

**Surrey and Sussex Local Dental Network**

08th December 2016 at 14:00-17:00

The Kent Room, 18-20 Massetts Road

Horley, Surrey, RH6 7DE

**Chair:** Brett Duane

| **Present** | **Name** | **Job title / Organisation** |
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|  | Brett Duane (BD) | Co-Chair Kent, Surrey & Sussex LDN |
|  | Gemma Michael (GM) | Business Support Administrator, NHS England |
|  | Jackie Sowerbutts (JS) | Locum Consultant in Public Health, Public Health England |
|  | Jeremy Collyer (JC) | Consultant, Queen Victoria Hospital |
|  | Paul Mellings (PM) | Dental Practice Advisor, NHS England |
|  | Snehal Sattani (SS) | Surrey LDC Representative |
|  | Agi Tarnowski (AT) | Dental Clinician, West Sussex LDC |
|  | Annie Godden (AG) | Senior Contracts Manager, NHS England |
|  | Nish Suchak (NS) | East Sussex LDC Representative |
|  | Geoff Thomas (GT) | Patient Representative, Healthwatch |
|  | Faye Eves (FE) | Dental Care Professional |
| **Apologies:** |  |  |
|  | Stephen Lambert Humble | Dental Dean, Health Education England |
|  | Jill Graham | Senior Contracts Manager, NHS England |

| **Agenda Item** |
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| **1. Welcome and Apologies**  BD introduced the meeting and apologies were given as above. |
| **2. Notifications of any other business and matters arising.**  **To be discussed:**  BD voiced he wanted to discuss the Surrey and Sussex Terms of Reference (ToRs) and LDN membership. Also to circulate an options paper regarding the structure of the LDNs.  Under any other business, JS from Public Health England (PHE) wanted to discuss oral health and children. |
| **3. Minutes of the previous Surrey and Sussex LDN – 15th September 2016**  The group agreed that the minutes taken from the meeting on the 15th September 2016 were a true and accurate record. BD signed off the minutes.  **Action: GM to ratify the minutes and send them for upload.** |
| **4. Actions form the previous Surrey and Sussex LDN – 15th September 2016**  **Action 6.** BD to email Nicolas Lewis to sit on the MCN.  **Action: Roll on action for BD.**  **Action 12.** BD to draw up a letter to send to those members who fail to attend 2 LDN meetings in a row.  **Action: Roll on action for BD.**  **Action 19.** JC to obtain information from the appropriate clinicians of the Oral Surgery MCNs (Surrey and Sussex). A nominated representative from this strategic umbrella will be asked to sit on the LDN.  **Action: Roll on action for JC.**  **Action 25.** SLH to get a theme together for March 2017 Challenges Conference regarding paediatric dentistry and ask for comments. **Update –** Roop Kaur has been asked to send out a ‘Keep the date free’ until formal invites go out, but confirmed that a date had not yet been set.  **Action: Roll on action for SLH.**  All other actions have been completed from the 15/09/16 log. |
| **5. Minutes from the KSS Dental Core meeting – 19/10/16**  BD informed the group that the minutes presented to the group were for information only.  BD asked if there were any comments regarding the minutes presented, none were forthcoming. |
| **6. Healthwatch update**  GT reported that there was no update that required to be presented to the group. BD stated that a closer relationship with Healthwatch was needed to ensure that there is public engagement in what the LDN will be doing. The group discussed how the LDN might be able to work with Healthwatch.  JS informed the group that there is preparation for a big re-procurement of orthodontic treatment. The new contracts will need to be in place for March 2018. As part of this process, a short questionnaire will be sent out to the carers of patients who have been recently referred through the DERS system, enquiring the level of satisfaction.  JS asked how this might be consulted on a wider basis to see what people views are when accessing care for their children. There is particular interest on what factors are taken into consideration to where individuals go to be treated; it is location to home or the proximity to the school. What information was given to the individual and also the choices they were given. Why did they choose the particular provider and what was the influence on how far they were prepared to travel to a practice.  The view of both parent and the child is important and the questionnaire is going to patients being referred to an orthodontist at this present time. DERS is being used to capture the required data as it was felt unsuitable to ask the already busy orthodontists to fill in more paper documentation.  With regard to the timescale. JS stated that the procurement timescales start very soon and the parameters for procurement need to be set within a specific timescale. AG further added that the Pre-Qualifying Questionnaire (PQQ) identifying eligibility and suitability will be starting next week and will run until the end of March 2017, however, this PQQ will not stop all the consultation that is continuing.  AG mentioned that there is the need to be mindful when creating the questions as not to raise expectations.  **Actions: JS to email Libby Lines and GT to co-ordinate responses. JS to send the questionnaire to the group. GT to take this discussion back to Healthwatch.** |
| **7. Website Users guide**  GM informed the group that she had communicated and sent a LinkedIn approval form to Linda Gregory who is assisting with the formal set up. When the account has been set up, GM will communicate this with the LDN.  The NHS Webpages have been updated accordingly with membership details and previous minutes.  **Action: GM to contact communications to add JC to the membership list for the Surrey and Sussex LDN**.  AG mentioned some concern over the administrative capacity to manage this LinkedIn account. GM stated that she would be able to oversee the LinkedIn page once a week to upload any information and to provide appropriate responses to any queries. AG further noted that any reply must be ratified before this can be communicated.  **Action: GM to send the LDCs the links to the webpages. GM to email all dental practices and LDN members to inform them that the webpages are up and running providing the links.**  NS voiced that the needs assessment should be sent out to every nhs.net account. AG asked JS if she was happy with this and JS confirmed she was.  **Action: AG team to send out the needs assessment to every GDS practice.** |
| **8. Orthodontic Health Needs Assessment**  JS informed the group that she has met with AG regarding the Orthodontic HNA. A minor revision was need on the HNA before consultation. The HNA will be circulated shortly for comment.  The key points taken from this discussion were:   * JS informed the group that there are a couple of associated papers with the Orthodontic Needs Assessment. One part is the questionnaire that the group has discussed a short referral guide for general dental practitioners (GDPs). Orthodontists have been asked to comment as it is believed that if the contract is used as efficiently as possible, there will be capacity in the system to commission at similar levels. * Part of what is seen in the use of contract, is very early referrals for children under 9, about 12%. A lot of work is already been carried out with assess and review and assess and refuse. There have been improvements already seen in the user contact so proportionally more of the contract is being used to treat patients rather than continually review children or refuse inappropriate referrals. * If the quality of the initial referral can be improved along with the level of knowledge and information of GDPs so that the best quality referral can be made at the right time. The idea is to produce a short one page guide for reference to be able to use as a tool. * These two documents have already gone through the MCNs for comment to make sure they are correct. The Orthodontic HNA will go out to all current orthodontic providers, orthodontic consultants, the MCNs, the LDCs, and the LDN members for comments. * Once circulated it will have a 3-4 week timeframe for comments. AG voice that everybody who receives should have the whole pack to get the whole picture. It may not be the final guidance, AG asked JS is she was happy for it to be circulated as a draft, and JS confirmed she is happy with this. * The main changes to the document are the updating of statistics on the numbers of assess and refuse etc. Part A is the work carried out by Brett Duane and the statistics, Part B is much smaller and Part C is the appendixes, the supporting details and information. JS confirmed that the key part that needs reviewing is Part B and asked if this could perhaps be mentioned in the email upon circulation. * SS wanted some clarification from JS regarding procurement. JS responded by stating that to procure at a certain level, highlighting 40,000 UOA sufficient to treat a certain number of patients. The predicted population growth will be approximately 8% and it would be understandable if there were a request for 8% more UOAs. There is an agreement that there is already capacity in the system to treat the predicted growth of 8% so there is no need to further commission more UOAs and there are also contract efficiencies in the past few years to be able to soak up this growth further.   SS acknowledged that there might be capacity to soak up the extra growth but stated that GDPs are being asked to do something that were not required before, to make exact IOTN assessments.  JS and AG confirmed that they were not required to do this. SS went on to explain that putting in the information on DERS is still being asked of GDPs and this was not necessary before and this is being done free of charge. JS stated this should be done as the initial part of the patient’s examination and the GDP will receive a UDA for doing this so they are not doing it for free. AG voiced that this is national and that the national commissioning guide clearly identifies that what is classed as a level one complexity, the GDP should be doing what is required of them within their mandatory service.    AG confirmed the reason that the number of assessing and refuses is declining is the introduction of the paper referral proforma. There is now the requirement to identify need i.e. overjet/underjet or crowding. DERS will identify further details as it will ask the referrer to select an option asking for additional information like how big is the overjet/underjet. Some referrals will not get through DERS as they will not have met NHS criteria and this is how the efficiencies are being made. SS still raised the point that GDPs were not asked to do this previously.  JS requested that any concerns be emailed to her directly.  **Actions: Comments regarding the Orthodontic HNA to be sent to JS.**  AT raised an issue given to the LDCs that there is concern amongst smaller independent orthodontists that putting UOAs in bundles disadvantages the independent providers. The bigger corporates are able to bid on big bundles of UOAs more easily than smaller providers. There is a request that prospective providers be offered some guidance from the commissioners. AG responded by stating that this was also requested at DEQUAP and they were given the same answer, NHS England cannot give any guidance as commissioners on how to prepare any bids as it is a complete conflict of interest.  There will be a minimum bundle size for the contract as it is not efficient use of public money or good patient care to have small bundles of UOAs. 15,000 UOAs is the minimum contract although it is recognised that there will be some rural areas that warrant something smaller and there will be the suggestion of a satellite of the main contract.  GT declared that local people view that small practices are being disadvantaged and this is concerning. AG confirmed that the advice given was that practices come together as either a federation or partnership etc. and contact the relevant legal services on how to prepare for procurement. AG further added that the orthodontic providers have been advised that procurements were happening and have been encouraged to get themselves ready for the last 2 years. Cherie Young has spoken to every single provider offering as much support as possible.  BD asked who sets the scoring and expressed that in the future we might question the difficulty smaller providers have bidding for these contracts compared with the corporates.  AG informed the group that the PQQ stage is set nationally and it is either pass or fail and for the individuals that is the purpose of the project group that is to start next week to come up with a list of questions that will be used across the whole of the South. There will be clinical input.  BD asked for it to be formally minuted that there will some due consideration given to something about localism. |
| **9. Anti-microbial resistance**  BD informed the group that a proposal was put in from Thames Valley to NHS England to see they can fund a project that is based on evidence to audit dentists on their microbial use and bench mark then against other dentists. This audit aims to improve the anti-microbial prescribing practices.  BD explained that the LDN was hoping to do something similar and that an expression of interest email would be sent out. The poster, leaflets would be provided as would support to produce the audit.  AG told the group that it has been agreed that for any project of interest; an outline proposal must be submitted identifying all the resources that are needed. This will need to be agreed by the KSS LDN in order to prioritise. There needs to be a business case to understand all of the aspects and decide who is to take the lead, who and how the funding will be managed and which pots need to be tapped into.  AT voiced that Jennifer Parry is running a research group trying to get research in to general practice. AT felt it is necessary to get all the workstreams together so it is not only a research project but also a learning platform through Health Education England creating a whole package.  There is an unofficial group established consisting of Tim Hogan, Brett Duane, Kandiah Thayalan, Jackie Sowerbutts and others and BD confirmed that a colleague is currently drawing up a two sided business case proposal based on a particular template which will be taken to the LDN in around two months for agreement and then the workstream can formally get started.  JS added that she also wanted to try and target all foundation practices and that the project will need funding to obtain all the information from practices and the other to audit the data. She expressed that the power of this will be the sharing of all the data into one pool and then to properly analysis the data which may result in acquiring a significant costing element.  BD expressed that the LDCs representatives also need to push this through their LDCs. |
| **10. Bariatric patients**  NHS England is keen as part of the GDS contacts for there to be provision for bariatric patients.  Over the last few months BD has with the dental trainees and HEE input produced a literary review of bariatric provision for dental care. A detailed specification will be written next week and this will be forwarded to Anna Ireland who will be doing the GDS procurement.  At the moment heavier patients without any further specific medical need are only able to access care through the CDS who is contacted on a one to one basis.  It is hoped there will be around 10 clinics across the whole of KSS. There may the requirement to travel on behalf of the patient but access to safe dental care can be offered to these patients. |
| **11. MCN update**  **Restorative –** At the present time there is an unofficial restorative MCN group with good attendance led by Andrew Elder. This group remains unofficial until the national guidance is received.  BD told the group that will be sending an MCN template to MJ and AG to commence setting up of the Restorative, Oral Surgery and Unscheduled Care MCNs.  A recent restorative meeting was unfortunately cancelled and will be arranged for a future date. This meeting was going to go over the work in regards to DERS with David Ezra from Vantage. AG wanted to highlight that there should not be an underestimation of how complex the restorative pathways have been.  AT voiced that there are local variations across KSS, AG responded by stating that there may still be the postcode lottery as the commissioning of the CCGs and access to dental care will relate to where the patient lives.  **Special Care & Paediatric –** No formal update given at the meeting.  **Oral Health Promotion –** JS informed the group that the first Surrey and Sussex Oral Health Promotion meeting will take place on the 14th December 2016 with approximately 20 attendees confirmed.  **Orthodontic –** This update has already been given in the meeting under Healthwatch and the Orthodontic HNA agenda items.  **Oral Surgery –** JC confirmed there was no update for oral surgery in Sussex.  AG told the group that there is now national guidance and terms of reference for the MCNs, however, she stressed it did not talk about remuneration so this will need to be discussed. For secondary care it is built into the CEQUIN payments, so the trusts will be receiving payment to allow clinicians to attend and all clinicians should have this built into their workplans.  AG confirmed she recognises that in primary care, individuals attending the meetings might require some form of payment to attend or it could be a reduction in UDAs to the same equivalent value. This subject needs to be discussed at a national level and will be taken to the Dental Leads meeting in January 2017.  NS formally stated that the LDC is very happy for its members to attend the LDN and MCNs and will fund this attendance.  JC voiced that Steven Walsh wanted to have evening meetings but this never progressed to setting up the Oral Surgery MCN as he received little support. AG responded by stating that it is very difficult to provide support for evening meetings, if they are in the day there is capacity to support the group and GM will provide the administrative support for this. NS expressed that he would provide administrative support for the initial meeting if required.  **Action: JC to enquire amongst his colleagues to set up an Oral Surgery MCN to at least have a primary meeting.**  **Regional Audit Group –** JS wanted to give the group a short update from the regional audit group. She was asked to look at the two week rule data that has come in for oral cancer. It was made clear that there is no clear two week rule in the referral pathway. BD and AG confirmed that there was but that is was not called the two week rule it is call suspicion of malignancy. BD confirmed it was easy to change this to the two week rule, JS added it should be on the front page as a flag.  BD asked JC what it should be and JC confirmed it should be the two week rule as this is the pathway that the general medical practitioners use and that it is an established pathway. AG confirmed that Nic Goodger did this for DERS as he is part of the cancer network and that he provided all the questions and signed it off as consistent with the cancer pathway.  **Action: DERS to change suspected malignancy to the two week rule.** |
| **12. Unscheduled Care**  The last MCN needed to be developed is the Unscheduled Care MCN network to improve the delivery and reduce the inconsistencies across KSS. Katie Humphreys, a dental care trainee is currently working on this.  BD confirmed he will have a discussion with AG on how to develop and take this further. The current provision needs to be understood as well as a health needs assessment that will be undertaken by PHE, BD hope that PHE might have the capacity to undertake the service review as well.  JS and BD are working closely on this workstream.  SS voiced concern that there is a discrepancy between the two Surrey CDS providers in the level of service provision.  He asked if there was any guide to understand what the current contract obligations are as there is a difference of opinions.  AG responded by stating that their contractual arrangements are very different so should not be compared as one provider is carrying out a lot of their CDS contract as secondary care activity which does not have a cap on activity and a different, higher payment tariff.  JS mentioned she will be doing a service review to understand this and that new contracts from 2019 would be consistent.  AG expressed that when the paediatric commissioning guides are received, this will be when the needs assessment itself happens for both Special Care and Paediatric. Upon the result there will the re-commissioning across the whole of the South region, AG expressed this would be a good starting point.  AG asked SS if he wanted to send in what he has on this subject, specific examples on patients that have not been accepted, she would cross reference with what the providers disclose to NHS England. AT further added that she would take this to the Special Care MCN.  **Action: AT to take this matter to the Special Care MCN.** |
| **13. Health Education England update**  Stephen Lambert Humble not present so there was no update at this meeting.  **Action: GM to ask Roop Kaur to send out a ‘Save the Date’ with regards to the March Challenges Conference.**  **Update –** GM has sent an email to Roop and she confirmed that no official date has yet been finalised. |
| **14. LPN Membership and Terms of Reference**  A KSS Strategic Core group was formed of seven people who would help set the strategic overview of the work of the Kent and Medway and Surrey and Sussex LDNs.    Both Chairs and the area team were keen to keep both LDNs to keep localism as the geographical area is huge. The Strategic KSS Core was set up to provide the strategic steer and vision producing a consistent work frame in order to avoid duplication and variation across the counties.  The structure and its membership had thought to be sorted and agreed, however at the Kent and Medway LDN meeting yesterday on the 07th December 2016, there were strong comments made on the group set up. Some of the comments such as “Why is there a KSS Strategic Core group?” “Where is the mandate for this group?” etc. AG expressed that the main issue was that projects that go to the LDN would need to go the KSS Strategic Dental Core as there is limited resource and the KSS Strategic Core group would make the final decision. It was felt that this rendered some of the committee members out of the decision making and that it was the LDNs responsibility to agree and not the KSS Strategic Core.  This discussion and its comments has prompted an LDN Options Paper that Mark Johnstone put together in order to formally receive comments and preference on the future structure of the LDN across KSS. It listed 2 options; the first option was to keep the status quo, the two LDNs and the KSS Strategic Core group. The second option was to create one larger group covering the whole of KSS.  BD stressed that if option 2 had the majority vote, the meetings would need very strict handling of both the agenda and the time allocation for discussion. The meetings would need to meet more regularly and AG suggested a minimum of every two months to have the same number of hours for discussion. She further added that the any feedback or update that are given as is currently done, would need to be circulated prior to the meeting so that only comments will be invited. Committee members will therefore need to read any papers circulated prior to the meeting.  AG wanted to highlight that there are six MCN groups and not 8 as indicated on the options paper and that she was not sure why there are two secondary care representative required in option 2 as when the MCNs decide who should sit on the merged LDN (if this is agreed the better structure) the representative would probably come from secondary care.  AG thought there should be two or possibly three patient representatives from Healthwatch covering the three counties as there is not enough patient engagement.  With regards to a dental practice advisor, it would only be necessary to have one if the LDNs are merged.  The group agreed that if the majority vote was for one KSS LDN, then the localism would come from the MCNs and any projects that are undertaken.  SS thought that to make service provision equal across KSS, then the option of forming one large LDN seemed the better option.  NS asked BD what his preference was and BD responded that he felt that option 2 to form one large KSS LDN was the better option as he wanted to ensure there is consistency across the whole patch and agreed that the MCN will be able to the give the local voice.  NS thought that option 1 was the better option with the separate LDNs and then having the KSS Strategic Core to then say yes or no.  GT felt he was not in a position to contribute to the decision as it is more of a professional matter but stressed that localism is important.  FE bought up the issues regarding clinical duties and the significance of this if the meeting are to more regular as it is already difficult to attend and might be more difficult if the meetings alternate between Horley and Tonbridge area offices.  JC announced that in the interest of transparency and consistency, a larger LDN was probably the best way to go and agreed that the MCNs could provide the localism.  **Action: GM to circulate the option paper to all committee members from the LDNs and ask that comments be sent in.** |
| **15. Plan on a Page**  This has been put on the agenda for information purposes only.  BD asked if was worth sending out the proforma that Anna Ireland sent through and outline the proposal. Individuals could give the LDN a five page slide presentation and if it is considered then it would progress to the requirement of writing up a two page business case.  BD thought it beneficial if the LDC could send it out to their members as this will give them the opportunity to put forward any projects for the LDN to consider.  NS informed the group of a number of workstreams that could be worked up to a potential project but the issue he felt was that proper research cannot be done without having practitioners nhs.net email addresses, he asked if he could have these details. AG responded by stating her team is happy to circulate on behalf of the LDC but previously the request asked for every named performer and these details are not available.  **Action: AG to send NS the template to fill for potential projects to be agreed by the LDN at a later date.** |
| **16. National Care Pathways**  Ag confirmed there is no update as the Restorative, Supporting Dental Specialties and Paediatrics have all been sent back for a re-write. The timeframe for release is not known. |
| **17. Dental Care champions**  BD told the group that a Dental Care Champions Network has been set up. The Chair set up the network and then sent in a proposal for funding to support the projects/workstreams that the network wanted to do.  BD expressed that the liked the idea of this network as he believed there are dental nurses, hygienists and therapist who want to be involved in community participation programmes. This could be set up with the LDN giving the support when and if required.  This network could be used for a number of projects such as adopting care homes, delivering of toothbrushes and toothpaste, participating in schools and nurseries. The group could also be used for anti-microbial work. It could further broaden the network and reach more dental surgeries with particular projects.  The current situation is that a trainee has worked this into a two page proposal and this group needs to agree this is a suitable way forward. BD stated there would be no extra funding required from NHS England.  A letter would need to written to the appropriate organisation, the British Association of Nurses and Therapists to ask for expressions of interest. Once this is received, a discussion needs to take place in order to understand the projects that are desired to be undertaken, what the LDN can do for that specific project and what the project might be able to do for the LDN.  AG further added that to make sure that all those who might be interested are made aware, an email should be sent to all practitioners asking them to cascade to all DCPs.  FE mentioned suggested that tutors need to be on board in order to cascade the information. Crawley Collage for example and that it could be practice led with the distribution of posters etc. with links to access the information.  **Action: FE to work with BD to facilitate the liaising of the DCPs and tutors to build up this group.** |
| **18. Sedation**  Removed from agenda. |
| **19. Challenges Conference – 05/10/16**  Stephen Lambert Humble not in attendance so no update given at this meeting. |
| **20. DERS update**  Surrey went live one week ago so DERS is now live across the whole patch. The Special Care and Paediatric pathways will be going to the first official meeting where most of the attendees are special care and paediatric dentists on the 19th January 2017.  BD has spoken to Mili Doshi on the 12th December 2016 regarding the Special Care pathway and with Jennifer Parry on the 20th December 2016 with regards to the Paediatric pathway.  The Restorative pathway is almost developed and will be finalised at the next meeting.  BD wants to form a user group to take on all the suggestions and comments in order to make DERS better. He confirmed it is working reasonably well and acknowledged that there are some issues.  AG and BD and the project team are going to be working on a fairly comprehensive evaluation of the process looking at auto-triage and triage asking what do GDP and their providers think of DERS.  NS queried if a response could be received from the providers after referral so the treatment for particular patients is disclosed. AG confirmed that this will be built into the contract requirement that all IMOS and the complex referrers send their discharge summaries through DERS. AG acknowledged that secondary care is a challenge but there are conversations on how to get the best out of DERS and to make it more users friendly and to integrate with Patient Administration System **(**PAS). This however will need a whole programme re-write and even then it will not be used at its full potential due to every trust using different systems.  NS asked if there could be a comment/complaints link within DERS to be able to communicate any issues. |
| **21. NHS England update including commissioning guides**  No update. |
| **22. Public Health update**  JS informed the group of the launch of Children’s Oral Health will be released in January 2017 consisting of a number of initiatives such as sugar swap etc.  JS is in a locum post and she informed the group that the substantive post has gone to advertisement in the BDJ. |
| **23. Special Care Survey**  A directory of services for DERS is being completed. |
| **24. Guidance and clarification from orthodontists in the run up to tendering and procurement**  This was not discussed in the meeting. |
| **25. Any other business**  JS informed the group that an East Sussex Public Health Consultant who will be doing supervised tooth brushing programming and she has received information back that dentists are stating that they should be consulted when the child is three years old. JS wanted it to be made clear that this is not the correct guidance and that every child should be seen by a dentist before they reach the age of one. |

**Dates, times and venue for the 2017 meetings for the Kent, Surrey and Sussex LDN.**

| Kent, Surrey and Sussex LDN | Venue | Time |
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| 20/04/2016 | Boardroom, York House, 18-20 Massetts Road, Horley, Surrey RH6 7DE | 14:00 – 17:00 |
| 21/06/2017 | Medway 1 & 2, Wharf House, Medway Wharf Road, Tonbridge, TN9 1RE | 14:00 – 17:00 |
| 17/08/2017 | Boardroom, York House, 18-20 Massetts Road, Horley, Surrey RH6 7DE | 14:00 – 17:00 |
| 18/10/2017 | Medway 1 & 2, Wharf House, Medway Wharf Road, Tonbridge, TN9 1RE | 14:00 – 17:00 |
| 14/12/2017 | Boardroom, York House, 18-20 Massetts Road, Horley, Surrey RH6 7DE | 14:00 – 17:00 |

Ratified 20/04/2017