

Draft Minutes of a meeting of the National UK NHS Cleft Development Group

Venue – Research Boardroom at the Royal College of Surgeons of England

Date & Time – Thursday, 18th May 2017, 11.00 – 16.00

<p>1. Present</p>	<p>Simon van Eeden (SvE)</p> <p>Scott Deacon (SD) Yvette Edwards (YE) Norman Hay (NHa) Peter Hodgkinson (PHo)</p> <p>Nichola Hudson (NH) David Landes (DL) Kate le Marechal (KIM) Jason Neil-Dwyer (JN-D) Ginette Phippen (GP) Susan Parekh (SPa) Marie Pinkstone (MP) Sandip Popat (SP) Jonathan Sandy (JS) Jackie Smalridge (JSma) David Steel (DS)</p> <p>David Stokes (DSt)</p> <p><u>Invited Guests</u> Marie Wright Jibby Medina</p> <p><u>In Attendance</u> Jackie Horrocks (Minutes)</p>	<p>Chair, CDG & Clinical Lead, North West, IoM & North Wales Cleft Network</p> <p>CRANE Clinical Project Leader CDs and Managers Group Clinical Lead, North Thames Cleft Service Clinical Lead, Newcastle Site, Northern and Yorkshire Cleft Service & Chair Cleft Centres Lead Clinical Nurse Specialist Public Health Consultant, PHE Clinical Psychologists CEN Clinical Director, Trent Cleft Service Clinical Director & Lead Speech and Language Therapist Paediatric Dentistry CEN Lead Speech & Language Therapists Restorative Dentistry CEN Lead, Cleft Collective Birth Cohort and Gene Bank Study Consultant Paediatric Dentist, CleftNetEast Chair Programme Director, National Services Division, NHS Scotland CLAPA Chief Executive</p> <p>Research Fellow CRANE Research Fellow</p> <p>Minutes / Administrator, Clinical Effectiveness Unit</p>
<p>Apologies</p>	<p>Lorraine Britton (LB)</p> <p>Alec Cash (AC) Sinead Davis (Sadh)</p> <p>David Drake (DD) Toby Gillgrass (TG) Per Hall (PH) Chris Hill (CH) Sian Lewis (SL)</p> <p>Jason Neil-Dwyer (JN-D) David Orr (DO) Ian Sharp (IS)</p> <p>Bill Shaw (BS) Alistair Smyth (ASm)</p> <p>Adrian Sugar (AWS) Jan van der Meulen (JvdM) Mike Winter (MW)</p>	<p>Lead Speech and Language Therapist, Trent Regional Cleft Lip & Palate Service Clinical Lead, South Thames Cleft Service Chair, CEN for Cleft ENT and Hearing and Consultant ENT Surgeon Cleft Surgery Training Interface Group Lead Clinician of Cleft Care Scotland Cleft Surgeon (BAPRAS) and Cleft Surgeon, CleftNetEast Northern Ireland Clinicians Acting Medical Director - Welsh Health Specialised Services Committee Clinical Director, Trent Cleft Service Cleft Services in the Republic of Ireland Vice Chair, CDG, Clinical Director, West Midlands Cleft Centre & CRG Representative for CDG Lead at Manchester Clinical Trials Centre Cleft Surgeon (BAOMS), Clinical Director Leeds Site, Northern and Yorkshire Cleft Service Wales Clinicians Senior Epidemiologist, Clinical Effectiveness Unit Medical Director, National Services Division,, Scotland</p>

ACTION

<p>2. Leavers and Joiners. Membership of the CDG</p>	<p>SvE introduced Ginette Phippen (GP) who has joined the CDG as the new Clinical Director of the Spires.</p>	
<p>3. Dates for meetings</p>	<p>Next meeting will be on Monday 16th October 2017 - venue - Research Boardroom, Nuffield Building, Royal College of Surgeons.</p> <p>The one after this will be held on Tuesday, 9th January 2018 in the same venue.</p>	
<p>4. Minutes of previous meeting</p>	<p>The draft minutes from 28.01.17 were amended and accepted by the committee.</p>	
<p>5. Matters arising from previous meeting</p>	<p>Contract for CRANE Database with NHS England SD reported that the CRANE contract is being reviewed and he is waiting to hear back from NHS England. DL noted that NHS England are busy at the moment and this is causing delays.</p> <p>Excelicare SvE noted that Excelicare who were to present at the CDG meeting had pulled out again at the last minute. JS felt it was a long standing issue and he suggested that the onus should be on Excelicare to say when they are ready to commit and then get back to the CDG. SvE agreed to write to them and ask when they would be ready to present.</p> <p>Quality Dashboard SD said that the comments on the Dashboard had been dealt with and that Neena had updated the matrix. Once all the dashboards have been received by SvE from the centres, he will put these together for discussion.</p> <p>Clinical Psychology ‘downbanding’ SvE noted that he had not received the notes from the Clinical Reference Group regarding the downbanding of Clinical Psychologists in centres mentioned by AWS. SvE said he had asked but had not had anything back from AWS and that he would ask AWS again.</p> <p>Terms of Reference GP agreed to remind SR about the revised Terms of Reference and SvE said they would be reviewed at the next CDG meeting. .</p> <p>CLAPA patient representative DSt said he was working on recruiting a patient representative to the CDG, preferably from London, as there was no money available for travel expenses</p>	<p>SvE to write to Excelicare</p> <p>SvE to ask AWS</p> <p>GP to speak to SR</p> <p>DSt looking into recruiting lay CDG member</p>
<p>6. Feedback from CENs</p>	<p>Paediatric Dentistry SP said that the annual Paediatric Dentistry CEN meeting had been held after the Craniofacial Society conference. There had been a presentation from the Acorn team to update the membership on who does what in each unit. There will be a</p>	

calibration and CEN day in January 2018 and SP will circulate the date to those interested.

Orthodontic CEN

JS said there had been a debate about ten year data. He said he and BS would like to retain these records but he is not sure what the decision had been on this.

Speech and Language CEN

MP said that the outcome data from SLT report had been shared at the SLT CEN in Newcastle. She said the report had been published with anonymised data. There was also support to from RCSLT to publish the report with changes. She said that she was meeting the CLAPA panel and the use of social media had been discussed at the Leads meeting. She said the political agenda had changed.

Nursing CEN

NH said that there had been a change in leadership in the CEN with Helon Robson taking the lead. She said the latest Manchester course had been very successful with 8 nurses from around the country completing the course.. There had been two representatives from Scotland, two from Cambridge, three from London and one from Alder Hey. Marie Wright from the BPSU (lead for the PRS study) had met with the Cleft Nurse specialists to correlate patient numbers.

Restorative Dentistry

SP said there had been a good CEN day in Cambridge. He said he had been invited to present to Cleft care Scotland. There is a research project being planned to compare resin bridge tooth replacement with implant replacement in cleft patients but the current proposal is too complex and needs to be revised.

Clinical Director CEN

Pho reported back on the meeting held at the CFSGBI in Newcastle. Audit was discussed and agreement was reached that this should be reviewed. It was felt that a day to discuss the collection of 10 year old records needs to be arranged. SD was asked to consider taking this forward.

Cleft Surgery

PHo said that robotic equipment had been available at the Conference for surgeons to practice on but people were not convinced of their value yet and generally felt more was achievable with microscopes. There had been a presentation from an expert in robotics. SvE felt there needed to be more robust evidence of efficacy but that it had been useful to try out the soft palate prosthesis. PHo said that robots will improve in the future and much was dependant on being skilled in using them. He noted that it had cost £150,000 to install the robot for a few weeks. SvE agreed that it was essential for people to be fully trained before being allowed to use the robot in operations.

THE said there was a proposal to conduct a national study to visit centres and examine surgical techniques and make records. CDG noted that the Newcastle Conference had been superbly organised. PHo pointed out that the new president of the CFSGBI should be invited to attend CDG and SvE agreed to invite Imogen Underwood to the CDG as the new CFS President.

**SvE to invite
Imogen
Underwood to
next CDG
meeting**

	<p>Clinical Psychology KIM said there was a need to get some papers out to use the large amount of data available but that there was no funding to do this. There had been discussion on strategy to get the data analysed and published. She said there had been work with CLAPA and that there would be a presentation at the CLAPA adults' conference. She said there had been work on orthognathic data with outcomes, and the PREM work with CRANE and Vanessa Hammond. She said psychology staffing was still a problem nationally but the CEN was working hard on this.</p>	
<p>7. Audit</p>	<p>CRANE Database SD had circulated an update report on the CRANE Database (enclosed).</p> <p>SD highlighted the issue with collection of speech outcome data at 10 years old. In light of the concerns raised at the Craniofacial Society meeting in 2016 about the burden of collecting this data and its analysis, CRANE will be consulting all stakeholders over the coming months and is hoping to hold a CEN day in mid to late 2018 to discuss this issue further.</p> <p>He also drew the CDG's attention to the adding of the five year psychology outcomes fields to CRANE. He said CRANE was working with Crown Informatics on additional outcomes including real time reporting on late cleft palate diagnosis, funnel plots and demographic data.</p> <p>He noted that the process involved in renewing CRANE's linkage to Hospital Episode Statistics (HES) was now more difficult and created delays. He also highlighted that due to the increased communication by other means and the time needed for CRANE staff to concentrate on the continuing redevelopment work, there will be no progress report for 2017 and the annual report will be produced later than usual in December.</p> <p>SD and DSt said that Scotland had agreed to contribute their data to CRANE.</p> <p>It had been decided at the combined Speech and Language and Surgeons CEN meeting on 7 April that CRANE should collect LAHSHAL (2Hs) and that the classification would be confirmed at the time of surgery. JS suggested that CRANE use the Cleft Collective surgical form to collect this data to avoid duplication and the burden on the centres – 609 surgical forms had been completed by surgeons around the country and collected by cleft collective to date. SD said that the proposed CRANE form was very small. PHo noted that the Cleft Collective form was very quick to complete and if the CRANE form was smaller, perhaps CRANE was not collecting all the relevant information. SvE said that the only issue was to make sure the form was included in the patient's notes. It was agreed that CRANE will use the same form and that SD and JS will liaise on this. SE asked if some centres were less participatory in the Cleft Collective. JS said that all 17 centres were on board now. He said that some may need to get up to speed as they have only just joined. SD asked if the CDG was happy for CRANE to collect the Double H data.</p>	<p>SD and JS to liaise on LAHSHAL fields form</p>

He said that this would involve adding another 'H' box to CRANE which will have a cost implication so he wanted to be sure that CDG agreed. SD agreed to look into integrating it into CRANE.

PREM Presentation

Jibby Medina (JM), the CRANE Research Fellow did a presentation on the Patient (and Parent) Reported Experience Measure (PREM) feasibility study to test PREM data collection, analysis and report with a view to developing a method to implement this nationally. The initial report has been circulated to the CDG.

The study involved:

- Data collection: 30 November 2015 – 31 January 2017
- 530 PREM questionnaires – self-completions or completed in paper format by parents/patients
- 3 types of questionnaires:
 - 10 or 11 year old patients
 - 15 or 16 and 20 year old patients
 - Parents – aged 4-24 months, 10 or 11 years, or 15 or 16 and 20 years

JM asked the CDG to help instruct cleft teams to help CRANE interpret the submissions by cleft team findings. e.g. Successful methodologies, challenges, burden, etc.

The Conclusion of the study were:

- Using this protocol allows cleft teams to meet the standards set in the National Service Specification commissioning document, which require teams to measure parent satisfaction with early years and patient and parent satisfaction in adolescence and at end of routine care
- However, collection and analysis of the data has a cost in terms of resource, both locally in cleft teams and nationally in terms of coordination and analysis.

JM said that CRANE had various questions for the CDG.

1. Are the CDG happy to adopt the measures and protocol used in the feasibility study?
2. Should cleft teams be collecting PREM data continuously or by taking a regular sample (eg for a 6 month period every 2 years)? If a sample method is used, each sample period is likely to have a slower return rate initially due to start up issues
3. Should target return rates relative to number of patients attending clinics in the time period be set?
4. Does the CDG want to ask cleft teams to support the feasibility study team in developing a better understanding of reasons for particular high and low return rates, to better inform the protocol and enable teams to meet potential target rates?
5. Does the CDG want to continue with the option of anonymous feedback in terms of patient identifier and team identifier?
6. If teams are to continue to collect PREM data, how will this be resourced and coordinated?
7. If teams are to continue to collect PREM data, how will this be reported?

DSt said that CLAPA can help with this study as it has done a

patient experience of surgery survey with 1200 responses, including data from pre-centralisation. He said CLAPA would be happy to have it on its website.

JS said that experiences of healthcare are difficult to capture so a third party such as CLAPA is more likely to get accurate results. DSt noted that there was also historical data to provide comparisons. SPa suggested that to avoid duplication the questionnaire could ask them if this is the only time they have filled this in. DL said it was important to note if data for a particular group was not being collected. MP said that her trust had a designated helper which helped boost collection of data. KIM felt that a note of where in the region the patient came from might be useful and SPa said that patient satisfaction may be linked to ease of journey.

SvE asked if the specific site where the patient was seen was noted, and GP felt this needed to be added to the dashboard. SD felt it was not necessary on the dashboard but needed to be reported. He said that CRANE was aware of the volume of work at centres. GP asked what the main objectives of the study were. SD said that it was to build a national picture of cleft care but that it was too blunt a tool to compare centres. He said it all takes time and effort. SvE said there is a problem in North Wales as the questionnaire would also have to be in Welsh. DSt said the CLAPA survey had to be in English only as the resources for it were limited. SD said translation was quite expensive with £400 or £500 charged for each language. He said the most common languages translated were Urdu, Polish and Welsh. It was asked if a native speaker of the particular language could do the translation but SD said it was a specialised job. DSt said that even if CRANE was not working directly with CLAPA, CLAPA was happy to promote the study. SD noted that there were two measures used in the study and asked the CDG whether this was necessary. KIM said the Friend and Family questionnaire was popular as it was well known but that it collected limited information. The other was more detailed. KIM suggested that patients/parents could be given the friend and family form to complete and then a link to the more detailed questionnaire. SPa said that the benefits from other studies could be mentioned to participants to encourage them to complete the forms. It was felt that the study should be kept simple. It was asked what could be done to improve response rates but GP felt that it should perhaps be accepted that there are limits on what is possible. SPa noted that patients/parents with either very good or very bad experiences were more likely to respond than others. PHo said that how centres were resourced made a difference. Newcastle was fully resourced so they can work at achieving high returns. SvE asked how the study can be taken forward. KIM said that after the feasibility study and pilot, the aim was to get on with the main study. The next stage was to go back to the CFSGBI with some recommendations. KIM, Vanessa Hammond and the CRANE team will draw up a proposal.

ICHOM

SvE said that two centres were actively collecting data using the ICHOM dataset– Erasmus in Rotterdam and Boston. The software cost £30,000 but was gaining good results. He noted that the only thing that had happened in the UK was

PREM study to draw up a proposal

	<p>benchmarking against the ICHOM dataset as trusts were so cash-strapped. MP said that her trust had secured funding and its IT department had been talking to Erasmus but the communication had gone silent. KIM noted that the ICHOM timescales were different from the UK and that ICHOM was using CleftQ which had not been validated. SD and SvE said that it had been now. KIM said she had had a long conversation with Tom about psychology but that there was not the interest in the UK. SvE said that their focus was not on demographics but on PROMs. He also mentioned that there would be an International Conference later in the year and that there was interest in holistic and psycho-social outcomes. He said he will keep the CDG updated.</p>	
<p>8.Research</p>	<p>Infoflex</p> <p>YE demonstrated the Infoflex system set up in the North West/North Wales. She said around five or six years ago a process was begun to bring both surgical units in the North West and North Wales together in one database. The system went live two years ago and different departments are gradually being phased in. It was organised around the patient pathway and she said there was little free text and the emphasis was on drop down boxes. The idea was to improve connectivity and the system can also produce reports. She said all the nurses were enabled to use the live system but not all the surgeons. The nurses were more proficient with the system and were trying to get reports produced. In theory it should be possible to do this yourself. There is a comfortable match with CIMS to do reports. Real time data reporting relies on WiFi and Citrix connectivity and there are sometimes problems connecting from Wales due to poor Wi Fi connectivity. Data transfer of old data to the new system had been successful.</p> <p>SvE said there was linkage between Infoflex and the hospital PAS system through the patient number. YE said that any changes in either system will update the other. There are demographic and cleft details screens with descriptions. There were also fields to enter the type of clinician specialist and a referral page. She said the description of cleft details can be added to such as updating with special assessment findings. KIM asked if patient appointments can be added. YE said there would be an extra charge but a link to these would be possible. Audit outcomes such as CAPS A and dental details can be added and a summary screen can be built. It was asked if Infoflex can be used to submit data to CRANE and SD said that this can be built into the system. YE said that Infoflex had been used for an oral health audit using a clinic planning tool. She said all pages can be used for reports. There is also an antenatal care pathway. Through an antenatal nursing screen, the mother's name will connect to a patient review page. SD said that it meant that all visits and other components were contained in one record. YE said that a pathway is built using all these screens. SvE said that it was very quick. The Surgical page can show all episodes, operation details, outcomes and videofluoroscopy. He said that each screen was built by Infoflex with input from the relevant specialty. The system can print off genetics summaries. SD said that unfortunately, his trust will not do deals with Infoflex. SvE suggested that other centres ask YE or himself for advice or contact them with any queries about the system. YE said that if a</p>	

clinical team knows what they want out of the system, it makes it much easier to set up. SvE noted that the price had doubled recently. SD felt that if enough centres want to use it, there might be a possibility of a deal. YE noted that nurses in the centre had been given electronic tablets to make it easier to use at the time of consultation. She said that the centre was now starting to see the benefits and now can use the system to investigate complaints and the data can be used to corroborate or dispute assertions made by patients about care. . SvE said it can be used for electronic notes.

Cleft Collective Birth Cohort and Gene Bank Study (Bristol) (enclosed)

JS had circulated a written report before the meeting. He noted that antenatal recruitment has started and that this will enable the Cleft Collective to measure the exposure of the mother and infant with cleft during pregnancy.

GP said the Clinical Nurse Specialist played a very important part in patient involvement. SvE asked if it was the same setup in every centre. JS said it varied with either a CNS or a local PI in place but the information was still obtained anyway. He said there was a shared care contract so the funding goes to cleft rather than maternity. NH said it was a very smooth process, with everything under control and any problems flagged up if necessary. She noted that in Oxford there were more contractual issues than in Salisbury.

JS said that the data was being cleaned. He said the Cleft Collective was looking for collaborators and the work with the clinical psychologists would be available first. Speech and language would follow soon. Team members are engaging with PPI activities and CLAPA and also with George Wehby, from Iowa with a view to developing collaborative future funding applications. He said it was getting to the point that the data was very useful and more interesting. He also said that the benefits in linkage were more apparent. The External Advisory Panel involving Liz Albery and Rona Slator and also a patient representative was providing challenging advice.

Linkage between Cleft Collective and CRANE Database

JS had prepared a paper on linkage between the Cleft Collective and CRANE (enclosed). He felt it was the way to go and in the patients' interest. But he felt the £9,500 asked for by CRANE was too much especially as the National Pupil Database link was free. He said he was asking the CDG if they thought linkage between the Cleft Collective and CRANE was a good idea and if they would support JS in this. SD said that he did not necessarily agree with the RCS costings but noted that CRANE itself was already underfunded at the moment and that this would involve additional costs. PHo asked if he was asking for endorsement from the CDG for the linkage and JS said he was. SD said he feels that CRANE would gain from the link also. The CDG agreed to support JS's proposal and SvE agreed to write formally to SD and JvM about this.

SvE to write formally to SD and JvM

Young Researchers Group (YRG)

JS said that the Young Researchers Group had collected all the data for David Sainsbury's report and that this was an example of

	<p>the benefits of collaboration. He said the YRG came out of the Clinical Studies Group. PHo felt the YRG should be funded by the Craniofacial Society and noted that Liverpool seemed vague about its funding. He asked if it was linked to the Cleft Collective and JS said that it was not. PHo agreed to write to Rona Slator to clarify.</p>	<p>PHo to write to RS</p>
<p>9. Social Media</p>	<p>SvE said that unfortunately DSt had to leave after lunch but that he raised the issue of social media and oversight over lunch, as there had been a couple of inappropriate posts out of hours locally. SvE reported that DST had confirmed that there was a CLAPA national policy on posting but that posts can only be policed in working hours -policing can be applied locally through contact with the national office. DL said there were sometimes inappropriate links between verifiable sites.</p>	
<p>10. Pierre Robin sequence national surveillance study: overview and interim results</p>	<p>Dr Marie Wright from the British Paediatric Surveillance Unit (BPSU) PRS study team had been invited to give a presentation on the project. She said that the study had had to decide on a definition although this was inevitably a compromise. It was defined as the combination of various factors. The case definition was:</p> <p>Live-born infants in the UK or ROI with the following clinical features:</p> <ul style="list-style-type: none"> • (1) Cleft palate <u>AND</u> • (2) Micrognathia/ retrognathia, or glossoptosis <u>AND</u> • (3) Evidence of resulting compromise, with at least one of the following features: <ul style="list-style-type: none"> • Signs of upper airway obstruction • Feeding difficulties • Faltering growth <p>She also noted three points regarding RS</p> <ul style="list-style-type: none"> • It can occur in isolation or as part of a more complex syndrome or multi-anomaly disorder • Substantial treatment burden requiring input from a large multidisciplinary team (MDT) • No current consensus or guidelines about best-practice approach to management <p>She noted that:</p> <ul style="list-style-type: none"> • Birth prevalence widely reported as 1 case per 8000 – 14000 live births based on national European studies • But that there is limited data regarding prevalence in the UK and Ireland <p>She said that British Paediatric Surveillance Unit had been established in 1986 and gave details of the Unit:</p> <ul style="list-style-type: none"> • It was a joint initiative of the RCPCH, Public Health England (PHE) and Institute of Child Health (ICH) • Its mission was to promote and facilitate the investigation of rare childhood disorders, or their complications, in the UK and Republic of Ireland (ROI) • Collection method monthly (orange) reporting card (electronic since 2011) sent to > 3400 paediatricians with >90% response rate • Multiple studies carried out simultaneously by study teams based across UK and ROI 	

The objectives of the study were:

- To identify the current birth prevalence of RS in the UK and ROI
- Describe the management practices utilised by different UK hospitals and cleft centres
 - Airway and feeding support, MDT approach (e.g. lead professionals, referrals)
- Describe the 12-month clinical outcomes of infants with RS
 - Duration of airway and feeding support, growth, neurodevelopment
 - Comparison of outcomes between different airway management practices e.g. length of hospital stay, readmissions, treatment duration

MW described the methodology:

- Study design:
 - Prospective population-based surveillance study
- Duration:
 - 13-month surveillance period (Jan 2016 – Jan 2017) with 12-month follow-up period
- Data collection:
 - Anonymised clinical data collected from the responsible health care team via paper or electronic questionnaire
 - Minimal data set of patient-identifiable information collected to enable de-duplication of reported cases
- Reporting sources:
 - British Paediatric Surveillance Unit (BPSU) via 'Orange Card'
 - Regional cleft teams via alternate reporting card

Cleft Team Participation

- Six cleft teams submitted reports via monthly reporting card
- Four teams submitting data for cases that weren't reported via the Orange Card

There were 245 notifications of cases with 80% coming from the card and 20% from cleft teams.

She demonstrated the geographic distribution of cases; patient demographics: antenatal and family history; timing of RS diagnosis; RS classification; airway management; feeding management and current status of patient.

Next steps were detailed as follows:

1. Complete data set from cases reported during surveillance period
 - Data collection questionnaires for 42 cases still awaited
2. Identify any 'missed' cases from the surveillance period
 - Cleft teams re-contacted to establish total number of RS cases seen in 2016
3. Calculate prevalence rates when annual birth statistics are published
 - Denominator source: Office for National Statistics (England & Wales), National Records of Scotland, Northern Ireland Statistics and Research Agency, Central Statistics Office (ROI)

	<p>4. Collection of 12-month follow-up data (ongoing until January 2018). This will collect:</p> <ul style="list-style-type: none"> • RS classification • Feeding and airway management over 1st year • Growth parameters • Neurodevelopmental progress • Investigation outcomes: genetics, sleep study, audiology, ophthalmology • Cleft repair status and perioperative airway support <p>MW noted that for cleft repair status, she will have to rely on centre staff to fill this in as she cannot access named notes.</p> <p>It was noted that methadone and alcohol use in pregnancy seemed to increase the prevalence of RS.</p>	
<p>11. Any Other Business</p>	<p>Alveolar Bone Grafting GP asked if alveolar bone grafting could also be done by oral surgeons with a dental background. PHo said this did happen and it depends on the level of competence. This view was echoed by the rest of the CDG. SvE said there was no restriction by the GDC.</p> <p>Dental Health Consultant DL noted that Ken Wragg had retired and asked the CDG whether they wanted to recruit another dental consultant in public health who could also act as a deputy if DL was unable to attend meetings. CDG agreed that this would be appropriate. DL had sent a draft letter to SvE requesting recruitment of another dental consultant in public health and SvE agreed to send this to Dr Yvonne Dailey, Chair of the Consultants Group in Dental Public Health.</p> <p>Training SvE said that there are three fellows currently. One is working at at North Thames and one at South Thames. SD noted that there was no start date yet for the one recruited to Bristol.</p>	<p>SvE to send letter to YD</p>
<p>12. Date of the next meeting</p>	<p>The next meeting will be on:</p> <p>Monday 16th October 2017 Venue - Research Boardroom, Nuffield Building, Royal College of Surgeons</p>	