QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Great Ormond Street Hospital for Children NHS Foundation Trust

Paediatric cardiology

Risk-based Review (on-site visit)

Quality Review report

21 February 2018

Final Report

Developing people
for health and
healthcare

www.hee.nhs.uk

THE NHS
CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	The Risk-based Review (on-site visit) to paediatric cardiology at Great Ormond Street Hospital for Children NHS Foundation Trust was proposed in response to feedback that had been provided by the previous cohort of trainees to the Head of the London School of Paediatrics and the Head of the East of England School of Paediatrics regarding the quality of the education and training provided. Specific issues were highlighted in relation to: poor educational supervision, a culture of harsh criticism by consultants on ward rounds of clinical decisions, limited access to hospital-wide teaching opportunities and a lack of departmental teaching provided. The trainees in the previous cohort reported no attempts to foster a culture of learning, growth or personal development. Health Education England therefore felt it was necessary to undertake a Risk-based Review (on-site visit) to ascertain whether the education and training environment was suitable for trainees.
Training programme / learner group reviewed	Paediatric cardiology
Number of learners and educators from each training programme	The review team initially met with the Director of Medical Education, the Post-Graduate Medical Education lead, the educational leads for both core and higher trainees, the Divisional Director and the College Tutor. The team then met with trainees and Trust grade doctors at the following levels: - Paediatrics specialty training year 3 – x3 The team then met with higher Paediatric Cardiology trainees within the department at the following grades: - Specialty training year 7 - Specialty training year 5 The review team further met with a number of educational and clinical supervisors based within the department.
Review summary and outcomes	Throughout the course of the Risk-based Review (on-site visit) the review team was informed of a number of areas that were working well with regard to the training provided within paediatric cardiology at the Trust: - Trainees at all level valued the depth, variety and complexity of the clinical experience that was available in the department. They reported that they enjoyed the clinical exposure they received whilst in their posts. - The review team was entirely reassured about the level of clinical supervision that was provided to all trainees both in and out of hours, which was reported to be robust and readily available. - The specialty training year 3 (ST3) trainees reported that a previous core trainee had created an induction package, which they found extremely beneficial and helpful when they started working in the department. - All trainees the review team met with indicated that they would recommend their posts to colleagues. However, areas for improvement were highlighted as follows:

	- The trainees reported that they received a two-day Trust induction, followed by a departmental induction. However, the trainees indicated that they had faced some difficulty in obtaining the relevant log ins and passwords for the various IT systems used within the department and that during some of their first shifts had had to use other colleagues' passwords to access the relevant systems to undertake tasks such as prescribing IV fluids. The review team felt that the Trust and departmental inductions needed to be synchronised to ensure that when trainees undertake their first clinical shifts, they can function safely and it is entirely clear which subjects are being covered in each induction programmes in order to prevent gaps or omissions. - The review team was informed that within a 24-hour period, up to four handovers took place on the ward, which meant that the trainee who handed over to the night team had not been on the morning ward round and therefore did not always know the patients in the level of detail necessary for a robust, safe and comprehensive handover. The review team ascertained that there did not appear to be a ST3 trainee on a long day shift, who could participate in the morning ward round and handover to the night team. This appeared to present the opportunity for important information to be missed and the review team felt that the number of handovers that took place should be reviewed. - The review team ascertained that there were clear educational programmes in place. However, they were not reassured about the overall ethos and approach to education in the department. It was felt that there needed to be a culture of encouraging learning and a more proactive approach to education to help trainees prioritise some of the training opportunities available in the Trust. Equally, many learning opportunities were available at the bedside, which needed to be signposted better. The review team felt that this would greatly improve the trainees' overall experience in the department. For example, the ST3 trainees indicated that a lot of the teaching programme was delivered by the higher trainees within the department, but that due to rota gaps, the sessions were not always delivered.

Quality Review Team			
HEE Review Lead	Dr Camilla Kingdon Head of the London School of Paediatrics	**External Clinician**	Dr Wilf Kelsall Head of the East of England School of Paediatrics
Deputy Postgraduate Dean	Dr Gary Wares Deputy Postgraduate Dean Health Education England, North Central London	**Lay Member**	Robert Hawker Lay Representative
Scribe	Elizabeth Dailly Deputy Quality, Patient Safety and Commissioning Manager Health Education England, London and the South East		

Educational overview and progress since last visit – summary of Trust presentation
The review team thanked the Trust for accommodating the review and for the efforts made in facilitating the process.

The review team was informed that the department had undertaken their own departmental audit of the trainees and that the feedback obtained had been positive. Additionally, the educational leads reported that they had met with the core and higher trainees to gain further feedback on their educational experience. The educational lead reported that they had acted upon the feedback to improve elements of the training provided, but that some of the difficulties highlighted were not easily addressed and resolved, such as how busy the unit was and the corresponding workload. However, it was highlighted that the busyness of the department could be viewed as a positive element of training as it adequately prepared trainees for such work and helped in their overall development.

The educational lead further reported that they did not allow the busyness of the unit to interfere with the core trainees receiving the four hours of dedicated teaching time planned, which took place every week and that this was only one element of the learning they received during their post.

The review team was informed that the core trainees had dedicated time within the cardiac day unit, which they felt gave them more autonomy. Furthermore, it was reported that during their time on the cardiac day unit, the trainees were often less busy and were encouraged by the cardiac nurse to access other learning opportunities that were available, such as attending the catheter laboratory, clinics or obtaining additional echoing experience.

The educational lead for core trainees reported that it was often a challenge to deliver a bespoke educational experience to a heterogeneous group of trainees, who often rated the quality of the educational experience and teaching sessions they received differently, depending on their own personal training desires and needs.

The review team was informed that it had been challenging to redesign the rota for the higher trainees following the introduction of the new junior doctor contract and that this had had a negative impact upon the trainees' on-call rota. The educational lead indicated that in relation to the higher trainees, the amount of on-call shifts the trainees had undertaken had limited the amount of training opportunities they were able to access. It was reported that this had been exacerbated by rota gaps at the higher trainee level and that the Trust were, at the time of the review, in the process of recruiting more doctors at higher trainee level. Furthermore, the review team was informed that the rota had subsequently been redesigned, which it was anticipated would resolve the rota issues and improve trainee feedback.

The review team was informed that the local faculty group took place on a quarterly basis and that there were designated trainee representatives for core and higher trainees. Furthermore, the educational lead for core trainees reported that all trainees within the department were invited to attend.

When discussing the international private patients (IPP) in the Trust, the review team was informed that the trainees had little contact with them as the majority were based within the specific IPP unit which is staffed entirely separately during daytime hours. It was reported that occasionally the higher trainee on-call may be called regarding an IPP patient in the unit and that they were able to escalate to their on-call consultant who would then contact the IPP's designated consultant the following day. It was stated that this was made clear to trainees during their induction.
Furthermore, it was reported that some IPP patients were based upon the wards, such as the intensive care unit (ICU) who were then seen by the trainees within the department, as they formed part of the daily ward round.

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services. **1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.**		
Ref	**Findings**	**Action required? Requirement Reference Number**
PC1.1	**Appropriate level of clinical supervision** The core trainees reported that they were always able to access clinical supervision and contact the higher trainees for advice if necessary, who were helpful and approachable. They further commented that they could always contact the higher trainee based in the Cardiac Intensive Care Unit (CICU) if they could not get hold of the higher trainee on-call for advice. Similarly, the higher trainees indicated that they felt well supported by the consultants within the department. They informed the review team that they were approachable and that they had no reservations contacting them when on-call.	
PC1.2	**Rotas** The specialty training year three (ST3) trainees indicated that they were aware of previous issues in relation to the core trainee rota and reported that prior to them starting in the department, there had been significant rota gaps. However, they indicated that since they had been in post, there had been full rota in place, which made the workload manageable. The core trainees indicated that when there were two core trainees based on the ward it worked well and felt adequately staffed, but the review team was informed of instances when there had been just one core trainee based on the ward, who therefore had to undertake both wards rounds (consultant and registrar-led) and complete all the jobs that came from them. During such periods, the trainees indicated that the workload on the ward was extremely high. The review team was informed that the ward was split into two teams, one led by a consultant and one by a higher trainee and that each undertook a morning ward round of approximately 12 patients. The trainees confirmed that one consultant was based on the ward for a full week but that this was not always the case in relation to the higher trainee. The review team was informed that when the same higher trainee was based on the ward for four consecutive days, the ST3 trainees found this extremely beneficial and felt it provided greater continuity of care for patients, as opposed to when a different higher trainee was based on the ward each day. Furthermore, the trainees reported that a third team, which consisted of a associate specialist and group of advanced nurse practitioners, also undertook a ward round each morning which targeted patients who were ready for discharge in order to improve the patient flow within the department. The trainees indicated that this had a positive impact upon their workload and worked well. The core trainees reported that during the evening shift, which lasted from 2.30pm until 9pm, they typically undertook jobs on the ward for a few hours, undertook another handover, and then predominantly were involved stepping down patients from the CICU. The trainees indicated that often four patients to be stepped down could arrive on the ward simultaneously, when the core trainee was alone managing the ward, as opposed to being staggered throughout the day and their shift, which had a negative impact on the trainees' workload as it represented a large workload in a very small period of time, at the end of their shift. The trainees reported that if the arrival of such patients was planned better and staggered, this would improve patient safety and the running of the ward.	

	The higher trainees reported that there had been significant rota gaps at the higher trainee level, which had had a negative impact upon training. The review team was informed that this had increased the number of on-call shifts the higher trainees had undertaken, which subsequently limited and compromised the amount of training opportunities they could access. However, the trainees informed the review team that the department was emerging from this period and was in the process of recruiting to the higher trainee rota. The higher trainees indicated that the changes to the rota that had been made following the introduction of the new junior doctor contract had had a negative impact upon the department and had reduced the amount of staffing available on the wards during the day, which then had a consequent effect upon their ability to access training opportunities. However, the review team was informed that the rota had been redesigned prior to the review and that the department was returning to a 24 hour on-call rota for the higher trainees, which they thought would work better.	
PC1.3	**Induction** The trainees reported that they received a two-day Trust induction, followed by a specific departmental induction, which lasted for a full day. The ST3 trainees reported that the cardiology induction included an introduction to the ward and how it was run and talks about some of the unique cardiology emergencies that may occur during their time in the department, which they found extremely beneficial. This was confirmed by the educational lead, who further stated that the local induction included: information about the research that was being undertaken in the department, a talk from the educational lead, ward sister, pharmacist, a demonstration on how they should take bloods and a discussion with the trainees regarding where their interests lay and what they wanted to get out of the placement. The trainees further stated that during their induction they received a document that had been created by a previous core trainee within the department, setting out what they needed to do in each situation, which they had found extremely valuable and useful when they began working within the department. Furthermore, as there were two core trainees who had already worked within the department when they started, they reported that this had made their transition into their posts much easier. However, the review team ascertained that there appeared to be a lack of coordination regarding the topics covered during the Trust and departmental inductions. The trainees indicated that the department had expected the trainees to have been able to undertake certain tasks when they started their clinical shifts, such as how to open a discharge summary, as they had presumed it had been covered during their Trust induction, when it had not been. Furthermore, the trainees indicated that the department used a number of different IT systems, for which various passwords and logins were required. The trainees reported that they had to complete numerous e-learning modules to receive some passwords or contact different people across the Trust. The trainees indicated that in some instances, there had been a lag between them completing the relevant online module and receiving the password in question. The trainees stated that they had not managed to get all of their passwords and logins organised before they started their clinical shifts and subsequently had to borrow colleagues passwords to logon to the relevant systems and prescribe IV medication.	Yes, please see PC1.3a Yes, please see PC1.3b
PC1.4	**Handover** When discussing the handover that took place on the ward, the ST3 trainees reported that they led the handover, but that the consultants, advanced nurse practitioners and sub-specialty teams also attended. The trainees reported that a morning handover took place from the night team to the day team, followed by a handover from the day core trainee to the evening core trainee at 2.30pm. A further handover then took place at 5pm from the evening core trainee to the night team and a subsequent one at 9pm.	

	This resulted in the evening core trainee handing over to the core trainee on the night team, despite the fact they had not attended the morning ward round and therefore were only able to hand over information they had received from the day core trainee and from the patients' notes. The trainees indicated that they felt there was a potential for vital pieces of information to be missed and that the quality of the handover would have improved if there was one core trainee on a long day, who attended the morning ward round and handed over to the night team. This was confirmed by the higher trainees, who reported that previously, before the rota had returned to a 24 hour on-call rota, the higher trainee undertaking the night shift would often come in early to ensure a single handover took place, as opposed to an additional one in which the person handing over had not been on the morning ward round. The ST3 trainees indicated that the conduct during the handover meetings was generally good; if the trainees had missed something they reported that this was often fed back to them in a supportive manner. However, the trainees indicated that on occasion, the behaviour displayed during handover meetings when things had gone wrong was often unconducive to a positive working environment, but that such incidents were resolved quickly. The review team was informed that during the Monday morning handover, from the weekend team to the day team, the consultants would often question the trainee who had worked over the weekend, about decisions that had been made the previous week by the previous ward based consultant. The trainees were unaware if there was a process in place for the consultants to handover to each other as they had the impression that a lot of the detail about clinical decision making from the previous week was handed over by them (i.e. the core trainee) on the Monday morning.	Yes, please see PC1.4
PC1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** Trainees at all level reported that they valued the variety and complexity of the clinical experience they received whilst in their posts and that they enjoyed the exposure they received to the high level of complex cases in the department, which they found beneficial for their training.	
PC1.6	**Protected time for learning and organised educational sessions** The trainees reported that the cardiology teaching they received in the post was good, but indicated that they had faced some resistance from the department when they tried to access other teaching opportunities available in the Trust. The review team was informed of a monthly afternoon teaching session provided for all ST1-3 trainees across the Trust, but reported that often they had been unable to leave the ward in order to attend. In relation to the local teaching provided, the ST3 trainees reported that every Monday they attended the morning catheter meeting and on Thursdays attended the joint cardiology/cardiothoracic surgery (JCC) meeting, which they indicated provided educational value and were useful. The review team was further informed of a Tuesday ultrasound teaching session they were usually able to attend, which they reported was of a high quality. The trainees also reported that there had been a rota in place for further teaching sessions provided by the higher trainees. However, they indicated that the sessions did not always take place and that the higher trainee who had taken responsibility for the sessions had left the department. Although the trainees reported that there had been an emphasis placed upon providing education when they began their posts, they indicated that this had reduced since December 2017. The trainees indicated that teaching provided by the higher trainees would have been extremely beneficial and would have provided them with the opportunity to receive more basic, general, paediatric knowledge. The ST3 trainees further stated that they would have welcomed the opportunity to participate in more case based discussions or other supervised learning events (SLEs) on some of the more complicated cases that were treated in the department.	Yes, please see PC1.6a . Yes, please see PC1.6b

	The review team ascertained that the lack of training sessions provided by the higher trainees for the ST3s had coincided with the rota gaps on the higher trainee rota, which had impacted upon their ability to provide set teaching sessions for the core trainees. However, the higher trainees indicated that when they had not been able to deliver the scheduled local teaching sessions, they often ensured they set aside to teach the core trainees when they were based on the wards and undertook on-call shifts with them. When discussing the bed-side teaching provided, the ST3 trainees reported that they learnt on the ward round and were sometimes able to stop and ask the consultant or higher trainee relevant questions, resulting in more teaching being provided. However, they stated that this was dependent on the consultant or higher trainee in question and that such teaching did not regularly and routinely occur due to the busy nature of the ward round and the large number of patients that needed to be seen within a short period of time. The review team ascertained that there were clear educational programmes in place. However, they were not reassured about the overall ethos and approach to education in the department. There seemed to be an assumption that trainees would access learning by their own initiative. For the confident trainee this probably would be adequate as there was evidence of learning opportunities (eg opportunities to learn echocardiography), however it is doubtful that a less confident trainee, or a trainee facing training problems, would be able to maximise their time in the department. It was felt that there needed to be a culture of encouraging learning and a more proactive approach to education to help trainees prioritise some of the training opportunities available in the Trust. Many learning opportunities were available at the bedside which needed to be signposted better. The review team felt that this would greatly improve the trainees' overall experience in the department.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

PC2.1	**Effective, transparent and clearly understood educational governance systems and processes** The review team was informed that the local faculty group (LFG) took place on a quarterly basis. It was reported that there were two trainee representatives who attended, representing both the core and higher trainees and that all trainees based in the department were invited to attend. Minutes seen by the reviews team showed poor attendance at LFG meetings by trainees.	Yes, please see PC2.1
PC2.2	**Impact of service design on learners** It appeared to the review team that the escalation process for international private patients (IPPs) out of hours was not entirely clear to the trainees. The higher trainees reported that they were not routinely involved with IPPs, but that on occasion they were	

	contacted out of hours to see a patient in the IPP unit with a cardiac condition. The trainees reported that in such cases, they attended and treated them, as they would with any NHS patient, but that it was not clear who they should escalate to if there was an issue. It should be noted that the trainees reported that they would always be able to access adequate clinical supervision and stated that they would either contact their own consultant on-call or the IPP's dedicated consultant. However, they indicated that they were not aware of any guidelines stating the correct procedure they should have followed. Furthermore, the trainees reported that there was not a handover list with the IPP patients' details, so they were unaware of their diagnosis and condition when they attended.	Yes, please see PC2.2
3. Supporting and empowering learners		
HEE Quality Standards **3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.** **3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.**		
PC3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The higher trainees indicated that the majority of consultants within the department were supportive and in particular, were complimentary of the educational lead for the higher trainees.	
4. Supporting and empowering educators		
HEE Quality Standards **4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.** **4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.**		
PC4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The review team was informed that the training provided for educational supervisors within the Trust was of a high quality and that there were a number of courses they could access through the Postgraduate Centre.	
PC4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The review team was informed that previously, there had only been a small number of consultants within the department who were educational supervisors for all the trainees. However, it was reported that this number had increased, to ensure that the trainees were more evenly allocated and that no educational supervisor was responsible for more than three trainees. Furthermore, the review team heard that at the time of the review, an additional two consultants were undertaking the relevant training to become educational supervisors. The educational leads in the department confirmed that they had the correct supporting professional activity (SPA) time included within their job plans. However, some of the educational supervisors the review team met with indicated that they had not had their job plans reviewed since they had taken on their educational responsibilities.	

5. Developing and implementing curricula and assessments		
HEE Quality Standards **5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.** **5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.** **5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.** **5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.**		
PC5.1	**Regular, useful meetings with clinical and educational supervisors** All trainees reported that they had been allocated an educational and clinical supervisor and that they were able to meet with them in order to complete their workplace based assessments and discuss their training and any issues they had.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
Trainees at all level reported that they valued the variety and complexity of the clinical experience they received whilst in their posts and that they enjoyed the exposure they received to the high level of complex cases in the department, which they found beneficial for their training.			
The trainees further stated that during their induction they received a document that had been created by a previous core trainee within the department, setting out what they needed to do in each situation, which they had found extremely valuable and useful when they began working within the department			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
PC1.3b	The Trust to ensure that trainees can obtain all the relevant passwords before they begin their first clinical shift and are aware of how to obtain each one	The Trust to outline what arrangements have been made for trainees during their induction to obtain all the necessary passwords and provide trainee feedback, through local faculty group (LFG) minutes or an audit, demonstrating that this issue has been adequately addressed and that trainees received all the relevant passwords before undertaking their first clinical shift within the department	R1.13
PC1.4	The Trust to review the handover system in place on the ward and the number of handovers that take place. The Trust to consider whether a handover system can be put in place whereby the core trainee handing over to the night team has also attended the morning ward round	The Trust to confirm the outcome of this review and what subsequent changes have been made to the handover process on the wards. The Trust to submit trainee feedback demonstrating that the issue has been adequately addressed and that the number of handovers taking place has reduced	R1.14
PC1.6a	The Trust to ensure that all of the core trainees are able to attend some of the Trust-wide teaching sessions for ST1-3 trainees that are provided. The Trust to plan the sessions into the trainees' rota to ensure that they can be released from the ward in order to attend	The Trust to provide trainee feedback from LFG minutes confirming that the trainees have been able to attend the ST1-3 Trust-wide teaching	R1.16
PC1.6b	The Trust to reinstate the weekly local teaching sessions provided by the higher trainees and ensure they take place. In the event of rota gaps amongst the higher trainees, the trust is to have a contingency plan that means the teaching programme can take place regardless.	The Trust to provide a timetable of the higher trainee (or appropriate substitute) led teaching sessions and trainee feedback confirming that they take place and that trainees are able to attend.	R1.16
PC2.1	The Trust to ensure that trainees are better represented at the Local Faculty Group (LFG) meeting and that at least two trainees attend. The Trust to review the frequency of the LFG meetings, as taking place on a quarterly basis often means that they occur just twice in the average trainee's time in the department, which doesn't allow time to improve any issues raised.	The Trust to submit registers of the LFG minutes, demonstrating that more than one trainee attends. The Trust also to confirm that the meetings are taking place on a more regular basis	R2.1
PC2.2	The Trust to ensure the correct escalation policy regarding international private patients is included in the trainees' induction material	The Trust to confirm the information is now included in the trainees' induction material and submit copies of the policy that is disseminated amongst staff	R1.13

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**

PC1.3a	The Trust to include an updated version of the induction document created by a previous core trainee, in each core trainees' departmental induction	The Trust to confirm this now forms part of the departmental induction material and submit a copy	R1.13

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Camilla Kingdon
Date:	01 March 2018

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.