Trust Board paper P2

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 October 2017

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Col (Ret'd) Ian Crowe, Non-Executive Director

DATE OF COMMITTEE MEETING: 31 August 2017

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE PUBLIC TRUST BOARD:

- **MORTALITY QUARTERLY REPORT (minute reference 58/17)**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR THE INFORMATION OF THE PUBLIC TRUST BOARD:

None

DATE OF NEXT COMMITTEE MEETING: 28 September 2017

Col (Ret'd) Ian Crowe – Committee Chair and Non-Executive Director

Paper A1

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
MINUTES OF A JOINT MEETING OF THE INTEGRATED FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE AND THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 31 AUGUST 2017 AT 12.30PM TO 1.00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Mr J Adler – Chief Executive
Mr M Caple – Patient Partner (QAC)
Col. (Ret'd) I Crowe – Non-Executive Director
Mr A Johnson - Non-Executive Director
Mr R Moore - Non-Executive Director
Mr B Patel – Non-Executive Director
Mr K Singh – Chairman
Ms J Smith, Chief Nurse
Mr M Traynor – Non-Executive Director (Chair)

In Attendance:
Ms F Bayliss – Deputy Director of Nursing and Quality, Leicester City CCG on behalf of Ms C West - Director of Nursing and Quality, Leicester City CCG
Mr C Benham - Director of Operational Finance
Miss M Durbridge – Director of Safety and Risk
Mrs S Everatt – Interim Corporate and Committee Services Officer
Mr J Jameson – Deputy Medical Director on behalf of Mr A Furlong – Medical Director
Mr D Kerr – Director of Estates and Facilities
Mr W Monaghan – Director of Performance and Information
Ms K Rayns – Corporate and Committee Services Officer

RESOLVED ITEMS

56/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms L Tibbert – Director of Workforce and Organisational Development; Mr A Furlong – Medical Director; Mr P Baker – Non-Executive Director; Ms E Meldrum – Acting Deputy Chief Nurse; Ms M Gordon – Patient Partner (IFPIC), and Ms C West, Director of Nursing and Quality, Leicester City CCG.

57/17 JOINT DISCUSSION ON QUALITY AND OPERATIONAL PERFORMANCE

Members of the Integrated Finance, Performance and Investment Committee (IFPIC) and the Quality Assurance Committee (QAC) held their last joint monthly meeting – providing for joint discussion of the monthly quality and performance report and other matters of joint interest. This joint meeting will be replaced next month by a new Trust Board sub-committee called People, Process and Performance.

57/17/1 Month 4 Quality and Performance Report

Executive Directors particularly highlighted the following issues from the 2017-18 month 4 quality and performance report:-

- continued strong diagnostic 6 week wait performance in July 2017 for a tenth consecutive month. The RTT 92% in 18 weeks standard was narrowly missed (91.8%)

due to high levels of referrals in March 2017 and cancelled operations due to disruption to two theatres at Glenfield Hospital for 12 weeks which will impact on elective work. The Director of Estates and Facilities outlined the three options available to remedy the issue;

- cancer performance for July 2017 continued to be encouraging, with 2 week wait (subject to validation) having remained compliant for 12 consecutive months. The 30-day standard was delivered for June 2017 and year to date which was an improvement from the previous year. The 62-day standard was not achieved in June 2017 and was again affected by late tertiary referrals from other centres. Oncology posts had been approved and were being recruited to but there remained a risk around delivery;
- there had been no cases of MRSA for 4 consecutive months and clostridium difficile performance remained within the threshold for July 2017 and the year to date. No correlation had been found between the last month's increase in clostridium difficile and pressure ulcers when compared to staffing levels. A discussion took place around the use of swab maps;
- good progress on avoidable grade 4 pressure ulcers with none reported in this financial year and grade 2 and 3 pressure ulcers were within trajectory for the year to date;
- inpatient and daycase satisfaction (friends and family test) achieved the Quality Commitment of 97%;
- statutory and mandatory training performance was 85% against a target of 95%;
- there had been a disappointing increase in moderate harms and above which was being investigated;
- fractured neck of femur was achieved for the third consecutive month, and
- the latest published SHMI for the period January to December 2016 was 101, which remained within the expected range.

Resolved – that the contents of Joint Report 1 be received and noted.

57/17/2 Update on Delayed Transfers of Care and the Role of the Integrated Discharge Team

In the absence of the Interim Chief Operating Officer the report was received and noted. The report provided an update on the implementation of the Integrated Discharge Team and delayed transfers of care. It was noted that the team was now operational and had been covering 8 medical wards across the Leicester Royal Infirmary since 1 July 2017 as planned. The next stage would involve developing the team to provide a trusted assessor role. The committee was specifically asked to note the progress with implementation and to comment on and support the next steps, acknowledging that further work was required on evaluating the success and planning the roll out.

Resolved – that the contents of Joint Report 2 be received and noted.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
MINUTES OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 31 AUGUST 2017 AT 1.00PM TO 4.00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Mr J Adler – Chief Executive
Mr M Caple – Patient Partner (non voting)
Col. (Ret'd) I Crowe – Non-Executive Director (Chair)

Miss M Durbridge – Director of Safety and Risk (non voting)
Ms S Hotson – Director of Clinical Quality (for minute reference 62/17/3, 63/17/3 and 64/17/2) (non voting)
Mr A Johnson - Non-Executive Director
Mr B Patel – Non-Executive Director
Mr K Singh – Chairman
Ms J Smith, Chief Nurse
Mr M Traynor – Non-Executive Director

In Attendance:
Ms F Bayliss – Deputy Director of Nursing and Quality, Leicester City CCG on behalf of Ms C West - Director of Nursing and Quality, Leicester City CCG
Mrs S Everatt – Interim Corporate and Committee Services Officer
Ms S Glover – Matron (for minute reference 62/17/2)
Mr J Jameson – Deputy Medical Director on behalf of Mr A Furlong – Medical Director
Mr D Kerr – Director of Estates and Facilities (for minute reference 63/17/2)
Mr G Warwick – Consultant Nephrologist (for minute reference 62/17/2)

RECOMMENDED ITEMS

58/17 MORTALITY QUARTERLY REPORT

The Deputy Medical Director presented paper M which detailed the work underway around mortality and the Trust's performance against the Summary Hospital Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR). It was noted that the Trust's latest SHMI was 101 (January to December 2016) and the Trust's HSMR was 102 (April 2016 to March 2017), which were both within the expected range. Work was ongoing around improving coding. In April the Trust received an alert from the Doctor Foster Unit at Imperial College in relation to 'Coronary Atherosclerosis and Other Heart Disease' diagnosis codes. A case note review was undertaken and actions were implemented.

In July, an alert letter was received in relation to the 'CABG other' procedure group. Analysis of coding suggests that the variance is due to differentials in the way the Trust codes compared to other trust's, meetings are underway to understand the impact on the Trust's relative risk. In July 2016, in collaboration with the Bereavement Service Office, the Trust implemented the Medical Examiner process at the LRI site, which was subsequently extended to patients at the other two sites in April 2017. Since July 2016 to end March 2017 86% of adult LRI deaths eligible for Medical Examiner screening have been screened.

In discussion of this item it was agreed to recommend this item to the Trust Board to alert their attention to the requirement to publish the mortality data in public on a quarterly basis. It was also agreed that the Committee Chair would seek confirmation from the Medical Director on the process for future reporting requirements. **Ctte Chair**

<u>Recommended</u> – that (A) the contents of paper M be received and noted;

(B) that the Trust Board's attention be alerted to the requirement to publish the mortality data in public quarterly, and **Ctte Chair**

(C) that the Committee Chair confirm with the Medical Director the process for reporting the quarterly Mortality Dashboard publicly. **Ctte Chair**

RESOLVED ITEMS

59/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr K Singh – Chairman; Mr W Monaghan - Director of Performance and Information; Ms J Smith, Chief Nurse; Mr P Traynor - Chief Financial Officer; Mr M Caple – Patient Partner (QAC), and Mr M Traynor - Non-Executive Director.

60/17 MINUTES

Resolved – that the Minutes of the meeting held on 27 July 2017 (paper A1 refers) be confirmed as a true and accurate record.

61/17 MATTERS ARISING

Paper B detailed both the actions from the most recent meeting, and also any which remained outstanding from previous QAC meetings. The Chair noted that good progress continued to be made in progressing actions. One update on action 19 of 27 July was provided which will be updated on the Matters Arising log.

Resolved – that the contents of paper B be received and noted.

62/17 SAFETY

62/17/1 Report from the Director of Safety and Risk including (1) Patient Safety Report – July 2017; (2) Complaints Performance Report – July 2017, and (3) Safety Walkabouts

The Director of Safety and Risk presented paper C which was comprised of three sections: (1) patient safety; (2) complaints performance, and (3) safety walkabouts. The patient safety report provided the patient safety data for July 2017 and noted that harm events had decreased at the Trust up until March 2017. The last two months has seen a rise in harm events (an increase in harm of 48% during quarter one) which may be normal variation but requires investigation. Five Serious Untoward Incidents were escalated during July 2017. Three Never Events during May 2017 would be reported in paper F but there had been a fourth Never Event in Dermatology in August 2017. The Patient Safety report provided comparators with peers and was largely positive. There continued to be 100% CAS compliance and no alerts had breached their deadline during the reporting period.

The report noted that there had been a decrease in formal complaints activity during the month, and that PILS activity had decreased by 6% compared to the previous month. Resolution of complaints was largely positive. No new Parliamentary and Health Service Ombudsman complaints were received in July 2017 but one new PHSO case was received in June 2017 since the last report.

The Safety Walkabouts report identified that there were 54 patient safety walkabouts undertaken (compared to 64 in quarter 4 of 2016/17) with more being undertaken by Directors. Weekly quality visits were due to commence. It was noted that a number of Alliance visits had been undertaken or were planned. Attendance on walkabouts was encouraged. There was a discussion around moving staff to provide cover on other wards and on releasing staff to attend training. A new points based accreditation scheme for nurses was due to be launched at the UHL Nursing Conference. **ALL**

In addition to the reports, two issues were highlighted for the attention of QAC members – (1) Freedom to Speak Up letter to all staff (a letter would be going out to all staff with the October payslips which details the work of the Freedom to Speak Up Guardian and the focus of future work streams), and (2) Incident/GP concern themes (two new incident clusters have come to light in the last two months: (1) medication errors in ITAPS, and (2) incidents relating to insulin/diabetic patients). The incident clusters are to be reviewed and actions for improvements identified.

The QAC was specifically requested to: (1) note the Trust's performance compared to peers from the NRLS data; (2) note the disappointing non achievement of the quarter one reduction in harm target; (3) note the improvement in complaints performance; (4) improve support for the Safety Walkabout Programme with required commitment to engage with it, specifically in regards to the prompt return of information to the Safety Walkabout Mailbox, and (5) to note the walkabout themes contained in the Walkabout update report.

Resolved – that (A) the contents of paper C be received and noted, and

(B) that support for the Safety Walkabout Programme be improved with required support to engage with it, specifically with regards to the prompt return of information to the Safety Walkabout Mailbox. **ALL**

62/17/2 Management of AV Fistulas Update

Mr G Warwick, Consultant Nephrologist and Ms S Glover, Matron presented paper D, at the request of the committee, which provided an update on the service following a cluster of deaths between 2013-16 in the Leicester haemodialysis network. It was confirmed that no further episodes of fatal vascular access haemorrhage (FVAH) had occurred in the past 12 months and assurance was sought (and received) that actions since the initial report of this matter to QAC in July 2016 had progressed. Ms S Glover was now a member of the British Renal Society who had recently issued advice on the management of life threatening bleeding from vascular access devices. The UHL team had written to the author of the Renal Association vascular access guidelines, the Renal Association patient safety lead and the president elect of the Vascular Access Society of Britain and Ireland around the use of military grade tourniquets and haemostatic dressings as there was currently no clear consensus on their use.

Resolved – that the contents of paper D be received and noted.

62/17/3 Safeguarding Assurance Report

The Director of Clinical Quality presented paper E which provided a summary of the current position of safeguarding practice within UHL and the developments that have taken place in the last month in relation to safeguarding practice. The report also provided assurance and updates to demonstrate compliance with all elements of the NHS contract SC 32 2017/18 and with local, regional and national guidance relating to safeguarding children and adults. The report outlined two recent visits – (1) by the CCG to Glenfield Hospital, and (2) by the CQC to Wards 42 and 43. It was noted that agreement with NHS Commissioners regarding payment requirements for the Paediatric Liaison Service remained outstanding but assurance was provided that in the interim the Trust would continue to operate the service. The Trust continued to await a national solution to the Child Information Sharing Project. There remained issues following the migration from eUHL to HELM around accuracy of training data. The Chief Nurse agreed to follow up the lowest levels of compliance which related to **CN**

the Alliance. Further work was required around release of staff for PREVENT training prior to March 2018. The reintroduction of the Independent Domestic Violence Advocate role was welcomed. The report was received and noted.

Resolved – that (A) the contents of paper E be received and noted, and

(B) to discuss outwith the meeting with the Alliance Head of Nursing the low training compliance rates for Alliance staff identified in the report. **CN**

62/17/4 Never Events – May 2017

The Deputy Medical Director presented paper F, providing the main highlights of three recent Never Events, all of which did not lead to any patient harm. Assurance was provided that all incidents had been investigated and an action plan had been developed to address the failings, and that details of the more recent fourth Never Event, detailed under minute reference 62/17/1, would be provided at a future meeting once the investigation had been undertaken. **MD** The Medical Director had held an urgent Safety Summit with all CMG teams following the first three incidents to discuss and seek assurance in relation to Quality and Safety processes within the Trust. As a result of this meeting an action plan had been developed with immediate actions relating to the specifics of the individual Never Events and containing medium-term actions around launching a Trust-wide safety campaign in October 2017 linked to a re-launch of the Safer Surgery Policy. In July 2017, the Trust received a Contract Performance Notice from Leicester City CCG in relation to the three Never Events. In response, the Trust shared the action plan developed at the Safety Summit. The concept of freedom to 'Stop the Line' was discussed and assurance was provided that local resources would be developed to communicate it. **MD/CN**

Resolved – that (A) the contents of paper F be received and noted;

(B) that the 4th Never Event (Dermatology) be reported at a future EQB and QAC meeting once the investigation report is available, and **MD**

(C) to provide an update on the training materials developed for induction and mandatory training to support the 'Stop the Line' approach. **MD/CN**

62/17/5 Regulation 28 and Response Letter

The Director of Safety and Risk presented paper G, providing a copy of a recently received Regulation 28 letter and the Trust's response. Further details of this case were due to be presented as a Patient Story to the next Trust Board. In discussion of this item it was agreed that the Director of Safety and Risk would seek assurances that the AAA referral pathway had been put in place. **DSR**

Resolved – that (A) the contents of paper G be received and noted, and

(B) to identify outwith the meeting whether the AAA referral pathway has been added on to the PRISM system. **DSR**

63/17 COMPLIANCE

63/17/1 Assurance Report for EWS and Sepsis

The Chief Nurse and Deputy Medical Director presented paper H, providing the Committee with a monthly update on the work programme being undertaken to

improve the care of patients with a deteriorating Early Warning Score (EWS) and Red Flag Sepsis trust-wide. It was noted that performance against the IV antibiotics within an hour indicator for the Emergency Department had been variable during the two-week period covered by the report and that some complex patients remained difficult to treat in this time but were still receiving antibiotics within a reasonable time period. There were clear expectations on the sepsis team providing 24/7 cover that continuous performance improvements should be seen. In response to a suggestion from the Chief Nurse to move to quarterly reporting of sepsis and EWS it was agreed that until performance was embedded monitoring at this committee would still be required but that a higher level headline report could be produced monthly with a more detailed quarterly report. **CN/MD**

The QAC was specifically requested to: (1) be advised that significant work had been undertaken to recognise and respond to the deteriorating patient and management of patients, and (2) advise on any required changes to the format of the report.

Resolved – that (A) the contents of paper H be received and noted, and

(B) that a monthly more timely higher level overview of EWS and sepsis be provided for EQB and QAC commencing from September 2017, with a more detailed quarterly report. **CN/MD**

63/17/2 Quarterly Compliance Assessment Analysis System (CAAS) Report

The Director of Estates and Facilities presented paper I, providing details of the introduction of a new assessment tool called CAAS (Compliance Assessment and Analysis System) which aimed to provide a high level overview of the Trust's compliance across a range of Estates and Facilities key performance indicators with the intention to provide assurance rather than acting as a performance measure. The system was designed to support the NHS Premises Assurance Model (PAM) and the mandatory annual Estates Return Information Collection (ERIC). UHL are a pilot site for developing and using the CAAS software tool. An independent external assessor reviews the Trust's CAAS performance to provide third party quality and consistency assurance across the assessment fields. The information would be reported quarterly to EQB and QAC and in the next iteration would include trend analysis and commentary. Soft FM measures would be developed in due course.

The QAC was specifically invited to note that the CAAS system has been developed, trialled and implemented to provide Estates and Facilities with a means of providing additional assurance that compliance performance is being suitably managed across the Trust's Estates and Facilities services. QAC was specifically requested to support the use of the CAAS high level reporting matrix as a primary means of reporting the quarterly CAAS position and for Estates and Facilities to map trends and include trend analysis in quarterly reviews going forward.

Resolved – that the contents of paper I be received and noted.

63/17/3 Care Quality Commission (CQC) Unannounced Inspection of Wards 42 and 43

The Director of Clinical Quality presented paper J, which detailed the initial findings and actions taken in response to an unannounced inspection of wards 42 and 43 undertaken by the CQC on 18 July 2017. The inspection covered only the domains of safe and caring. No issues requiring immediate action were raised at the time of the inspection, although prompt action was taken in a number of areas and evidence to support this had been collated. The final CQC report had been received from the CQC

today (31 August 2017). Further assurance was being sought from all areas that similar issues were not prevalent across the Trust and this would be shared with QAC following discussion at the September 2017 Executive Quality Board (EQB). In discussion of this item it was noted that further work was required on medicines management, and this was due to be discussed at the September 2017 EQB.

There was a discussion around the new process of inspections by the CQC. The CQC had recently requested the Trust to complete a PIR (data request for all services on all sites), this would then be returned and the CQC would undertake a well-led inspection at the Trust within 12 weeks. An inspection of at least one of the nine core services would also be undertaken. Guidelines had been received for the characteristics of safe but provider handbooks for core services had not yet been received. A Trust action plan was being developed for the next Trust Board Thinking Day to provide a gap analysis. The NHSI would also be undertaking a Use of Resources inspection of all trusts.

The QAC was specifically requested to: (1) be advised that immediate concerns highlighted by the CQC have been appropriately addressed, and (2) be advised that Trust wide assurance was being sought regarding the CQCs findings.

Resolved – that the contents of paper J be received and noted.

64/17 QUALITY

64/17/1 Nursing and Midwifery Quality and Safe Staffing Report – June 2017

The Chief Nurse presented paper K which detailed triangulated information (using both hard and soft intelligence) relating to nursing and midwifery quality of care and safe staffing. This information provided an overview of patient areas to highlight where improvement was required and also to highlight areas of high performance. One ward had triggered as a Level 3 concern, 7 wards had triggered as a Level 2 concern and 14 wards had triggered as a Level 1 concern. One ward at LRI had triggered as causing particular concern to the Chief Nurse and Corporate Nursing Team, due to challenges with nurse staffing vacancies and poor nursing metrics for a third consecutive month. In discussion, assurances were sought (and received) that the ward continued to be supported to progress the issues whilst providing safe care. Infection Prevention metrics continued to be challenging and had led to the escalation to Level 3 for some of the wards.

Registered nurse vacancies had increased in the Trust in month from 486 whole time equivalents to 500 whole time equivalents, although the Trust was not an outlier nationally. There was a discussion around the local and global shortage of nursing staff and the future picture. The Trust had successfully recruited 102 newly qualified nurses who would commence employment with UHL throughout September, October and November 2017. This included 25 nurses from outside the area and 10 nurses who qualified with dual NMC registration or Mental Health registration. The UHL Internal Rotation Programme had been expanded significantly in an attempt to increase the retention of nurses. There had been a disappointing lack of engagement with student recruitment at De Montfort University but this was being progressed by the Chief Nurse with the University. The Trust had successfully recruited to 30 housekeeper posts which were due to commence in September 2017. A new project ‘Team around the Patient’ was being developed and would be presented to the Trust Board Thinking Day in August 2017. Improvements were expected in staffing levels next month, and further work was to be undertaken in anticipation for shortfalls next Summer.

Assurance was sought (and received) that the Trust were communicating any potential impacts of Brexit to European staff as information became known, although it was noted that there was a natural turnover of European staff.

Resolved – that the contents of paper K be received and noted.

64/17/2 Director of Clinical Quality: Quarter 1 performance against the 2017/18 Quality Commitment

The Director of Clinical Quality presented paper L which provided a quarter one update of performance against the 2017/1 Quality Commitment. Assurance was provided that recommendations around strengthening governance following a review by Internal Audit had been incorporated into the report. It was noted that for the next iteration of the report the executive summary would require amending to ensure that it met the new requirements as discussed at the UHL Sponsorship Committee. The report was received and noted.

Resolved – that the contents of paper L be received and noted.

65/17 ITEMS FOR INFORMATION

65/17/1 Claims and Inquests Quarterly Report

Resolved – that the Claims and Inquests Quarterly Report (paper N refers) be received and noted.

65/17/2 UHL Health and Safety Committee Minutes – 5 June 2017

Resolved – that the UHL Health and Safety Committee Minutes (paper O refers) be received and noted.

66/17 MINUTES FOR INFORMATION

66/17/1 Executive Quality Board

Resolved – that the notes of the meeting of the Executive Quality Board held on 1 August 2017 (paper P refers) be received and noted.

66/17/2 Executive Performance Board

Resolved – that the notes of the meeting of the Executive Performance Board held on 25 July 2017 (paper Q refers) be received and noted.

66/17/3 QAC Calendar of Business

Resolved – that the QAC Calendar of Business (paper R refers) be received and noted.

67/17 ANY OTHER BUSINESS

67/17/1 It was noted that the National Freedom to Speak Up Guardian would be visiting the Trust on 19 September 2017.

68/17 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that a summary of the business considered at this meeting be presented to the Trust Board meeting on 7 September 2017, and one item around mortality (detailed in Minute Reference 58/17) was noted as needing to be brought to the attention of the Trust Board. **Cttee Chair**

69/17 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday 28 September 2017 from 1.00pm until 4.00pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 4.06pm.

Sarah Everatt
Interim Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2017-18 to date):
Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	5	5	100	*R Moore*	5	0	0
S Crawshaw (until May 2017)	2	2	100	*B Patel*	5	5	100
I Crowe (current Chair)	5	4	80	*K Singh*	5	3	60
A Furlong	5	4	80	*J Smith*	5	3	60
A Goodall	5	0	0	*M Traynor*	5	4	80
A Johnson	5	4	80	*C West – Leicester City CCG*	5	2	40
K Kingsley – Leicester City CCG	5	0	0				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	5	4	80	*D Leese – Leicester City CCG*	5	0	0
M Durbridge	5	4	80	*C Ribbins/E Meldrum*	5	4	80
S Hotson	5	4	80	*L Tibbert*	5	0	0