Hand and Wrist Pathway (V7) – 30.04.2019

SELF-CARE AND SELF-MANAGEMENT

Integrated MSK Service Website: https://sussexmskpartnershipcentral.co.uk/

OUTCOME MEASURES

- MSK-HQ
- Patient-Rated Wrist and Hand Evaluation

Referral reason / Patient presentation	**Thumb Base Osteoarthritis** • *OA at the base of the thumb metacarpal and one of the small bones of the wrist, the Trapezium.* • *Symptoms can start in the forties or earlier they are more common in women and are initially intermittent.* • *Present with difficulty opening jars and bottles and pain gripping and pinching*
Primary Care Assessment and Diagnostics	**History – mechanism of onset, location of pain, severity and longevity of symptoms, limitation to function.** **Examination of hand/ wrist:** 1. Active ROM CMCJ & thumb opposition 2. Grind test Link to website for video of grind test: https://www.youtube.com/watch?v=1kJtO4NLzBY 3. Grip strength **Investigations:** X-ray not needed to confirm diagnosis but may be indicated if suspecting inflammatory arthropathy or if trauma to exclude bony injury **Differential diagnosis:** CMCJ vs De Quervain's (see section below for guidelines)
Management within primary care self-management guidelines	**Self-management for 6 – 8 weeks** Pain relief in line with agreed formularies/ guidance. Patient education exercise sheet particularly thumb stabilising exercises http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2018/02/Microsoft-Word-Arthiritis-at-the-base-of-the-thumb-FINAL.pdf Activity modification–thumb splint if symptoms are moderate -severe. Do not use splint in early OA as risk weakening muscles http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2018/02/Microsoft-Word-The-Principles-of-Joint-Protection-2.pdf
Threshold to initiate a referral	Direct patients to self-refer to SMSKP H&W pathway if: • Diagnostically uncertain • symptoms persist beyond 6/52 and interfere with ADL's • Exceptionally severe. If patient does not want an injection for pain relief refer to physio/ CMC OA class

Management pathway for ICATS	Investigations: x-ray AP/ lateral of CMCJ +/- wrist – not needed for an injection but for differential diagnosis. Shared decision making re treatment options: • Pain mx advice • Splinting/joint protection advice • Exercise advice • Injection to joint • Surgical pathway to be discussed. If patient needs, wants and is fit for surgery then offer choice of provider. Patients from East Grinstead can be referred to Hand Therapy at QVH
Management in secondary care or co-located clinic	Surgical Options to be decided by surgeon: 1. Simple Trapeziectomy 2.Trapeziectomy with LRTI 3.Trapeziectomy with Tendon Interposition 4.Trapeziectomy with ligament reconstruction 5.CMC Replacement http://sussexhandsurgery.co.uk/downloads/surgery/hand/Trapeziumectomy.pdf http://sussexhandsurgery.co.uk/downloads/surgery/hand/Thumb%20CMC%20Joint%20Replacement.pdf http://sussexhandsurgery.co.uk/downloads/surgery/hand/Thumb%20base%20Ligament%20Reconstruction.pdf
Referral reason / Patient presentation	**Carpal Tunnel Syndrome (CTS)** *Caused by compression of the median nerve in the carpal tunnel at the wrist.* *It is more common in females. Often worse at night and with gripping activities.* *Presentation can include:* • *pain in wrist,* • *altered sensation in the median nerve distribution (thumb, index finger, middle finger, and radial half of the ring finger)* • *weakness/muscle atrophy of the thenar eminence*

	Prognosis can vary. Even if untreated 34%-49% can significantly improve or resolve spontaneously.
Primary Care Assessment and Diagnostics	**History – mechanism of onset, location of symptoms (median nerve distribution), severity and longevity of symptoms, limitation to function.** **Examination :** 1. Light touch sensory testing tips of fingers 2. Modified Phalen's, Tinel's and Durkan's test can support the diagnosis (?link to video of these tests?) **Investigations:** NCS are not indicated in primary care **Differential diagnosis:** Cervical spine/ radiculopathy (increase index of suspicion if bilateral).
Management within primary care self-management guidelines	Treatment of any underlying condition, e.g. diabetes, OA, RA hypothyroidism. Patient education, activity modification and exercise sheet http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/12/Median-Nerve-Gliding-Programme-Final-Version.pdf Night splinting of wrist in a neutral position. If work related suggest workplace adaptations, reduction of exposure to hand-transmitted vibration or temporary change of duties. Corticosteroid injection if available within practice and symptoms not resolving with the above conservative management. Do not prescribe NSAIDS or diuretics to treat CTS.
Threshold to initiate a referral	Direct patients to self-refer to SMSKP H&W pathway if: • Diagnostically uncertain • Symptoms persist beyond 6/52 and interfere with ADL's • Exceptionally severe. If suspect a cervical source, particularly if bilateral symptoms – refer to physiotherapy through usual pathway.
Management pathway for ICATS	BOSTON questionnaire at point of triage: Mild or moderate score -CTS class/physio Moderate score with previous physiotherapy or for an injection - For shared decision making re treatment options: • Conservative management including median nerve glides, activity modification, night splint, http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/12/Median-Nerve-Gliding-Programme-Final-Version.pdf • injection (refer to injecting clinician in AP clinic) • If more than 2 injections in one wrist, or severe symptoms i.e. thenar atrophy , constant sensory change then If meets Clinically effective commissioning (CEC) thresholds then surgical pathway to be discussed. If patient needs, wants and is fit for surgery then offer choice of provider. X-ray if advanced CMC/STT OA - may need to be managed as part of the carpal tunnel Severe score – If no previous conservative management refer to AP clinic/ if muscle wasting or constant sensory loss/ previous injections and if CEC compliant refer

	direct to secondary care or direct listing through co-located clinics CEC threshold CTS CEC NCS are only required for atypical symptoms, diagnostic confusion
Management in secondary care or co-located clinic	Carpal Tunnel Decompression http://sussexhandsurgery.co.uk/downloads/surgery/hand/Carpal%20Tunnel%20Decompression.pdf Horsham and Crawley refer to SASH and Gatwick Park Brighton and Hove refer to SOTC Mid - Sussex can refer to Montefiore and SOTC – counter signed by Chris Williams
Referral reason / Patient presentation	**Trigger finger / Thumb** *A painful condition caused by thickening of the flexor tendon around the A1 pulley which causes abnormal gliding of the tendon within sheath. Presentation can include snagging or locking of the affected digit in flexion or occasionally extension.*
Primary Care Assessment and Diagnostics	**History – mechanism of onset, location of pain, severity and longevity of symptoms, limitation to function.** **Examination:** 1. Observe for visible triggering 2. Palpate for thickening, tenderness and palpable triggering **No investigations at this stage** **Differential diagnosis:** Dupuytren's disease vs RA synovitis
Management within primary care self-management guidelines	**Self-management and advice, patient information leaflet:** **http://sussexhandsurgery.co.uk/downloads/what-we-treat/hand/Trigger%20finger%20or%20thumb.pdf** Use of a finger support for night time. Splint should stop movement at the MPJ but not at the PIPJ and DIPJ - for example **https://www.amazon.co.uk/Trigger-Aluminium-Straightening-Stenosing-Tenosynovitis/dp/B071JDVWCG/ref=sr_1_9_a_it?ie=UTF8&qid=1537355066&sr=8-9&keywords=trigger+finger+splint** Self massage nodule for up to 6 wks and monitor. Corticosteroid injection if available within practice and symptoms not resolving with the above conservative management within 6 wks. **Urgent referral to secondary care for locked trigger finger**
Threshold to initiate a referral	**Direct patients to self-refer to SMSKP H&W pathway if:** • Diagnostically uncertain • Symptoms persist beyond 6/52 and interfere with ADL's • Exceptionally severe. • Significant hand co-morbidities

Management pathway for ICATS	**Investigations: usually none but ultrasound scan if diagnostically uncertain?** **Shared decision making re treatment options:** • Tendon gliding exercises http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2018/02/Microsoft-Word-Tendon-glides-FINAL-2.pdf • Taping • Steroid injection • Referral to secondary care if symptoms recurrent or failure to respond to 2 steroid injections or locked trigger finger and patient wants it and is fit for surgery then offer choice of provider. **CEC threshold** 180118 Trigger Finger CEC V2.docx
Management in secondary care or co-located clinic	**Trigger finger release** **http://sussexhandsurgery.co.uk/downloads/surgery/hand/Trigger%20finger%20or%20thumb%20release.pdf** Horsham and Crawley refer to SASH and Gatwick Park Brighton and Hove refer to SOTC Mid - Sussex can refer to Montefiore and SOTC – counter signed by Chris Williams
Referral reason / Patient presentation	**Dupytren's disease** *A hereditary condition which causes thickening and shortening of the palmar fascia in the hand. Over the time, this can pull the finger towards the palm and extension of the finger is not possible. Usually but not exclusively affects ulnar sided fingers* *More common in men.* *In females it usually develops in late 60's-70's* *Presentation:* • *May have pain in the initial stages can be confused with symptoms of triggering* • *Skin puckering or nodules over the palm or the finger.* • *Dupuytren's cords can develop running towards the proximal phalanx.*

Primary Care Assessment and Diagnostics	**History: Family history, severity and longevity of symptoms, limitation to function.** **Examination :** 1. Check for nodules/ cord, 2. A Positive Huston Table top test or pen under MCPJ 3. Measure Angle of fixed flexion deformity **No investigations required**
Management within primary care self-management guidelines	Explanation of cause and natural history Self-management and advice, patient information leaflet: **http://sussexhandsurgery.co.uk/downloads/what-we-treat/hand/Dupuytrens%20disease.pdf**
Threshold to initiate a referral	Direct patients to self-refer to SMSKP H&W pathway if: • Diagnostically uncertain • Patient meets the CEC threshold for surgery and wants surgery. Minimum degree of contracture >10° PIPJ and / or >30° MCPJ CEC threshold 180604 Dupuytrens.docx
Management pathway for ICATS	**Virtual clinic for discussion re secondary care provider**
Management in secondary care or co-located clinic	To be decided by the surgeon: Needle Fasciotomy to be carried out with MPJ flexion deformity. Xaipex injections to be considered if there is a >30° of MPJ flexion with >10° of PIPJ flexion Fasciectomy to be considered with >30 of PIPJ flexion deformity and Xiapex Criteria are excluded NB: Xiapex injections only available at BSUH, Vale, Montefiore hospital
Referral reason / Patient presentation	**De Quervain's tenosynovitis** *The tendons of extensor pollicis brevis and Abductor Pollicis Longus become painful, inflamed and/or constricted within their tendon sheath.* *Common with mothers who look after their new-born or toddler age babies* *Very common with Diabetics* *Presentation:* • *Pain on moving or using the thumb* • *Pain often radiates upwards into the forearm*

	• *May have swelling or thickening over the radial side of the wrist* • *May have pain at night*
Primary Care Assessment and Diagnostics	**History – mechanism of onset, location of symptoms, severity and longevity of symptoms, limitation to function.** **Examination:** 1. Range of wrist movement and general hand function. 2. Palpate for pain and swelling over the distal radial styloid **No investigations at this stage.**
Management within primary care self-management guidelines	Self-management for 6 – 8 weeks Pain relief in line with agreed formularies/ guidance. Anti-inflammatories do not work. Patient information and isometric exercises http://sussexhandsurgery.co.uk/downloads/what-we-treat/hand/de%20Quervain's%20Disease.pdf Activity modification /thumb splint/ taping. NB. Sometimes the pressure from splints can increase symptoms. Warn patients to stop splinting if symptoms are aggravated. Corticosteroid injection if available within practice and symptoms not resolving with the above conservative management within 6 wks.
Threshold to initiate a referral	**Direct patients to self-refer to SMSKP H&W pathway if:** • Diagnostically uncertain • Symptoms persist beyond 6/52 and interfere with ADL's • Exceptionally severe.
Management pathway for ICATS	Investigations not indicated Refer to physio if first onset of symptoms If recurrent symptoms/ failed physio shared decision making re treatment options: • Taping/splints • Isometric exercises • Steroid injection • Referral to secondary care if symptoms recurrent or failure to respond to 2 steroid injections and patient wants it and is fit for surgery then offer choice of provider.
Management in secondary care or co-located clinic	De Quervain's Release http://sussexhandsurgery.co.uk/downloads/surgery/hand/de%20Quervain's%20Release.pdf Horsham and Crawley refer to SASH and Gatwick Park Brighton and Hove refer to SOTC Mid - Sussex can refer to Montefiore and SOTC – counter signed by Chris Williams
Referral reason / Patient presentation	**Ganglion** *A benign accumulation of synovial fluid within a sac with a narrow base which is connected to a joint or a tendon.* *Can develop in any joint but are very common in the wrist joint.* *Fluctuation in size is common* *Most disappear on their own accord but can last several years.* *Presentation:*

	• *May or may not be painful on movement* • *Restriction of range of movement can develop*
Primary Care Assessment and Diagnostics	**History – mechanism of onset, location of symptoms, severity and longevity of symptoms, limitation to function.** **Examination:** 1. Range of movement and general hand function. 2. Palpate for pain **No investigations required**
Management within primary care self-management guidelines	Explanation of cause and natural history Patient information sheet http://sussexhandsurgery.co.uk/downloads/what-we-treat/wrist/Wrist%20Ganglia.pdf If pain free and not affecting range of movement and function then advise that these are best left without any intervention. Aspiration only of dorsal wrist ganglia, but advise patient that 70% of wrist ganglia will recur within a week. Patient to self-monitor
Threshold to initiate a referral	Consider referral to secondary care if: • Symptomatic - severe pain • Interfering with activities **and** • If patients wants and is fit for surgery - include CEC guidance then offer choice of provider CEC for ganglia 180604 Ganglia (hand and wrist)).doc
Management pathway for ICATS	Not seen in ICATs service
Management in secondary care or co-located clinic	Surgical excision Wrist - http://sussexhandsurgery.co.uk/downloads/surgery/wrist/Wrist%20Ganglia%20Excision.pdf Fingers - http://sussexhandsurgery.co.uk/downloads/surgery/hand/Mucous%20Cyst%20Excision.pdf http://sussexhandsurgery.co.uk/downloads/surgery/hand/Seed%20Ganglion%20Excision.pdf Horsham and Crawley refer to SASH and Gatwick Park Brighton and Hove refer to SOTC Mid - Sussex can refer to Montefiore and SOTC – counter signed by Chris Williams
Referral reason / Patient presentation	**Finger soft tissue injury** http://www.bssh.ac.uk/patients/conditions/hand_injuries Sprains/strains of the fingers due to injury or overuse. Presentation: • Pain on movement of the finger

	• Tendon or ligament injuries may present with deformity • May have swelling • May develop stiffness due to immobilisation resulting from pain or swelling **Acute traumatic tendon/ligament ruptures need urgent orthopaedic opinion – for referral to A&E within BSUH for appointment with hand surgeon** http://sussexhandsurgery.co.uk/downloads/what-we-treat/hand/Mallet%20finger.pdf http://sussexhandsurgery.co.uk/downloads/what-we-treat/hand/Tendon%20injuries.pdf
Primary Care Assessment and Diagnostics	**History – mechanism of onset, location of symptoms, severity and longevity of symptoms, limitation to function** **Examination:** 1. Range of movement and general hand appearance and function. 2. Look for deformity and loss of active range of movement 3. Assess swelling **Investigations:** If history of trauma may need x-ray to rule out bony injury
Management within primary care self-management guidelines	Self-management for 6 – 8 weeks Pain relief in line with agreed formularies/ guidance. Patient education /exercise sheet and swelling management http://sussexhandsurgery.co.uk/downloads/rehabilitation/hand/Finger%20Exercises.pdf https://www.nhs.uk/conditions/hand-pain/
Threshold to initiate a referral	Direct patients to self-refer to physiotherapy for simple finger pain – no trauma Direct patients to self-refer to SMSKP H&W pathway if: • Diagnostically uncertain (virtual clinic) • Tendon rupture (not acute) • Symptoms persist beyond 6/52 and interfere with ADL's • Exceptionally severe.
Management pathway for ICATS	Investigations: US/X-Ray of the involved finger may be needed for differential diagnosis. Shared decision making re treatment options: • If soft tissue trauma swelling management and exercises • Physiotherapy/hand therapy (Patients from East Grinstead can be referred to Hand Therapy at QVH) • Patients needing hand therapy /bespoke splinting Horsham and Crawley refer to orthopaedics • Referral to secondary care if indicated (e.g. tendon repair) and patient wants it and is fit for surgery. Offer choice of provider.
Management in secondary care or co-located clinic	Surgical Options to be decided by surgeon: http://sussexhandsurgery.co.uk/downloads/what-we-treat/hand/Mallet%20finger.pdf http://sussexhandsurgery.co.uk/downloads/what-we-treat/hand/Tendon%20injuries.pdf
Referral reason / Patient presentation	**Wrist Pain** *Commonly caused by Osteoarthritis but it can also develop as a result of trauma/ injury or due to inflammatory arthropathy.*
Primary Care Assessment and Diagnostics	**Assessment: History – mechanism of onset, location of symptoms, limitation to function/ co-morbidities** **Post trauma** – needs urgent x-ray and assessment within 6 weeks – window for repair of scapholunate injury is 6/52

	Examination: 1. Range of movement and general hand appearance and function. 2. Look for signs of synovitis/heat/ stiffness – red flags for rheumatology referral **Investigations:** X-ray to exclude bony abnormality. If trauma (PA and True lateral views). If there is suspicion of a scaphoid fracture, then request scaphoid views Bloods to exclude inflammatory arthritis **Differential diagnosis:** 1. OA of the wrist 2. Soft tissue injury 3. Inflammatory Arthropathy
Management within primary care self-management guidelines	Pain relief in line with agreed formularies/ guidance. Wrist Trauma – x-ray and urgent assessment in AP clinic to exclude scapholunate injury. Patient advice information leaflet on exercises http://sussexhandsurgery.co.uk/downloads/rehabilitation/wrist/Wrist%20Exercises.pdf Consider recommending a splint for painful activities. **Onward referral if symptoms persist beyond 6 weeks**
Threshold to initiate a referral	**Direct patients to self-refer to physiotherapy for simple wrist pain – no trauma** **Direct patients to self-refer to SMSKP H&W pathway if:** • Diagnostically uncertain (virtual clinic) • Symptoms persist beyond 6/52 and interfere with ADL's • Exceptionally severe.
Management pathway for ICATS	**Investigations:** X-ray to exclude bony abnormality Ultrasound if suspecting inflammatory arthropathy or symptoms of ganglions If inflammatory arthritis is suspected then blood tests. If positive refer to rheumatology. If suspecting a ligamentous injury then MRI arthrogram or T3 MRI is essential. Refer to secondary care If a diagnosis of instability is made and surgery is required, discuss the risk and benefits of surgery then refer to secondary care Atraumatic wrist pain: Link to leaflet on activity modification and pain mx https://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2018/08/Wrist-Sprain-Advice-and-Exercises-1.pdf Refer to hand therapy- if patient lives in the Mid-Sussex area. Elsewhere patient needs to be refer red to secondary care. Horsham – hand therapy - via secondary care Or physio if appropriate Refer to Secondary Care for surgical intervention/ management or further investigation if indicated
Management in secondary care or co-located clinic	Surgical Options to be decided by surgeon:

	Suspected TFCC injury http://sussexhandsurgery.co.uk/downloads/surgery/wrist/TFCC%20Repair.pdf Scaphoid lunate ligamentous injury http://sussexhandsurgery.co.uk/downloads/surgery/wrist/Scapholunate%20Repair%20or%20Reconstruction.pdf STT Arthritis http://sussexhandsurgery.co.uk/downloads/surgery/wrist/STT%20Arthritis%20Surgery.pdf Severe OA of the Wrist http://sussexhandsurgery.co.uk/downloads/surgery/wrist/Proximal%20Row%20Carpectomy.pdf http://sussexhandsurgery.co.uk/downloads/surgery/wrist/Partial%20Wrist%20Fusions.pdf http://sussexhandsurgery.co.uk/downloads/surgery/wrist/Total%20Wrist%20Fusion.pdf http://sussexhandsurgery.co.uk/downloads/surgery/wrist/Wrist%20Replacement.pdf OA ulnar side of the wrist: http://sussexhandsurgery.co.uk/downloads/surgery/wrist/Ulnar%20Head%20Replacement.pdf Severe synovitis http://sussexhandsurgery.co.uk/downloads/surgery/wrist/Tenosynovectomy.pdf Horsham and Crawley refer to SASH and Gatwick Park Brighton and Hove refer to SOTC Mid - Sussex can refer to Montefiore and SOTC – counter signed by Chris Williams
Referral reason / Patient presentation	**Lumps and Bumps**
Primary Care Assessment and Diagnostics	Not seen within the MSK service – direct to secondary care for further investigation or surgical intervention e.g. mucous cysts / seed ganglion / giant cell tumour / neurofibroma / mass malignancy / skin lesions
Management within primary care self-management guidelines	
Threshold to initiate a referral	
Management pathway for ICATS	
Management in secondary care or co-located clinic	

Referral reason / Patient presentation	Elbow pain – Non-traumatic Ulnar Neuropathy
Primary Care Management (including Assessment and Diagnostics)	**Assessment**: history - mechanism of onset, location of symptoms. Neural symptoms in ulnar distribution. Elbow examination - often positive tinels sign over cubital tunnel. No diagnostic at this stage. **Management** (including condition-specific self-care options): Patient education Avoid sustained elbow flexion especially at night. Avoid local elbow pressure. Refer to physio for mild sensory symptoms that persist despite following leaflet advice. Hyperlink leaflet http://sussexmskpartnershipcentral.co.uk/wp-content/uploads/2016/09/Elbow_Ulnar_Neuropathy.pdf
Thresholds for Primary Care to initiate a referral	Progression of intrusive symptoms - refer iCATS Fixed sensory loss – loss of two point discrimination at 3mm Hypothenar muscle wasting and weakness. Clawing of ring and little finger
Management Pathway for the Integrated MSK Service ***Outcome tools: MSK HQ, Oxford Shoulder score***	Consider investigations with NCS. Consider XR to exclude Elbow bony pathology. Consider excluding C8 nerve root, MRI for clinical correlation.
Management within co-located clinic (seen by an AP with a consultant present) or secondary care	**Urgent referral to secondary care** for presentation of severe nerve compromise e.g. clawing of the little and ring finger.
Thresholds for referral to Specialist In-patient care *(Choice)*	**Risk / benefit information Cubital Tunnel Decompression** Cubital Tunnel Decompression.docx
Management pathway for Specialist In-patient care	**Secondary care surgical guidelines Cubital Tunnel Decompression** SE Pathway Guidelines Secondary

Hand and Wrist group 19th December 2013
Peter Devlin (GP, BICS)
Bertie Brincat (ESP Hand Therapist, BICS / SCT)
Sarah Bell (ESP Physiotherapist, SCT)
Paul Forsdick (GP)
Ian Francis (Consultant Radiologist, MIP)
Helen Kuhn (Occupational Therapist, WSHT)
Miguel Oliveria (Orthopaedic Consultant, WSHT)
Matthew Carr (Service Manager, Horder Healthcare)
James Nicholl (Orthopaedic Consultant, Horder Healthcare / MTW)

Hand and Wrist group 17th July 2014
Peter Devlin (BICS, Clinical Director)
Bertie Brincat (BICS/SCT, Hand Therapist)
Di Finney (BICS, Consultant Rheumatology Nurse)
Natalie Blunt (BICS, Service Manager)
Kasia Kaczmarek (BICS, MSK Integrated Care Manager)

Sarah Bell (SCT, ESP)
Ian Francis (MIP, Consultant Radiologist)
Jane Vince (Horder Healthcare Service Manager)
Anita Vincent (Service Manager, SASH)
Liz Green (GP, B&H CCG)
James Blair (QVH, Consultant Plastic Surgeon)
Lisa Tourett (BSUH, Orthopaedic Consultant)
Sally Dando (SASH, Head of Therapies)
Kathryn Pank (QVH, Clinical Specialist)
Issy Heppenstall (ESP, SASH)
Laura Finucane (SCT, Consultant Physiotherapist)

(total email distribution list (Natalie Blunt, Bertie Brincat, Peter Devlin, Liz Green, Di Finney, Ian Francis, Iben Altman, James Blair, John Bush, Kathryn Pank, Laura Finucane, Lisa Tourett, Lucy Hague, Matthew Carr, Murali Bhat, Paul Forsdick, Paul Gable, Rachel Dixon, Richard Bell, Sally Dando, Sarah Bell, Anita Vince, Jenny Whales, Jo Richardson, Jude Benharoch, Natasha Cracknell, Penny Bolton, Simon Oates, Fiona Howells, Jennifer Mantle, Sue Golby, Kasia Kaczmarek)