

Rt Hon Wes Streeting MP
Secretary of State for Health and Social Care
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

13 March 2026

Dear Secretary of State,

Ending of Training Interface Group (TIG) Fellowships for Cleft Surgeons

I am writing on behalf of Cleft Lip and Palate Action (CLAPA) to express our serious concern regarding the decision to end Training Interface Group (TIG) fellowships for cleft surgeons.

For patients and families affected by cleft, treatment is not a single intervention but a lifelong pathway of care. Surgical treatment begins in infancy and continues through childhood and adolescence, often extending into adulthood. High-quality outcomes depend on surgeons with deep, highly specialised expertise developed through structured training pathways that sit across multiple surgical disciplines.

TIG fellowships have played a vital role in supporting this complex training pathway. Cleft surgeons sit at the interface of oral and maxillofacial surgery, ENT surgery and plastic surgery. The TIG programme has provided a structured national route enabling surgeons to develop the specialist competencies required to deliver safe, high-quality cleft care within multidisciplinary teams.

CLAPA is therefore deeply concerned by the decision to end TIG fellowships without clarity about what will replace them. To date, neither the cleft clinical community nor patient organisations have been provided with clear information about whether a new national training pathway is being developed, how it will operate, or when it will be implemented.

This lack of clarity raises a number of serious concerns.

Firstly, there are potential implications for patient safety and long-term outcomes. Cleft surgery involves complex staged procedures delivered over many years, often beginning when a baby is only a few months old. The quality of these early surgeries can have lifelong consequences.

If surgical outcomes are not optimal, children may experience long-term speech difficulties, sometimes requiring years of speech therapy or further corrective surgery. In some cases, unsuccessful palate repair can leave a hole between the mouth and nose

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(a fistula), making eating and drinking difficult and painful and requiring further operations to correct.

Many children with a cleft lip are also born with a gap in the gum that requires bone graft surgery later in childhood. If this surgery is unsuccessful, teeth may not develop or erupt correctly, leading to pain, complex orthodontic treatment and additional surgery.

Where early outcomes are poor, patients can face multiple additional operations and many more years of treatment, placing additional strain on children, families and NHS services.

Secondly, there are significant workforce planning implications. The cleft surgical workforce is relatively small, and maintaining a strong pipeline of well-trained surgeons is essential to the long-term sustainability of services. Without a clear, nationally recognised and adequately funded replacement for TIG fellowships, there is a real risk of future workforce shortages, increased pressure on existing cleft teams and poorer outcomes for patients.

Thirdly, we are concerned about the potential for growing regional inequality. If training pathways become inconsistent or unclear, some areas may struggle to recruit or retain appropriately trained cleft surgeons, undermining the principle that patients should receive high-quality cleft care regardless of where they live.

Finally, there appears to have been no clear transition plan for trainees currently considering a career in cleft surgery. This uncertainty risks discouraging talented surgeons from entering an already demanding and highly specialised field.

Clinicians within the cleft community have expressed particular concern about the long-term implications of these changes. As one senior cleft surgeon recently put it, ending TIG fellowships without a robust alternative risks taking cleft training “back to the 1980s, before there was a clear, structured national pathway for developing specialist cleft surgeons”.

CLAPA fully recognises that training systems evolve over time. However, if TIG fellowships are to end, it is essential that any replacement pathway is transparent, nationally consistent, adequately funded and at least equivalent in quality and rigour to the existing framework.

We would therefore welcome clarification on the following points:

- What assessment was undertaken of the workforce and patient care implications before the decision was made to end TIG fellowships?
- What national training pathway will replace TIG fellowships for cleft surgeons?

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- Which organisation will hold responsibility for oversight, governance and standards for cleft surgical training going forward?
- What transition arrangements are in place to ensure continuity in the training pipeline?
- How will the Government ensure the long-term sustainability of the cleft surgical workforce?

Given the potential implications for patient safety, workforce sustainability and service resilience, we believe this issue requires urgent attention.

CLAPA would welcome the opportunity to meet with you or a member of your ministerial team to discuss these concerns and to ensure the voice of the cleft community is considered as decisions about the future of surgical training are made.

We look forward to your response.

Yours sincerely,

Claire Cunniffe

Chief Executive

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