflets will still be re-printed and the costings have been updated. |
| **14.  Managed Clinical Networks (MCN) Chairs Paper – Discussion/Decision**  MJ informed the group that guidance for the MCNs has now been received and includes the terms of reference and a job description for the Chair.  Currently there are colleagues in the South already chairing MCNs but there is a need to formalise these roles through recruitment.  The issues are how do the MCNs function and how the Chairs are paid.  The guidance is not very helpful in these areas.  Another question to be answered is how many MCNs will there be across KSS as some cover all the patch and some cover part of the patch, there are also implications on how the Chairs for each of these gets paid according to geographical area.  MJ voiced that it is up to the South East LDN network to decide on how to take this forward.  AG confirmed that in regards to the Chair payments, there is no budget to formally pay the Chairs a salary.  If the Chair is from secondary care, a Commissioning for Quality and Innovation (CQUIN) payment is already given to the Trust to allow their clinician to engage with the MCN.  AG confirmed that is was a significant amount of money and that clinicians need to have this included in their workplan as recognition of the work provided.  If the Chair is outside of secondary care, then a calculation will be made in line with the dental guild rate of £285.00 per 3.5-hour session to a number of Unit of Dental Activity (UDAs) or Unit of Orthodontic Activity (UOAs) that would have to be delivered as per contract.  This will allow the Chair to carry out MCN duties without concern that they are underperforming on their contracts.  There will be an agreement of the number of sessions they are to provide in a year; travelling expenses will also be accepted.  RJ queried and gave himself as an example as someone who is a NHS contract holder and has a practice that delivers this contract but does not actually give hands on service other than consultations and so would not benefit from either of these payment systems.  AG agreed that in his circumstance this would be the case, however stressed that there is some flexibility to get the right individual in post.  WW queried if this payment system applied to LD primary care members, AG confirmed that it does not apply to anyone other than the MCN Chairs.  NS asked if the Department of Health was agreeable if the Local Office misses the Patient Charge Revenue (PCR).  AG responded by this could be potential issue but that the loss is minuscule.  Orthodontics there is no PCR, Oral Surgery is from Intermediate Minor Oral Surgery (IMOS), AT voiced that there would also not be any UDAs either.  Restorative would be unlikely to have any either.  AE agreed that the goodwill had been exhausted and confirmed that in his MCN Chair role, he had gone beyond the job plan over the last couple of years.  He also questioned whether the CQUIN payments would work and would actually cover the work expected and if it would be fair.  He voiced that if you want the enthusiasm and the expertise then recognition of this must be given and paid for which could come from the budget for actual clinical provision as it is part of providing high quality patient care.  AE felt the CQUIN payments is adequate for attending the MCN meetings and the referrals but not enough to Chair the MCN and the work involved in taking the MCN forward.  AG responded by stating that she could not remember the actual figures but is aware that Trust are paid tens of thousands of pounds in CQUIN payments and this would be more than enough to cover the Chair role.  Alternate CQUIN arrangements is an area that can be discussed when the contracts expire in 2019.  She expressed that the Trusts are already being paid to allow their clinicians to engage with MCNs, if a separate payment is then made, this would result in double paying and not an acceptable spend of public money.  The MCN structure will be:  Orthodontics – 3 Chairs, Surrey, Sussex and Kent  Oral Surgery – 2 Chairs, Surrey and Sussex and Kent and Medway  Restorative – 1 Chair, Kent, Surrey and Sussex  Urgent Dental Care – 1 chair, Kent Surrey and Sussex  Special Care and Paediatrics – 1 Chair, Kent, Surrey and Sussex  Oral Health Promotion – 2 Chair, Surrey and Sussex and Kent and Medway |
| **15. Dental Electronic Referral System (DERS) update**  Restorative dentistry is waiting for sign off and Special Care and Paediatrics are almost ready to be signed off.  An evaluation is underway, as a questionnaire has been sent to dentists; a patient questionnaire to go through DERS will take place when Vantage confirms they are ready.  A lessons learned document is being created.  BD confirmed that the implementation stage would be by the end of July 2017.  AE had not received confirmation on the confusion in Kent on local practices having been resolved. Kent practices are only seeing a form on DERS for prosthodontics and restorative resulting in the referral can to London providers, as there is no other choice. This could result in an increased wait for urgent consultations. AE suggested seeing if referrals have gone up in the last few months to see whether there is an increase, as this would discriminate local services. BD suggested this needs to be brought up at the Project Planning Group, as it needs to be approved by NHS England.  AG responded by confirming that the contract NHS England commission from East Kent NHS Foundation Trust is not for general restorative referrals. There is the requirement to honour existing contractual arrangements from General Dental Practitioners (GDPs). Historically in Kent, if patients need restorative treatment for endodontics, have been referred to London. |
| **26. AOB**  None declared. |

Ratified on the 20/06/2017

**Dates of Meetings 2017/18**

| Date: | Meeting Room: | Time: |
| --- | --- | --- |
| 14/06/17 | Weir Room, Wharf House, Medway Wharf Road, Tonbridge, TN9 1RE | 13:30 – 16:30 |
| 11/10/17 | Sussex Room, York House, 18-20 Massetts Road, Horley, RH6 7DE | 13:30 – 16:30 |
| 07/02/18 | Weir Room, Wharf House, Medway Wharf Road, Tonbridge, TN9 1RE | 13:30 – 16:30 |