Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 24 NOVEMBER 2022 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Members Present:

Ms V Bailey – Non-Executive Director (QC Chair)
Mr A Furlong – Medical Director
Dr A Haynes - Non-Executive Director
Ms B O'Brien – Deputy Director of Quality Governance/Deputy Chief Nurse (on behalf of Chief Nurse)
Professor T Robinson – Non-Executive Director
Ms S Taylor – Deputy Chief Operating Officer (on behalf of Chief Operating Officer)

In Attendance:

Dr R Abeyratne – Director of Health Equality and Inclusion
Mr M Clayton – Head of Safeguarding (for Minute 109/22/5)
Dr J Cusack – Clinical Director, Women's and Children's CMG (for Minute 102/22)
Ms L Davies – Head of Leicester Radiation Safety (for Minute 109/22/3)
Miss M Durbridge – Director of Transformation
Ms H Hutchinson – ICB Representative
Mr J Jameson – Deputy Medical Director for (for Minute 109/22/1)
Mrs H Majeed – Corporate and Committee Services Officer
Mr R Manton – Head of Risk Assurance
Dr P McParland – Consultant Obstetrician (for Minute 102/22)
Ms J Nichols – Consultant Trauma Orthopaedics/ Lead for #NOF (for Minute 109/22/2)
Dr S Salta – Haematology Consultant (for Minute 109/22/4)
Dr G Sharma – Non-Executive Director
Ms J Smith – Patient Partner
Ms H Stokes – Corporate and Committee Services Manager (for Minute 103/22)
Mr J Worrall - Associate Non-Executive Director (non-voting)

	RECOMMENDED ITEMS	
102/22	Mortality and Learning from Deaths Report	
	The Committee received the quarterly report on mortality rates and progress against the learning from deaths programme which included facilitation of death certification paperwork, medical examiner process, bereavement support service, specialty mortality reviews, child death/perinatal mortality reviews, clinical team reviews & reflections and triangulation of learning related to mortality (paper F refers). The following points were highlighted in particular: - i. The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remained within the expected range; ii. the Mortality Review Committee continued to receive details of reviews undertaken of diagnosis groups where the relative risk was above expected. Some learning had been identified from these reviews, however, there had been no deaths in these 'alert groups' which were more likely than not due to issues in care; iii. UHL had a higher-than-expected perinatal mortality rate identified in the recently published MBRRACE report for 2020. The Medical Director provided a detailed update on the internal/peer/cluster reviews that had been undertaken in respect of still births and neonatal deaths, highlighting that the outcome of some of these reviews had been presented to the Quality Committee previously. The mortality review process continued for all perinatal deaths through both the Perinatal Mortality Review Group (PMRG) and the use of HSIB and/or Serious Incident Investigations, where applicable. Through the PMRG, the work largely so far had been around stillbirths. A detailed review of neonatal deaths would be undertaken in mid-December 2022, the outcome of which would be submitted to the Quality Committee in due course. The number of neonatal deaths was much smaller, and a small number of cluster cases could affect the mortality rate significantly. HSIB had undertaken a cluster review and had not identified any particular themes. The MBRRACE report had been shared with	

	the National Maternity Safety Champion Clinical Director. His view was that UHL was taking all the correct actions and there were no particular areas of concern. He also highlighted that the Trust was not an outlier on the funnel plots. Responding to a query on mechanisms of equitable access of appropriate services for pregnant women with language barriers, it was noted that this was a multifaceted issue and several workstreams in terms of language, ethnicity and culture had already been put in place to take this work forward. The Director of Health Equality and Inclusion reassured members that a system-wide Task & Finish Group had been established to consider the differential experiences of BAME mothers; iv. work was underway to expand the Medical Examiner process across LLR in line with national requirements, the Trust was working closely with the ICS Medical Director team in respect of this and had appointed more Medical Examiner/Officers with a further recruitment round in progress; v. the Bereavement Support Service had been expanded to include child deaths and cover all adult deaths in both UHL and LPT. Remedial actions had been taken to address the follow up call backlog and additional bereavement nurses had been recruited to support this increased activity; vi. two deaths during quarter 2 of 2022-23 had been more likely than not due to issues in care and were currently being investigated as serious incidents, and vii. a regulation 28 report relating to anticoagulation might be issued by the Coroner, however, the Medical Director advised that appropriate actions had been taken and a response had been sent to the Coroner.	
	In respect of the level of detail of this report for the System Quality and Safety meeting, the Medical Director and ICB Representative undertook to discuss this outwith the meeting.	**MD/ICB Rep**
	In summary, the Committee was assured with this update, although noting that there were some issues which were not unknown.	
	<u>Recommended</u> – that (A) the Medical Director and ICB Representative be requested to discuss outwith the meeting, the level of detail of this report for submission to the System Quality and Safety meeting, and **(B) the Mortality and Learning from Deaths Report be endorsed and recommended to the Trust Board for approval.**	**MD/ICB Rep** **MD**
103/22	<u>Quality Committee Terms of Reference and Work Plan</u>	
	Members received the reviewed QC terms of reference and supporting work plan (paper E refers). The review had been undertaken as part of the Head of Internal Audit opinion work to standardise and update all Trust Board Sub-Committee terms of reference and work plans. The work plan was based on the 'duties' set out in the proposed QC terms of reference. In discussion, the following comments were made in respect of the workplan:- (i) the organ donation report needed to be bi-annual; (ii) an annual report on dementia and learning disability to be included ; (iii) in relation to the workforce report (i.e. staffing establishment), consideration be given to whether there was duplication (i.e. would this be better placed under the remit of the People and Culture Committee (or) was some assurance required in terms of safety that needed consideration by QC). In relation to the terms of reference, the following suggestions were made: - (a) inclusion of a Patient Partner in the membership; (b) the job title of 'Deputy Chief Nurse with responsibility for Clinical Governance' in the standing invitation list to be replaced with 'Associate Director for Quality Governance' and 'ICS' to be replaced with 'ICB', and (c) inclusion of wording re. any escalation in terms of the broader context of overall patient pathway care to be taken forward by the System Quality and Safety Committee as part of the ICB governance structure.	
	The Committee Chair undertook to forward to the Corporate and Committee Services Manager, the terms of reference of the Quality Committee meeting of another NHS Trust, in order that there was a double-check that all statutory requirements that needed to be seen by QC had been included in the work plan.	

	Recommended – that (A) the Corporate and Committee Services Manager/ the Director of Corporate and Legal Affairs to update the QC terms of reference following suggestions made at the November 2022 QC meeting and submit it for Trust Board approval, and **(B) the Quality Committee Chair to forward to the Corporate and Committee Services Manager, the terms of reference of the Quality Committee meeting of another NHS Trust, in order that there was a double-check that all statutory requirements that needed to be seen by QC had been included in the work plan. The QC work plan be updated accordingly and include the suggestions made at the November 2022 QC meeting.**	**CCSM/ DCLA** **QC Chair/ CCSM/ DCLA**
104/22	Changes to CQC Registration	
	Paper J highlighted the following updates to the Trust's CQC Statement of Purpose (a) to include the new satellite location of St Peter's Health Centre under registration regulation 9 for Outpatient Dermatology services to relocate in January 2023, and (b) to accept children aged 13-18 to the Dialysis units under registration regulation 1.	
	Recommended – the report highlighting the changes to the CQC Registration be endorsed and recommended to the Trust Board for approval.	**CN/ DCN**
	RESOLVED ITEMS	
105/22	**APOLOGIES**	
	Apologies were received from Ms C Trevithick and Ms C West, ICB Representatives; Ms J Hogg, Chief Nurse; Ms B Cassidy, Director of Corporate and Legal Affairs and Mr J Melbourne, Chief Operating Officer.	
106/22	**DECLARATIONS OF INTERESTS**	
	Resolved – that no additional declarations of interests were received.	
107/22	**MINUTES**	
	Resolved – that the Minutes of the Quality Committee meeting held on 24 November 2022 (paper A) be confirmed as a correct record.	
108/22	**MATTERS ARISING**	
	Paper B updated Quality Committee on progress against previous actions. Any updates now provided would be reflected in the next iteration of the log. All '5' rated actions would be removed after this meeting, and the QC Non-Executive Director Chair noted work underway to progress the remaining actions as a matter of urgency.	
	Resolved – that the discussion on the matters arising log (paper B) and any associated actions be updated accordingly.	
109/22	**ITEMS FOR DISCUSSION AND ASSURANCE**	
109/22/1	Deteriorating Patient Board, Resuscitation Committee, and the End-of-Life Steering Group	
	The QC noted the report from the Deteriorating Patient Board (paper C refers) and the following points were highlighted. The numbers of cases of coded sepsis had been stable. The mortality data was also stable, fluctuating between 18 and 22%, which was within the nationally reported control limits. The time to first antibiotic dose continued to be monitored and harm reviews were being undertaken in cases where antibiotics had been delayed beyond 3 hours. Although some case reviews were outstanding, no harm had been identified. The Academy of Medical Royal Colleges had published updated guidance on the initial antimicrobial treatment of sepsis, and it was anticipated that next year's NICE guidance was likely to reflect this and to be significantly different from current guidance. Therefore, the Sepsis Working Party would delay the amendment	

	of the Trust's current guidance on this matter. The Intensive Care National Audit and Research Centre (ICNARC) data for 2021-22 was now available and all metrics, when considered over the whole year, were within the expected range. The Resuscitation Committee update encompassed the following matters – the Service Level Agreement for provision of cardiac arrest team to LPT areas at GGH had been reviewed and updated with the support of UHL contracts department. The current paper version 2 ReSPECT form had started transitioning to the new version 3 ReSPECT form. Work was ongoing to develop an electronic version in NerveCentre which was being coordinated through the LLR End of Life working group. A defibrillator replacement strategy was being considered as one of the defibrillator models currently in use in the Trust was being discontinued by the supplier. A deep dive investigation of the bleep system issues surrounding response to emergency bleeps had identified that it was not a technical issue fundamentally. There was a need to improve both the organisational and human factor aspects around emergency bleeps response and an action plan would be developed to address any outstanding issues. As part of the End-of-Life Steering Group update, the Deputy Medical Director highlighted that there had been successful recruitment to the specialist palliative care workforce. Incidents relating to syringe drivers continued and were mainly around the nursing administration and checking of the pumps. Work was ongoing to address these issues which were related to nursing workforce levels and inadequate understanding/ward processes relating to pump management. Implementation of a NerveCentre solution to identify patients known to the palliative care team was being progressed. In response to a query from the QC Chair relating to palliative care discharge prescription risks, it was noted that discussions were on-going LLR wide to resolve this matter and an update on these discussions would be included within the next quarterly report to the QC. Responding to a query on the insulin safety dashboard relating to the increase in the numbers of hypoglycemic episodes, the Deputy Medical Director undertook to discuss this with the newly appointed Lead Clinician for Diabetes.	**DMD**
	<u>Resolved</u> – that (A) the contents of the report be received and noted; **(B) the Deputy Medical Director to include an update in the next quarterly report regarding the discussion with LLR colleagues to resolve the palliative care discharge prescription risks.**	**DMD**
109/22/2	<u>Fractured Neck of Femur (#NOF) Report</u>	
	The QC received an update (paper D refers) on the impact of waiting times for #NOF on mortality including an update the Trust's performance against the national standard for operating on #NOF within 36 hours of presentation in the Emergency Department. Currently, on average the CMG operated on 3 #NOF cases per list and there was need to increase this to 4 cases per list to achieve the national target. It was noted that the major constraints to improvement related to theatre capacity and bed availability. Part of the issue around capacity in theatres was also around the capacity for adult trauma cases. Consideration was being given to including some additional adult trauma theatre capacity, particularly ambulatory trauma cases, potentially at the Leicester General Hospital (LGH) site. The intention was to move pain sessions out of theatres at the LGH site to the Alliance. The MSS CMG was developing a business case to explore the best use of these sessions. The CMG were also considering extra theatre days, however, members were advised that since the Covid-19 pandemic, patients coming in for a #NOF operation had been increasingly frail and complex from an aesthetic point of view. It was highlighted that the cases were complex, and the operating time was only one aspect of how long these cases took and how quickly they were processed through the theatre environment. The #NOF list also incorporated several prosthetic fractures which were quite complex surgeries. The Medical Director advised that discussions had taken place at the Mortality Review Committee and the mortality data highlighted the importance of achieving the 36-hour time to theatre target, and the consequences of failing to achieve this. In the National Hip Fracture Database, for the 2020 data, mortality rates at UHL was 8.4% whilst the national average was 8.2%. In summary, UHL was within the funnel plot but slightly higher than the national average. The Medical Director	

	reiterated that the focus needed to be on creating capacity to increase the average cases per list to operate on these patients within the time frame. In response to a further query, the Lead for #NOF assured members that the CMG had undertaken a large quality improvement project on looking at the efficiency of the list and the 'golden patient' initiative. However, this did not translate into getting an increased number of cases per list. The Director of Quality Transformation and Efficiency Improvement noted that when the target had been introduced, many years ago, it was because of the increased mortality for patients waiting longer than 36 hours and queried whether any targeted actions could be taken. In response, it was noted that the fundamental solution was the need for increased theatre capacity which needed to be achieved by ring fencing capacity for this group of patients. In summary, the Medical Director highlighted that the Trust was not an outlier in respect of the mortality data. Responding to further queries, members were advised that the Trust's performance in respect of inpatient falls was better, and the numbers had been reducing. Patients had received bone health assessments, however, the key performance indicator (KPI) required a follow-up at 120 days following surgery. This KPI had not been met due to staffing issues in terms of data collection. Recruitment was underway and this post would be filled in due course which would assist in the achievement of this KPI.	
	<u>Resolved</u> – that the contents of the report be received and noted;	
109/22/3	<u>Annual Radiation Safety Report</u>	
	Paper G detailed the work of Leicester Radiation Safety Services throughout 2022 and provided assurance that in general, there were appropriate governance structures in place around radiation safety. Whilst there had been an improvement in compliance, there had been workforce issues in all areas related to the use of radiation, but particularly in Nuclear Medicine and Radiation Safety. A national shortage of staff in Nuclear Medicine had been reported. Due to the challenges around recruitment to senior positions, additional training was being provided to current staff in the interim. There was an increased legislative oversight, and the Health and Safety Executive would be inspecting all areas which required consents to undertake certain higher risk activities in Nuclear Medicine and Radiotherapy services. Members noted that there were several areas that required improvement in terms of compliance and the Trust was already aware of this. The following areas were highlighted in particular (a) compliance and engagement in the radiation governance activities by small users of radiation across the Trust (e.g., mini c-arm users); (b) lack of a dedicated molecular radiotherapy suite which required an ensuite and additional shielding, and (c) aging estate within Nuclear Medicine, which made the control of spread of contamination challenging. All radiation safety related risks were escalated to the Radiation Safety Committee and a new Chair for this Committee needed to be identified. The Medical Director undertook to have a discussion regarding this outwith the meeting.	**MD**
	<u>Resolved</u> – (A) that the contents of the report be received and noted, and **(B) the Medical Director be requested to identify a new Chair for the Radiation Safety Committee.**	**MD**
109/22/4	<u>Thrombosis Prevention Safety Update</u>	
	The Committee received a report (paper H refers) on the outstanding issues regarding VTE assessment and anti-coagulation. There had been a sustained positive performance for VTE assessment and investigation of Hospital Associated Thrombosis against the Quality Schedule which was above the agreed thresholds (>95%) for quarters 1 & 2 of 2022-23. However, patients in Emergency Department with prolonged bed waits had not been receiving VTE assessments to the same standard as any admitted patient. The introduction of NerveCentre E-prescribing in ED was expected to bring improvement, however, it was too early to assess the effect given that this had only commenced in October 2022. In discussion on this matter, it was agreed that a report be brought to QC in six months' time if appropriate progress was being made. If there were any issues, then a report be presented to QC in three months' time which should also include an update on the themes from the root cause analysis undertaken. In terms of the anticoagulation dashboard, the percentage of omitted doses remained steady. The most common reason for	

	missed doses of thromboprophylaxis was due to patients declining administration. An audit was being undertaken to review the reasons for refusal by patients. A review of patient safety data had identified that the main safety issue was in relation co-prescribing of Warfarin and LMWH which was on a paper chart. An electronic prescribing solution for warfarin on Nerve Centre was being put in place imminently. In the meantime, the paper chart was being amended to highlight the importance of checking if the patient was receiving another anticoagulant. The Medical Director thanked the Consultant Haematologist and her team for their efforts in developing an electronic prescribing solution for warfarin.	**CH**
	<u>Resolved</u> – (A) that the contents of the report be received and noted, and **(B) the Consultant Haematologist to review the effect of the introduction of NerveCentre E-prescribing in ED, and a report be brought to QC in six months' time if appropriate progress was being made. If there were any issues, then a report be presented to QC in three months' time which should also include an update on the themes from the root cause analysis undertaken.**	**CH**
109/22/5	<u>Safeguarding Update Quarter 2 2022-23</u>	
	Paper I highlighted the current level of reported safeguarding assurance against set standards. There had been an increase in safeguarding children activity. The Trust had been notified that Ofsted and the CQC would undertake a joint inspection of frontline child protection services within Leicester City. The Trust submitted data for the inspection prior to onsite visits, however, the inspection had been deferred due to unforeseen circumstances within the inspection team. It was expected to be reconvened. A brief update on the work to improve responses for children abandoned in the Emergency Department was provided and the Committee noted the continued challenge of abandoned children.	
	<u>Resolved</u> – that the contents of the report be received and noted.	
109/22/6	<u>Pertinent Safety Issues</u>	
	<u>Resolved</u> – that it be noted that there were no issues to update at this meeting.	
109/22/7	<u>Patient Safety Report – October 2022</u>	
	The Deputy Chief Nurse highlighted the following points in particular from the patient safety report (paper K refers): i. 5 serious incidents (SI) had been escalated in October 2022 which comprised of one never event relating to wrong-site surgery in dermatology outpatient department; ii. the number of moderate and above harm incidents had decreased. However, in maternity services, moderate and above validated harms had risen in October 2022 compared to September 2022. iii. increase in the number of patient safety incidents reported whilst attendances had decreased; iv. lack of nursing staff incidents was the highest reported incident theme. This matter was discussed at the November 2022 Executive Quality Board where the Chief Nurse had indicated that the Care Hours Per Patient Day (CHPPD) data did not correlate with this, as recent figures had shown an improvement in CHPPD. Further to the EQB meeting, a review of incidents on Datix highlighted that some of the incidents reported were the perception of staff and staff would always report incidents when they felt that the area they were working in was short staffed; v. significant increase in incidents with evidence gaps in Duty of Candour in comparison to the previous month. This was being raised at the CMG Performance Review meetings; vi. no CAS Alert breaches during this reporting period, and vii. a patient safety theme had been escalated from discussion of the closed SI investigations at the October 2022 Adverse Events Committee. The theme was in respect of the risk presented by having a dual system for documentation of clinical care whilst transitioning to an Electronic Patient Record system.	

	Resolved – that the contents of the report be received and noted.	
109/22/8	Actions Being Taken to Improve the Management of Complaints in UHL	
	The Executive Team had supported a number of measures to improve the management of complaints and the Deputy Chief Nurse highlighted those measures (paper L refers). An external review of end to end of the complaints process was being undertaken. Members noted this and suggested that timescales for the key stages be included in the report and a further update be brought to QC in due course.	**DCN/ HPS**
	Resolved – that (A) the contents of the report be received and noted, and **(B) the Deputy Chief Nurse/ Head of Patient Safety be requested to include timescales for the key stages in the report and a further update be brought to QC in due course.**	**DCN/ HPS**
109/22/9	Safer Surgery Update	
	Paper M provided an update on the safe surgery work-stream in UHL's Quality Strategy. It incorporated an update on the never event action plan and updates from the Consent and Patient Information Committees. The Trust was collaborating with a number of other Trusts to share good practice. The Safe Surgery Quality Assurance and accreditation programme was being rolled out with full visits having taken place to ten areas. National guidance had been issued on how to improve safety procedures before anaesthetic blocks were given and the ITAPS CMG was leading on implementation of the new guidance.	
	Resolved – that the contents of the report be received and noted.	
109/22/10	Board Assurance Framework (BAF)	
	The Head of Risk Assurance presented the report (paper N refers) advising that the report was reviewed by the Medical Director and Chief Nurse on a monthly basis. Any issues raised from the discussion of the reports presented at the QC meeting would be reflected in the controls and assurance section of the BAF. The QC Chair queried whether the discussion under the #NOF report at today's meeting had been appropriately reflected in the BAF/risk register and suggested that consideration be given to this outwith the meeting.	**MD**
	Resolved – that (A) contents of the report be received and noted, and **(B) the Medical Director be requested to give consideration to whether discussion under the #NOF report at today's meeting particularly regarding theatre productivity had been appropriately reflected in the BAF/risk register.**	**MD**
110/22	**REPORTS FROM UHL BOARDS**	
110/22/1	Nursing, Midwifery and AHP Committee (NMAHPC) Report	
	Paper O provided a summary of the first NMAHPC meeting held in November 2022 in relation to Reducing Avoidable Hospital Acquired Harm and Making UHL the Employer of Choice for NMAHPs. QC noted that actions were being taken to support the reduction of Hospital Acquire Pressure Ulcers and Falls. A brief update was provided on the Pathway to Excellence programme and the positive progress made. Members were advised that there was a shortfall of NMC Registered Children's Nurses working within the Emergency Department which constrained the opening of the Children's Short Stay Unit (CSSU). There were ten Internationally Educated Registered Nurses (IENs) working in the CSSU who have NMC registration in adult nursing but also have extensive children's nursing experience in their home country prior to moving to the UK. Therefore, risk assessment to support rapid flow and risk assessment to support IENs (adult) working in the CSSU had been undertaken and approved for inclusion on the Trust's risk register. There had been a positive reduction in Registered Nurse vacancies and increase in Care Hours Per Patient Day (CHPPD). A simple process had been put in place to triangulate data to inform and monitor wards or departments which required additional support and oversight until the	

	'exemplar model' was in place. As part of the Assessment and Accreditation programme, all adult inpatient wards (except CDU) had now had at least one assessment in quarter 2 of 2022-23. The QC Chair requested an overview about the assessment and accreditation process. (i.e., what is the process when a ward moves from 'green' to 'red' rating). The QC Chair was interested to know if there were any predictive factors which would require an earlier intervention rather than undertaking the assessment of the ward through a routine programme of visits. Ms B O'Brien, Deputy Chief Nurse undertook to feedback these comments to Mr R Binks, Deputy Chief Nurse.	
	Resolved – that the contents of this report be received and noted.	
111/22	**LLR QUALITY BOARD**	
	Resolved – the Mortality and Learning from Deaths report be referred to the LLR Quality Board from this QC meeting.	
112/22	**ITEMS FOR NOTING**	
112/22/1	Data Quality and Clinical Coding update	
	Resolved – that the contents of paper P be received and noted.	
112/22/2	CIP QIAs 2022-23 Q2 Review	
	Resolved – that the contents of paper Q be received and noted.	
112/22/3	Clinical Audit Programme Quarterly Report: End of Q2 2022-23	
	Resolved – that the contents of paper R be received and noted.	
113/22/4	Integrated Performance Report – Month 7 2022/23	
	Resolved – that the contents of paper S be received and noted.	
114/22	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
115/22	**IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**	
	Resolved – that an external review of end to end of the Trust's complaints process was being undertaken (Minute 109/22/7 refers) be brought to the attention of the Trust Board.	**CN**
116/22	**DATE OF THE NEXT MEETING**	
	Resolved – that the next meeting of the Quality Committee be held on Thursday 22 December 2022 from 2pm via Microsoft Teams.	

The meeting closed at 4.00pm Hina Majeed – Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2022-23 to date).

Voting Members

Name	*Possible*	*Actual*	*% Attendance*
V Bailey (Chair)	8	8	100
A Furlong	8	7	87.5
A Haynes	8	7	87.5
J Hogg (from May 2022)	7	5	71
E Meldrum (until May 2022)	1	0	0
T Robinson	7	4	57

Non-voting members

Name	*Possible*	*Actual*	*% Attendance*
B O'Brien	8	6	75
M Durbridge	8	8	100
G Collins-Punter (until May 2022)	2	1	50
G Sharma	8	6	75
J Smith (PP)	8	5	63
J Worrall	8	8	100
C Trevithick/C West/ H Hutchinson/S Bailey (ICB Representative)	8	7	87.5