DERBYSHIRE COUNTY LOCAL DENTAL COMMITTEE		
Draft Minutes of an Ordinary Meeting		
Date:	21st June 2015	
Venue:	Higham Farm Hotel, Higham	
Members:	Drs: K Bola, B K Dawett, H Hammond, A Hannah, D Hannah, R Khatib, H Kshitij, P Moore A North, Y Nsamba, N Preston, N Rodick, H Sanghera, J Ward	
	Co-opted: Drs:	
	In attendance: Dr S Thackery, GDPC, BDA Rep	
1.	**Welcome** Dr H Sanghera was welcomed to his first LDC meeting and gave a brief introduction about himself and his experience. He had qualified in 1997 from Birmingham and after completing his VT he had worked in London for 10 years, before moving to Nottinghamshire. His current practice was in Swadlincotes, South Derbyshire and he had spent 6 years as a VT trainer. Dr North invited all the LDC members to introduce themselves for the benefit of Dr Sanghera, which they did.	
2.	**Apologies** Dr A Hannah, D Hannah	
3.	**Declared Other Business** There was no other business declared.	
4.	**Guest Speaker Section** Dr Simon Thackery was welcomed to the meeting: he was to report to the committee on the GDPC Meeting of 6th May 2016 Dr Thackery reported that it had been a large agenda for the meeting, but that the main discussions had been around satisfactory completion of DFT, New models of care, GDPC policy on capitation, DDRB Uplift, and Support for 'Plan B'. He would also briefly touch on a few other points. *Satisfactory completion of DFT*: Dr Thackery reported that there was a general feeling that new graduates were seen as less of a 'finished product' then in the past. There were attempts underway to not have satisfactory completion of dental foundation training being perceived as just another exam and that the principles of assessment were not intended to be another level of bureaucracy. It was felt important that they be fair and transparent, and	

developmental rather than judgmental

During the process there were points of review at–6-8wks, 6mths, then 10/11months, with a process of appeal and there was a framework to support this. Dr Thackery was asked what would happen if the trainee failed and it appeared that they would be allowed to take the DFT again, although it was acknowledged that this would then tie up a place on the scheme with a knock-on effect of fewer places for recent graduates and there would probably be no funding to support individuals want to do this. However, there hadn't been any concerns raised over the possibility of tying up trainee places.

There had been discussion around DFT being undertaken over 2 years, but the GDPC had expressed concerns about the workload of trainers and the possibility that they might lose trainers if this route was followed. It had not been rejected at this point, but it was felt that there needed to be more clarity around the issue.

Dr Thackery said that the next meeting was in October and he was happy to take back and comments or raise concerns from the LDC.

Dr North said that Dr A Hannah, an LDC member, was now a training programme director. There had been attempts to have a 2-year DFT for a while, but these had not been successful. There were also some Deaneries where not all places were being filled and it was possible that those vacancies could be used to support those needing to take the DFT again.

New Models of Care: A summary of the 5-year forward plan for NHSE had been presented and Dr Thackery emphasised that dentistry needed to get involved via the LDC. A workshop for dentists was to be organised by the BDA to look at this.

The Chief Dental Officer was not on a par with the Chief Medical Officer, and the CDO was aware of the lack of clarity in the contract, but seemed to be fighting the corner of the GDPs.

New contracts were likely to be time limited over 3-5 years for GDS contracts. Dr Moore said that at a meeting a couple of months ago the CDO had stated the contracts were likely to be 8+2 years and Dr North said that the CDO seemed more hopeful on longer-term contracts.

Dr Thackery reported that dentistry received less funding that GPs and as there was a lack of recruitment issues there was no funding available to help support this. The overall message had been that there would be no increase in funding, with a possibility of less.

*GDPC Policy on Capitation: Dr Thacker reported that there had been a l*engthy discussion about what options GDPC should support in a new contract. One major issue is that discussions involved potentially unlimited treatment, for and unknown number of patient, for an unknown amount of money. However, the GDPC appeared to be pushing to get as high a capitation amount as possible into the new contract.

The options were:

- Blend B model (bands 1 & 2 under capitation) which was is likely to be the end point. With falling disease rates a higher capitation rate was preferable. Those in the prototypes were demoralised as they were still chasing UDA's as that is the only metric being measured, and more clarity is needed.

- Blend A model had a capitation on band 1 payments. In Blend A prototypes staging of treatment was discussed to hit UDA targets, which is not yet being monitored but will be.

Blend B was seen as being more successful, although patients numbers were supposed to be increased by those in Blend B in order to keep the DoH happy. The GDPC stance was to push for as close to 100% capitation as possible knowing this is not going to be likely, in order to get as close to blend B as possible.

The government prefer Blend A, but Blend B had a higher core income, topped up by band 3 treatments, although the intention was for there to be less need for band 3 treatments

Dr North said that at the recent LDC conference there had been discussion around not being allowed to over-produce on UDA component, but over-perform on capitation element.

Dr Thacker said that access should be improved with Blend B, but these practices were supposed to be seeing more patients for no extra money. Overall, there were major issues and a lack of clarity around the matter.

Dr Moore said that at a recent LDC liaison meeting Blend A practices were reported as having to let go of therapy and hygienist staff and employ more associates, as retaining the therapists and hygienists was not viable.

DDRB Uplift: Dr Thackery reported that the DOH want to lock in a 1% uplift for 4 years in order to bypass the DDRB. If this is locked in and bypasses DDRB then dentists will get something (1%), although there was no clarity around what the DoH would want in return: however, if the profession still go to DDRB then there might be no uplift or possibly a reduction as funding has been prioritised to the medics.

DoH want a package in return for this lock in, which could be a 4% further efficiency savings, although how such savings were to be made was unclear.

There had been a long debate about this, with the general feeling of distrust about the government or DDRB so are in a difficult situation. However, it was thought that 1% from the DoH the least bad option if DDRB award 0.1% due to targeting. Negotiators were returning to see if a shorter deal with no package of concessions was available.

The LDC was asked what their opinion was on this? After brief discussion and a show of hands the majority felt that it would be better to stay with the DDRB, although more information was needed to make an informed decision. Dr Thackery was happy to feedback that whilst the LDC was leaning more towards DDRB, more clarity was needed.

Support for 'Plan B' _ The BDA was to set up a subcommittee/discussion group to look at how to advise and assist those practitioners wanting to move out of the NHS. It was felt to be especially important as some practices now have UDA rates lower than the Patient charge revenue. Overall, the BDA still felt a social responsibility to the NHS and wanted to support businesses operating within that: however it would be down to individual businesses to make the decision about how to proceed. Dr Moore felt that if the BDA was seen to be looking at assisting practices to move away from the NHS, then the government might pay more attention to the situation.

It was felt that there was a lack of understanding in government circles that GDPs were self-employed and it was the BDA's responsibility to educate the government about this fact.

	Dr Thackery reported that other points discussed at the meeting included: • Discussion about Compass and who sanctioned it at the year end point. • Contract reform – prototypes had been asked to collect info about the private treatment provided on NHS patients. The DoH have been asked about the legality of this as, if the patient doesn't consent to providing the information, they are not allowed to have any private treatment. • Occupational Health services – There was no funding to support those suffering from stress or burnout, and practitioners were being referred to their GMPs to go onto normal waiting lists for treatment. There is still variable availability for dental staff to access OCC Health throughout the country. • The 111 Service will change to a clinical triage platform. There is currently little detail available on the Urgent Care Pathways and if this will involve dentistry. Dr Thackery was thanked for attending and it was agreed that he would attend the LDC following each GDPC meeting.
5.	**Chairman's inaugural position statement and mandate** Dr North said that as an LDC the group needed to carry on with business as usual. He had, however, made some slight changes in the way that the agenda was put together. In addition, members were asked that if they attended a meeting on behalf of the committee, that they submit a written report before the next LDC meeting. Dr North said that he felt the LDC was already more pro-active in providing educational events for its practitioners and the courses were proving very popular and were very good for CPD. However, it was felt that the courses should just be offered to Derbyshire practitioners. Dr Ward said that one issue had been HEEM sending out the course details to all practitioners in the Trent region. Dr North felt that a future challenge would be to keep the Derbyshire County and Derby City LDCs separate. There were also concerns that it was proving difficult to get a list of who the constituents were and attempts were being made to get a comprehensive list. Concerns were also raised about e-mails being sent out to constituents and the need to BCC recipients. There were also issues around e-mails being sent out as they often went to the practice rather than individual practitioners, who sometimes didn't get to see what was sent. Dr Ward said that he was supposed to be receiving a list of performers. Dr North also wanted the LDC to be more community-facing and to make a difference. He suggested LDC members be responsible for a 'patch' and support the practitioners in that area and bring to meetings any issues/queries. Dr North was also interested in developing peer reviews. Previously these had taken place because they were responsible practitioners, but it had stopped, mainly due to a lack of funding: however, Dr North was suggesting a practice to practice process and he had discussed how to implement this with Dr Khatib. They were looking at setting up a small group to start with, and it was felt that there would be many benefits to this. Dr North asked the LDC if this was something that could be supported. Dr Moore said that he didn't like the idea of a community facing approach, and that he could see difficulties with the peer review from a geographic viewpoint. Dr Dawett also thought that there would be issues around time and, whilst he felt that it was a good idea, thought that a formal process might deter practitioners from participating. Dr Sanghera suggested introducing the concept via the educational events and Dr Dawett thought that a small group discussion at the end of events might be useful.

	Dr Moore said that Nottinghamshire LDC had recently held an AGM where attendees were asked to complete a questionnaire identifying their top 5 issues: they had agreed to share this information as it was felt the issues being experienced would be very similar for local GDPs. Dr North also suggested that it would be useful to have representation on the committee other than GDPs. In the past Bev Harston had attended and Dr North was willing to invite her again, but was also happy if anyone knew of any other DCPs who would be interested in attending. **Actions:** • **Dr North to ask Bev Harston to the next meeting** • **All members to ask DCPS at their practices if they were interested in sitting as a DCP rep on the committee.**
6.	**Minutes of the last meeting** These were agreed as an accurate record.
7.	**Matter's arising** There were no matters arising.
8.	**Standing reports**
a.	Chair's report Dr North had discussed with Helen Watson regarding delivering a first-aider course as all practices were required to have a one. It was a full-day course, for 12 attendees and Dr North would check on the cost.
b.	Secretary's report Dr Moore stated that all relevant e-mails had been forwarded to committee members. He reported that Julie Theaker was moving to Nottinghamshire CCG in September.
c.	Treasurer's report Dr Ward circulated a copy of the Treasurer's report showing that the LDC was financially well off. In the first quarter on this financial year £3k had been used to support training events. Discussion took place about for what the monies could legitimately be used and it was okay to use it to benefit the practitioners in this area, for example, education events. Dr Dawett asked a different venue could be used, possibly with attendees paying a small amount and the rest being subsidised by the LDC and it was agreed it was possible. Dr Ward said that he had held off donating to dental charities as it had gone to legal opinion if it was acceptable to use statutory levies to pay what used to come out of voluntary levy payments. It had been agreed that as long as it was for the benefits of practitioners it was ok. Dr Ward suggested that the same be paid this year as had been paid last year. The BDA benevolent fund, British Dental Guild and Dentists' Health Support Trust had suggested a donation figure on £20 - £25 per dentist, but this was difficult as the LDC did

	not have an updated list of practitioners to give this suggestion proper consideration. Dr Moore proposed that the same amount be paid this year as had been paid last and this was carried.
d.	LDC website and CPD courses Dr Khatib was unable to attend but had sent a report. *Website:* This was being updated regularly with more traffic coming through it. The website has been updated to reflect new officers, but some were still lacking a profile, so all committee members were asked to e-mail details for the profile to Dr Khatib so that he could update the website. E-mails advertising the courses also had a link to the website to promote it further. **Action: All members to check website and if there was no information on their profile, to forward the information to Dr Khatib.** *Courses*: The next course was booked for 5th July and the topic was Medical Emergencies. So far 50 people booked, and whilst it doesn't seem as popular as previous courses it is still a good number and more people were booking every day. Dr Khatib would send another mailshot in the next few days. The course after that was on 20th September – with Safeguarding Children and Vulnerable Adults – Level 2 as the topic. This has now been confirmed by Derbyshire County Council's Safeguarding team and Dr Khatib would begin advertising this soon. Dr Khatib had e-mailed Ashley Latter and he had called Dr Khatib and they had had a lengthy discussion. Ashley latter said that he would be happy to do a session. The topic suggested was something along the lines of "communication for the whole team" to go under legal and ethics core CPD. The dates he was available are either; 17th January 2017 or 24th January 2017 (fully booked up to then). His fee is £850 + VAT "include travel from Manchester, preparation delivery etc." Dr Khatib asked what the LDC thought about that? Oral Cancer: Dr Khatib had e-mailed Ann Hegarty from Sheffield Dental School and she had said that she would be happy to do this and that she regularly does a 2- hour presentation with her colleague, Keith Hunter, consultant in oral pathology, covering oral cancer and pre-cancer. She asked if the LDC would be happy to have both of them as she said this works well, but she said she could do something on her own if this was preferred. Dr Khatib though that this was acceptable. Looking at dates, 6 weeks after 20/9/16 would be Tuesday 1st November 2016. Dr Khatib asked if this was acceptable and if availability could be checked for this date with Higham Farm? LDC to let Dr Khatib know and he would email Ann Hegarty.
e	FGDP Dr North reported that there were no changes and that locally he was still trying to pull together a meeting to discuss the fellowship and how this could be taken forward.

f	DFT No report had been received: however, it was the DFT celebration day on Friday. There had also been concerns raised about the rowdy behaviour of DFTs and their lack of paying attention.
9.	**Tabled reports**
a.	LDC conference report Dr North reported on the LDC conference which he and Drs Ward and Rodick had attended and overall it was felt to be very interesting. *Preamble:* - Early view of agenda showed many of the motions poorly worded and difficult to vote on. Many of the questions and been rhetorical. - Use of iPads was a risky change. There were some glitches but overall it went reasonably well. *BDA:* An update from Dr Henrik Overgaard-Nielsen, Chair of the General Dental Practice Committee (GDPC) of the BDA. Dr North felt that the presentation was interesting, but cautious and covered the following points: **Contract reform** - Capitation and Activity = 90% - DQOF = 10% - Risk Cap & Act =-10% - Over delivery on Cap not Act - Blend A ; B1= Cap, B2&3=UDAs - Blend B ; B&2= Cap, B3= UDAs - Capitation = • Fewer targets • Prevention • Improve access • Reduce treatment need. • No new money - What do we want? (BDA) • Capitation centred • Correct weighting • Minimum practice income guarantee. (MPIG) • Remove cap on dentistry *GDC:* The presentation was from Matthew Hill, (who did not a dental background) Director of Strategy, at the General Dental Council: he spoke about: - Promote good practice rather than punish – the aim was to help people. - Government wants 9 regulators 9in healthcare) reduced to 3

	- Collect information then Feedback - Local resolution needed – the move was in preventing matters escalating to a fitness to practice panel. - He accepted shortcomings of GDC in the past and apologised - Whilst a little cagey he stopped short of criticising the current chair - *CDO:* This presentation was from Dr Sara Hurley, Chief Dental Officer for England and she covered: - She wants registrants to take ideas to the DH rather than wait - Contract reform will be multidisciplinary teams. - Information cascade needed. - DFT no information on contract reform - She wants to hold DH responsible - She welcomes the BDA being around the table - PHE under 5s health - Residential oral care (ROC) for Sheffield and Rotherham - Wait for LDN LDC consultation - Oral health and dental care formal review - OCDO Office of CDO - David Geddes and Carol Reece article in the Guardian - LDN leadership proof of concept - Agile but future proof commissioning - DQ0F and KPI and remuneration - Keen to not have health tax for patient charges - Evening off of UDA values - Forward rolling on contracts - LDC can work up advice - Brave new world - LDM place based commissioning - Dental landscape forgotten. Now back on agenda - England's oral health relatively good - 31% of contract holders not meeting 96% target - Julie Theaker introducing regional breach notices against underperforming practices. Sara Hurley considering this at the national level for consistency. *In Summary* • The conference was of a refreshing new style under the Chairmanship of Nick Stolls. • The use of information technology to simplify proceedings and reduce paperwork was partially successful and will benefit from development for next year. • Poor formulation of motions led to some of them being difficult to vote upon. • All GDPC supported motions were carried. Most of the other debated and credible motions were also carried. A few motions were rejected where GDPC advised that to carry them could put the profession in a poor light. The GDPC speaker was somewhat cautious in his recommendations. The GDC speaker and the CDO spoke clearly and candidly about the future and if we can believe what they said things look somewhat brighter.
b.	NHSE

	No report received.
c.	PAG This report from PAG (Performance Advisory Group) meeting 15/06/16 which was attended by Allan McCulloch on behalf of the LDC. '*I took a copy of the cases which were heard by their area. You will note that Shrops/Staffs are grouped together and the same goes for Derbys / Notts.* *It was difficult in the short time frame to decifer who was from which area , so I will have to group all together.* *It was interesting to be back in the process again. It has been much streamlined since I last attended resulting in a quick turnaround at the meeting .* *It was obvious that the case handling had improved enormously and that each case was risk assessed by the handler prior to the meeting.* *All BSA reports were to hand and any comments made by DPA's who had made practice visits.* *Any input from the GDC was also available and it was also noticeable (thank goodness) that their processes had improved turnaround times as well.* *A recurrent theme with regard to record keeping was the dislike of the BSA for formatted notes prevalent in modern management programmes – but I thought this was an aid to speeding up the box ticking process ??* *My overall impression was that the group wished to close cases of low risk and if compliance to any recommended actions had been taken.* *I look forward to repeating this message as the 6 months proceeds.*' Dr North was not happy not to have had representation from the LDC at the meeting and he was to explore if it was possible for him to attend.
d.	HEEM There had been no meeting since January and the next one was on the 23rd June. Dr North confirmed that he would be able to attend.
e.	LETC *LETC (Local Education and Training Committee) report 18-05-16 for DCLDC meeting 21-06-16* Dr North reported that this had been an interesting meeting, although there was little relevant to dentistry. The main points were as follows: *Assistants:* No appetite for derby Junior doctors Wanting 'bang for buck'

Disclaimer problem

Primary care workforce & planning:
Collection of data
Datasets – there were issues with corruption of the data.
Need accurate baseline
Practice submission
Crude uplift factor estimate
Collection tool
Retirement projections
Raised issue of GDP
LETC to include local authority

Pharmacy workforce:
Comm ph contract
Poor workforce data and outcomes
ESR wrong elect staff rec
Again outsource helpers
No final numbers!
Rearranging deckchairs need more
Fewer delivering more
It's a transformation process

Reduce LETB in number:
LETC will disappear
Transform to local workforce action boards. LWAB (Local Workforce Action Board) transformation 1/8/16 money. Membership should be same. Bigger area
Vanguard risks needed
5 year forward concept
STP? Sustainability workforce plan

Chair LMC group
Asked DirMedEd why consultants don't form partnerships
Reply was this in next NHS reform
Consultants in hospitals to form "Chambers-like associations.

Make em attractive from Sheona
D2n2? £1.4 million enterprise partnership few healthcare providers!
End of life education

Summary & opinion

1. I managed to get the words dent* into the discussions at every opportunity.
2. I imprinted the words on them by the end of the meeting.
3. I asked the PCWP lead how dentistry fitted into all this. He confessed he didn't know but would find out.
4. The LETC appears to be a well-run and reflective committee.
5. Unfortunately it's about to be terminated.
6. Training is being overtaken by workforce.
7. Pharmacy in a worse position than us. Chaos!
8. Chair LMC related GMP partners have same commercial conflicts as dentists in quality of care / finances domain.
9. DirMedEd says Consultants to form partnerships similar to Legal Chambers in next NHS reform. Opinion? Consultants less likely to support Junior Doctors if they have a commercial interest!

Actions

	1. To be aware of changes. 2. Probably unable to change direction but to inform future meetings on risks and amendments. 3. To reinforce Training – not just Workforce. A trained workforce is essential.
f.	LPN There was nothing to report
g.	LDC Liaison Meeting Dr Moore had attended this meeting and felt that there wasn't much new at all, but there had been a presentation from Liz Hughes of Frank Taylor Associates on the range of presentations available to LDCs and they would be willing to come and do one. They offer courses aimed at associates and have 4500 associates registered with them in England and Wales, looking to buy a practice. First course covers business planning, cash flows, employment law and H.R. The second covers succession planning and exit strategy. Apparently, principals start planning on average from 52 years of age now, previously 58. They have never seen a downturn in interest in buying NHS contracts. Currently 14 banks lending to dentists. Issues with incorporation and selling time limited ortho practices in various areas. Several young associates have failed their CQC interview, due to lack of management skills. Massive bank of mum & dad, especially after last year's pension changes. Banks normally like a 10% deposit, or the parents to be guarantors. Can't see this buyer driver slowing down. Often go to a sealed bid process, though a seller doesn't have to accept the highest bid. FTA also talk a lot about the legal process, especially when it comes to the freehold/lease. Takes, at best, 6-12 months to go from terms of business to completion. Beyond this presentation, other matters included a discussion of whether it was viable to set up and support a whistle-blowing support scheme in our area.
12.	**AOB** Dr North proposed a vote of thanks to Dr Rodick for his many years of service. This was agreed unanimously by the committee members.
13.	**Date, Time & Venue of Next Meetings** Unless stated all meetings commence at 7.30pm, at Santos, Higham Farm, Higham. **2016** 26th July

	6th September Educational 5th July – Topic to be announced 20th September – Topic to be announced