

Independent external review into the Leeds Congenital Cardiac Service

Public Board Meeting 31st July 2025

Presented for:	Information and approval
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Previous Committees:	Board Workshop – November 2024 Board Workshop – March 2025 Board Workshop – May 2025

Our Annual Commitments for 2025/26 are:	
Recognise and act upon moments that matter to our patients	✓
Support our patients to get home a day sooner	
Be in the top 25% for patient experience and efficiency in outpatients	
Support each other to act with kindness and compassion	✓
Reduce our carbon footprint by creating greener patient pathways	
Support our staff to manage every £ wisely	✓
Make best use of our estate, equipment and digital assets	

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk		Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply.	Cautious	Moving Towards
Workforce Risk		Workforce Deployment Risk - We will deliver safe and effective patient care through the deployment of resources with the right mix of skills and capacity to do what is required.	Cautious	Moving Towards
Clinical Risk		Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Cautious	Moving Towards

Key points	
1. This paper summarises the key findings of an independent external review of the paediatric congenital cardiac surgery service in Leeds.	Information
2. There are key recommendations which include increasing bed capacity and nurse training for delivery of ECMO on PICU, and the appointment of a new lead surgeon. These require urgent attention.	Information
3. The paper contains a number of other important recommendations including the monitoring of the unit and individual surgeon outcome data and the building of professional and collaborative relationships within the multidisciplinary team.	Information
4. Ongoing development and implementation of the action plan to deliver the recommendations will be taken forward.	Approval

1. Summary

The external review of the paediatric congenital cardiac surgery service in Leeds was commissioned following concerns raised by the clinical team in November 2023. These concerns included an increased paediatric cardiac surgical mortality rate, concern about an individual clinician's performance, waiting lists, patient flow and team dynamics within the multi-disciplinary team.

There were a number of key findings within the report requiring actions to deliver necessary improvements to service delivery and patient experience.

The Board is requested to note the report and approve the recommendations as detailed in this paper.

2. Background

In November 2023 the Chief Executive of Leeds Teaching Hospitals NHS Trust (LTHT) received a letter from clinicians setting out concerns around aspects of the paediatric congenital cardiac surgical programme. These included an increased paediatric cardiac surgical mortality rate, concern about an individual clinician's performance, waiting lists, patient flow, and team dynamics within the multi-disciplinary team.

Following a meeting with local clinicians in December 2023 the Trust commissioned a 'whole service' independent external review. This review was carried out by Professor Massimo Caputo, Consultant Cardiothoracic Surgeon and Dr James Fraser, Consultant in Paediatric Intensive Care, both from Bristol Royal Hospital for Children.

The key findings within the report included bed capacity and provision of extra corporeal membrane oxygenation (ECMO) within PICU, the appointment of a new lead surgeon to the service, and to cease the treatment of adult patients in the Children's Hospital cardiac catheter lab.

A separate review of eight cases of potential concern was carried out by Mr Andrew Parry, a consultant paediatric cardiac surgeon in Bristol. Seven of the eight reviews have been completed. The parents of the seven children have been contacted by the Clinical Director for the Children's Hospital, with a short summary of Mr Parry's findings provided. Where concerns in care were identified, an apology was offered. All families have been offered an opportunity to speak to the clinical team or Mr Parry to receive a more detailed account of the report's findings.

An eighth case has subsequently been shared with Mr Parry. It is anticipated that the review of that child's care will be available in the next two months.

3. Proposal

The independent external review is included with this Board paper, including a summary of the review into seven individual cases. A summary of the report into seven of the individual reviews has been provided to the Board as the original report contains a significant amount of patient confidential information. The eighth individual review is still ongoing.

A detailed interim action plan to address the key recommendations is included in Appendix 4. Further actions will be added to this plan to ensure we address all the recommendations in the report.

4. Financial Implications

The report highlights the need to enhance the recruitment and retention of nursing in the Paediatric Intensive Care Unit (PICU). A business case will be submitted to increase the PICU nursing establishment to Paediatric Critical Care Society (PCCS) standards. This will require investment from the Trust.

5. Risk

Risk	Mitigation
Clinical Safety	<ul style="list-style-type: none"> • Monitoring of unit and individual surgeon outcomes. • Appointment of a new lead surgeon to replace retiring colleague. • Continued mentorship and professional development of junior consultant surgeons.
Confidence and Trust	<ul style="list-style-type: none"> • Proactive and open communication with families of children whose care has been reviewed.
Staff Wellbeing	<ul style="list-style-type: none"> • Engage with directly affected groups to ensure they are appropriately supported – professionally and pastorally.

The recommendations within the paper help bring issues around our paediatric congenital cardiac surgery service back into our defined risk appetite.

6. Communication and Involvement

The independent external review was commissioned following concerns raised by colleagues working in the service. Information about the review taking place was shared with staff in the service areas affected and the families of those children whose care has been reviewed.

This report has been shared with:

- Senior leadership team and staff within the affected services
- Families of the children whose care has been reviewed with the offer of an in-person meeting to discuss the findings.

7. Equality Analysis

There are no issues about equality of care.

8. Improving Health Equity

There are no issues regarding health equity.

9. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

10. Recommendation

The Board is asked to:

- Note the independent external review report.
- Approve the Quality Assurance Committee having delegated authority to oversee the further development and implementation of the action plan and report progress back to board.

11. Supporting Information

The following papers make up this report:

- Appendix 1 – External Review Terms of Reference
- Appendix 2 – ‘Whole Service’ Review Report
- Appendix 3 – Review of ‘cases of concern’ Summary Report
- Appendix 4 – Interim Action Plan

John Adams
Deputy Chief Medical Officer
23rd July 2025

APPENDIX 1

External Review Terms of Reference

1. Mortality rates for the last two years, including comparison to peer hospitals and the specialty arrangements for reviewing all deaths to identify and share learning.
2. Cases with unexpected adverse outcomes for the last three years, including comparison to peer hospitals and the specialty arrangements for reviewing all cases with unexpected adverse outcomes and surgical complications to identify and share learning.
3. Theatre provision and practice, including weekly capacity, start and finish times and on the day cancellations, including the process for escalation.
4. Paediatric intensive care provision and escalation.
5. Role and deployment of perfusionists and the provision of ECMO, including specialist commissioning arrangements.
6. Processes for prioritising patients on the waiting list for surgery, including patients waiting for acute, urgent intervention and patients waiting for a planned intervention.
7. Processes for specialty team to review patients on the waiting list for surgery to identify harm as a result of delays in surgical treatment, including communication with families.
8. MDT meeting arrangements, including attendance by clinicians and criteria for referral to MDT.
9. Culture and behaviours within teams and the working relationships between teams, including congenital cardiac surgery, paediatric intensive care, paediatric cardiac anaesthesia, paediatric cardiac theatre staff and paediatric cardiology.
10. Operational plan for the congenital cardiac service for the next three to five years to meet demand, including congenital cardiac surgery, paediatric intensive care, paediatric cardiac anaesthesia and paediatric cardiology.
11. Plans for service expansion, including developing ACP and nurse-led services.
12. Recruitment plan and workforce model for the next two to five years for all relevant specialties, including consultant congenital cardiac surgeons and consultant paediatric anaesthetists.

APPENDIX 2

INDEPENDENT EXTERNAL REVIEW INTO THE LEEDS PAEDIATRIC CONGENITAL CARDIAC SURGERY SERVICE

Published July 2025

The external review was undertaken by Professor Massimo Caputo, Consultant Cardiothoracic Surgeon at Bristol Royal Hospital for Children/University of Bristol and Dr James Fraser, Consultant in Paediatric Intensive Care, Bristol Royal Hospital for Children. The review of seven individual patient cases was carried out by Mr Andrew Parry, Consultant in Congenital Cardiac Surgery, Bristol Royal Hospital for Children.

1.0 CONTEXT

In November 2023 the Chief Executive of Leeds Teaching Hospitals NHS Trust (LTHT) received a letter from clinicians setting out concerns around aspects of the paediatric congenital cardiac surgical programme. These included an increased paediatric cardiac surgical mortality rate, concern about an individual clinician's performance, waiting lists, patient flow, and team dynamics within the multi-disciplinary team.

Following a meeting with local clinicians in December 2023 the Trust commissioned a 'whole service' independent external review. Terms of Reference were agreed with the Chief Medical Officer (see appendix 1).

This report provides the overview of the findings and recommendations from this independent external review into aspects of the paediatric congenital cardiac surgical programme at Leeds Children's Hospital (LCH), part of Leeds Teaching Hospitals NHS Trust.

The external review was undertaken by Professor Massimo Caputo, Consultant Cardiothoracic Surgeon at Bristol Royal Hospital for Children/University of Bristol and Dr James Fraser, Consultant in Paediatric Intensive Care, Bristol Royal Hospital for Children. The individual review of patient cases was undertaken separately by Mr Andrew Parry, Consultant in Congenital Heart Surgery at Bristol Royal Hospital for Children.

2.0 INTRODUCTION

Leeds Teaching Hospitals NHS Trust is one of the largest providers of specialist services in England serving the population of Leeds and the surrounding areas.

Leeds Children's Hospital is currently one of the largest specialist hospitals for the children and young people in the country. Over 80% of the services it delivers are specialist and it provides one of the most comprehensive ranges of paediatric services in the UK, including cancer treatment, liver transplantation, cardiac surgery, and paediatric intensive care.

The Paediatric and Adult Congenital Heart Disease (CHD) Service at Leeds General Infirmary provides services for all patients with congenital heart disease from birth to the age of 16 years and then any ongoing care for adults who live in Yorkshire, Humber and North Trent. At the time of this report, the surgical team consisted of five full-time surgeons. In the last Nicor report (2020-2023) the Unit performed 800 paediatric (<16 years) and 247 adult (>16 years) congenital surgical procedures.

The Paediatric Intensive Care Unit (PICU) is one of two tertiary PICUs (the other being Sheffield) that provides care for critically ill and injured children in West Yorkshire and Humber. It is a 'mixed' unit that cares for cardiac surgical and other patients within the same geographical footprint. Most children are admitted from areas within the children's hospital, but some are transferred from their local hospital via a specialist children's transport service.

The methodology for the independent external review involved a series of face-to-face interviews with a range of staff from relevant services. A review of existing available information was also carried out by the team.

The areas this independent external review has been asked to consider are outlined below in the summary findings. Key recommendations are highlighted.

3.0 SUMMARY FINDINGS AND RECOMMENDATIONS

3.1 Concerns about mortality

The last Nicor report (2020-2023) (<https://www.nicor.org.uk/interactive-reports/national-congenital-heart-disease-audit-nchda>) showed that the LGI survival rate for the paediatric population undergoing congenital heart surgery was as predicted by the PRAiS2 risk adjusted model. The Unit performed 800 surgical cases with a 30-day actual survival of 98.1% (predicted 97.7%). Furthermore, Leeds General Infirmary performed 247 adult congenital cardiac operation with 100% survival. The complication rate (ECMO and renal support, unplanned pacemaker insertion and prolonged chest drainage) for the paediatric cohort, was similar to the one observed in the other UK Units.

Several concerns have been expressed by the clinicians about the outcomes of paediatric cardiac surgery delivered at Leeds General Infirmary in the last 24 months. Even though the three-year (2021-2023) risk-adjusted mortality rates were within the expected range, the outcomes after April 2023 have shown a worrying and significant deterioration with risk adjusted mortality rate running around three times the national average. During the same period, the rate of significant complications has increased, including need for re-operations and very protracted length of stay.

One possible triggering factor for the worsening of the surgical outcomes in the last 12 months was that a senior surgeon left the unit on a one-year sabbatical and has recently decided not to come back to Leeds.

The reviewers were not able to comment in any depth about the individual patient cases. The Trust commissioned a separate review of individual patient cases by a paediatric cardiac surgeon who is a consultant at University Hospitals Bristol NHS Foundation Trust. A summary of these findings (as the full report contains significant patient confidential information) are set out in Appendix 3 of this report.

The Review concluded that there was a prompt and rapid response by the clinical and managerial team regarding the increased recent mortality and complications rate with appropriate steps taken.

Recommendations

- The Trust should continue with its separate independent review of any patient cases with unexpected adverse outcomes and surgical complications in the last three years to identify and share learning.

3.2 Theatre provision and practice

There are five full day paediatric cardiac theatres and two full day adult congenital theatres in separate buildings. The scrub and anaesthetic technician teams are the same covering paediatric and adult. During the week this arrangement helps provide a larger pool of theatre staff. However, out of hours and at the weekend there are significant issues affecting cover across both sites. Data for the period between 4/23 to 3/24 regarding overrun of paediatric cardiac theatre show that 68% did not overrun, while around 10% overran more than two hours. Regarding theatre utilisation, around 75% cases started on time or were delayed less than one hour while the remaining 25% were delayed more than one or two hours. Data for 'on the day' cancellation (overall 162 cases) show that lack of PICU/ward bed was responsible for 34% of the overall cancellation rate, followed by acute cases taking priority (15%), previous case overrun (12%), unfit for surgery (9%), operator

led change in surgical plan (7%), perfusionist (5%), theatre staff (4%), anaesthetist (2%) and surgeon (1%) availability.

We were told that the 'team brief' occurs in all cases prior to sending for the patient. This is an essential part of the WHO safety check list. The Reviewers also heard that a recent loss of theatre staff has caused significant stress to the system, but this is now being corrected with new recruitment.

Recommendations

- To help improve delayed start times, an early bed meeting should help to confirm later bed availability and facilitate a timely surgical brief at 07.45 am. Future quality improvement meetings should focus on the pathway of discharge from PICU.
- The issue of sharing out-of-hours theatre staff across the adult and the paediatric service is a significant issue that needs to be resolved.
- The paediatric hybrid lab continues to be used by both adult congenital and paediatric patients which has been criticised previously. Children's and adult patient pathways should be separated.
- Consideration should be given to re-instituting the CNS-led pre-assessment service and putting in place robust measure for MRSA screening, as part of the Trust's commitment to reduce hospital-acquired infections.

3.3 PICU provision

Demand for paediatric critical care services continues to rise year on year because of an increasing cohort of highly complex patients. The 2024 GIRFT report recorded that Leeds has 16 commissioned PICU and 12 HDU beds. This gives it the lowest ratio of paediatric critical care beds per 100 inpatient beds in England.

Leeds PICU is a large, busy and efficient unit, which performs equal to or better than its peers across a wide array of monitored metrics. There exists a strong team ethos and a self-belief in shared goals. Compared to other PICUs, Leeds PICU admits a higher proportion of patients at the most severe end of critical illness. Like other large PICUs, Leeds has a high bed occupancy rate that impacts upon its ability to admit emergency and elective admissions. There is evidently an issue with patient flow. On most days the cardiac surgical admission is dependent on PICU being able to discharge a patient. Between October 2023 and March 2024 29% of cardiac surgical admissions and 20% of PICU discharges occurred out of hours. Cancellation of surgical cases on the day of surgery is commonplace due to lack of a PICU bed. There are no 'ring-fenced' beds for paediatric cardiac surgery patients on PICU.

The Trust's improvement method, known as the Leeds Improvement Method (LIM) had been used to improve patient flow and availability of PICU beds for surgical cases. However, this did not always lead to a bed being available on the day of surgery and some staff expressed the view that the LIM meeting had overly focused on ensuring the first patient on the operating list arrived in theatre in a timely fashion, rather than on the wider pathway that prevented patients on PICU being discharged on time.

An 'Enhanced Cardiac Recovery' or 'Fast Track' pathway is the term used when the patient is extubated in theatre rather than on the PICU. These are now standardised approaches in many UK paediatric cardiac surgical programmes to help expedite patient flow through PICU back to the cardiac ward. The paediatric cardiac anaesthetic group should work with PICU colleagues to develop this programme.

Recommendations

- The Trust should continue initiatives to enhance retention of nursing staff and recruitment to PCCS standards while working with the Operational Delivery Network (ODN) and NHS Specialised Commissioning to restore PCC capacity to its required and funded position.
- A designated PICU consultant acting as 'lead' for congenital cardiac surgery may help to 'build bridges' between the PICU and congenital cardiac surgery teams.
- An Enhanced Cardiac Recovery or 'Fast Track' for cardiac surgical patients should be developed to help expedite patient flow through PICU back to the cardiac ward.
- Leeds PICU is a highly consultant led unit. Its model of ward rounds is like other PICUs. In Bristol it is standard practice for the PICU consultant on duty to always take the cardiac surgical hand over when the patient comes out of theatre. Leeds PICU might audit their practice in relation to this.
- The hospital-wide group that coordinates the development of care for critically ill children should monitor progress against the GIRFT recommendations that may enhance elective surgical scheduling over summer months while reducing it over the peak of winter (e.g. annualized hours contracts, short notice 'flex off' models, short term contracts).
- Future LIM meetings should be coordinated across the relevant CSUs and look at the entire patient pathway. They should take into account considerations such as the flow of patients to the ward, acute admissions overnight, and nurses phoning in sick on the morning shift.

3.4 Provision of ECMO

Cardiac ECMO is used in certain circumstances to support a failing heart, either before or after surgical intervention. All level three paediatric cardiac surgical centres in England are expected to provide cardiac ECMO. Every cardiac centre providing ECMO should have a lead PICU consultant with responsibility for that service. In some units, the PICU nursing team run the ECMO support, whereas Leeds is frequently reliant on perfusionists from the theatre team.

ECMO numbers in Leeds have increased, some of those being for non-cardiac conditions for which the Trust is not commissioned. In Leeds, survival rates are comparable to national and international outcomes. Nursing staff are currently delivering 40% of ECMO shifts, but it is commonplace for them to be called away to cover a staffing gap. Most shifts are covered by perfusionists which anecdotally are within the adult cardiorespiratory CSU. Both the adult and paediatric cardiac surgical lists are affected when the perfusion team manages the paediatric ECMO circuit on PICU. This results in cancellations of the elective lists and difficult judgments about emergencies. The current arrangement is placing the perfusion team under considerable pressure. We heard that Leeds aims to have full time nursing cover for PICU ECMO within 12 months. A nursing ECMO co-ordinator has recently been appointed.

The issues with PICU ECMO are symptomatic of a wider service that is under great strain.

Recommendations

- A priority must be for adequate PICU nurses to be trained on the Birmingham ECMO course to be able to provide an autonomous credible service. This ambition

might require specific investment to enable an uplift to the projected nursing establishment of the unit. The Trust should work with the Operational Delivery Network (ODN) and NHS specialised commissioning to enable this.

3.5 Prioritisation of patients

Weekly paediatric and adult congenital Multidisciplinary Team are well attended and well structured. Patients are prioritised according to a P1-4 system which has now been adopted in most of the other national Units. The team has also established an acute board for all the P2 patients at home whose operations are time-sensitive and must be prioritised. The number of patients on this acute board is increasing along with waiting times. The cardiology Operational Delivery Network monitors these patients closely while they await their operation. It is not clear that acute patients are always prioritised over urgent cases.

Recommendations

- There is a need to separate discussions around pre-operative patients for the week and patients to be added on the surgical waiting list with a separate one-hour discussion for all the operative patients booked that week.

3.6 Review of patients on the waiting list for surgery

It is clear that waiting longer for paediatric cardiac surgery may impact on outcomes. There is currently no specific SOP within Leeds which describes the approach to reviewing patients on the waiting list. The system of monitoring patients is primarily dependent on a surgical secretary who is retiring shortly and has been cited as a risk. There is also a surgical planning meeting every Thursday attended by the database manager, the surgical secretary, CSU management and surgeons.

There did not appear to be a systematic governance approach for tracking morbidities arising from patients waiting for surgery on the waiting list.

Recommendations

- The Trust should seek assurance from the cardiac governance team around their approach to identifying harm in patients as a result of delays in surgical treatment.

3.7 MDT arrangements

Multi-disciplinary team (MDT) meetings relating to the paediatric cardiac surgical programme are typical of those in other centres. They are generally well attended and functional.

The main planning meeting for the cardiac programme is generally well attended. It was described by some as adversarial in nature and inferred that case allocation was influenced by personal preferences for individual surgeons.

A full day monthly cardiac governance MDT meeting reviews the previous month's activity, outcomes and complications. It is well attended, with an opportunity for all to provide their feedback and reflections.

Within the cardiac programme, deaths are reviewed in a traditional 'M&M' format which better guarantees the attendance of the surgeons and cardiologists. Scrutiny is felt to be appropriate.

Rapid MDT meetings are called to inform time-sensitive discussions about critically ill patients, although it was not clear that the decisions from the meeting were always cascaded, and some staff felt their voices were not always heard.

Recommendations

- The Trust might gain insight to how effective they are by carrying out an audit of the terms of reference, attendance, minutes and actions logs of each meeting.

3.8 Cultures and behaviours

Effective teamwork is fundamental to the effective delivery of healthcare and is associated with higher quality of care, improved staff wellbeing, higher patient satisfaction, and lower levels of avoidable patient harm. Psychological safety is a sense of confidence that your voice is valued, and a belief that your workplace is safe for speaking up with ideas, questions, concerns and even mistakes.

This Review is being undertaken in response to concerns raised by clinicians and their confidence to do this, and the Trust's swift response, willingness and openness to undertake an independent external review should be recognised.

Service pressures and personality clashes often manifest themselves as poor behaviour across the sub-specialties. This had not always been consistently challenged. Theatres and PICU were consistently described as potential flashpoints. Some staff stated that they no longer escalated concerns about poor behaviour as there was sense that nothing would be done. Other staff cited examples of excellent teamworking and professionalism.

Many specialist teams were outstanding and generally inter-team working is good, respectful and functional, with everyone pulling together to deliver a great service. We saw leadership visible in many forms during our time with the Trust. However, there were areas of tension. A job planned PICU cardiac intensive care lead (see earlier recommendation) may help to build bridges between the PICU and cardiac surgical teams.

Although compassionate leadership and effective team-working is set at the top of the organisation, psychological safety is not experienced by some members of staff at Leeds. Some colleagues were apparently advised not to speak up and other felt that their Datix reports 'fell on deaf ears'.

Recommendations

- Consider how psychological safety is experienced by colleagues across Leeds Children's Hospital
- Consider how the Trust responds to poor behaviour, ensuring it is not tolerated and dealt with immediately.

3.9 Operational plan for paediatric congenital cardiac services for the next 3-5 years

LTHT has plans to build a new hospital, estimated to open in 2030¹. This will have 36 critical care beds (20 PICU, 16 level 2 beds). This plan has been significantly delayed due

¹ Building The Leeds Way and the opening of a new Children's Hospital in Leeds have now been delayed following a Government review of new NHS capital projects.

to political decisions and some colleagues felt frustrated about not being sighted on the detail.

It is not clear why the current PICU bed base had been reduced from 16 to 14 beds. Nursing staff retirement, retention and recruitment were inevitably important factors, as was the impact of Covid. A commissioning process is ongoing to incrementally re-open the available bed base on PICU to 16 and eventually 18 beds. Many of the significant operational day-to-day challenges experienced by all those working in the paediatric cardiac surgical programme will be alleviated by restoring the PICU bed base.

Recommendations

- The PICU nursing workforce should be modelled as per PCCS standards. The Trust should work with the ODN and NHS specialised commissioning at each annual funding round to incrementally plan for a Level 3 PICU capacity of 20 beds in preparation of moving to the new hospital. The HDU adjacent to PICU should be re-established.
- Paediatric ECMO needs to be separated out from the perfusion service. The Trust should separately model what uplift to the nursing workforce is required to accommodate a dedicated stand-alone cadre of PICU ECLS nurses. Related to this the Trust should liaise with NHS England around its intentions for commissioning respiratory ECMO.
- Adults and children are still both treated in the Hybrid lab at the Children's hospital. A five-year plan commenced in 2020 to separate adults and children in the hybrid lab has not come to fruition. This brings operational challenges and potentially creates other issues round safeguarding etc. The Trust should ensure in the short term that adequate mitigations are in place and that in the new hospital the service is separated.

3.10 Workforce plan

The cardiac surgical group currently comprises three permanent surgeons. The senior surgeon is planning to retire in May 2025². A fourth experienced surgeon is not planning to return to the Trust after leaving for a sabbatical³. At this stage, neither of the two junior surgeons are in a position to take on the role of senior surgeon. This has necessitated a senior surgeon from Newcastle visiting this year to support the service while the senior surgeon is on leave. LTHT management has actively been seeking to recruit an experienced neonatal cardiac surgeon for 12 months and in the short term has appointed two locum positions as a cost pressure. One is trained in adult acquired surgery and is gaining further experience in congenital paediatric surgery. A second locum, a trainee on the Birmingham rotation, has now started with the Trust.

The cardiac anaesthetic group is currently understaffed. While funded for six WTE, one colleague has recently retired and another resigned. The team has appointed a locum. No specialty trainee rotations exist for paediatric cardiac anaesthesia, although two fellow posts have been created. The intention is that these posts will inform plans for consultant succession.

PICU currently has nine WTE consultants with eight on the call rota. Two consultants are appointed to shared PICU/MBRACE posts. There is a good mix of seniority with several

² This retirement has now been delayed until January 2026.

³ This surgeon is now returning to the Trust as lead surgeon in January 2026.

new appointments over recent years in anticipation of older colleagues retiring. In addition, the consultant role had expanded to include HDU cover, a model that is common in many other centres.

With respect to nursing staff, there are 94 + nine WTE staff employed on one roster across the PICU/ HDU team to provide greater flexibility of provision across both units. There has been real progress on recruitment in the last 12 months and the vacancy rate has reduced from around 30% to 8%. There is an ambition to recruit to an establishment of 20 PICU beds.

No specific concerns were raised relating to cardiology or other teams in relation to recruitment⁴.

Leeds Children's Hospital should be exceptionally proud of what the congenital cardiac programme has achieved in the last 10 years. We were told it is a '*phenomenal unit with enormous potential*'. Patient numbers are increasing, its NICOR surgical results have historically been very good, and it has one of the largest outpatient and intervention programmes in the country. However, Leeds is facing a pivotal moment in its congenital cardiac surgical programme. A failure of succession planning with the retirement of its senior surgeon would have national consequences through directly impacting on adjacent surgical centres (Liverpool and Newcastle). It would also have significant local consequences since the loss of paediatric cardiac surgery would threaten the viability of its intervention programme, PICU, and the status of the Children's Hospital as a whole.

Recommendation

- An experienced surgeon should be recruited to lead the department for the next 10 years while training up junior colleagues to succeed them. LTHT Board and senior CSU management should take direct responsibility in overseeing such as appointment. However, no senior surgeon would presently wish to come to Leeds due to the capacity issues on the PICU. It is therefore imperative that the LTHT board prioritises PICU nurse recruitment to enable the existing PICU bed base (18 beds) to be fully operationalised in the next 12 months.
- An alternative strategy would be for one of the younger surgeons to take on the responsibility of leading the department. This plan is dependent on maximising operating time for junior surgeons under the mentorship of the senior surgeon. LTHT Board and the senior CSU management should monitor closely the development of the junior surgeons, taking a clear view on what progress looks like, to ensure the sustainability of its cardiac surgical programme.
- Consideration should be given to paediatric anaesthesia trainees rotating through cardiac anaesthesia to add resilience to the fellow programme.

3.11 Leeds Children's Hospital (LCH) – the Clinical Service Unit (CSU) structure

Leeds Children's Hospital exists within a complex structure of clinical service units (CSUs). In common with other children's hospitals that sit within larger Trusts, paediatric patients are managed across several divisions of the organisation. Past clinical leaders described difficulty identifying appropriate colleagues 'higher up in the organisation with whom to raise their concerns. The reviewers were told that, in relation to the cardiac surgical pathway, Theatre and Anaesthesia CSU and the Children's CSU did not always work

⁴ One consultant in paediatric cardiology is currently on sick leave.

cohesively and lacked a joined-up vision for their shared services. Senior management within the CSUs were not always fully sighted on the challenges that had been escalated and the Trust is encouraged to look at ways to improve communications and joint working across the CSU structures.

Recommendations

- The existing division of responsibility across three Clinical Service Units (Children's, Cardio-Respiratory and Theatres & Anaesthesia) has hampered the design and implementation of patient pathways. This should be reviewed.

4.0 CONCLUSION

Leeds Children's Hospital should be exceptionally proud of its congenital cardiac programme and of the dedicated team of professionals that work tirelessly to continuously improve the service it provides to its patients. However, some recent poor patient outcomes and the imminent retirement of its senior surgeon now places the entire programme in a very precarious state.

Senior clinicians should be congratulated on raising concerns. It should also be acknowledged that the management team have proactively sought to investigate matters through commissioning this far-reaching review of the wider programme. They have additionally proactively sought a replacement for the lead clinician these last 12 months.

We believe Leeds has too large a paediatric cardiac surgical programme for it to be allowed to fail. However, the failure to secure a replacement surgeon to undertake complex neonatal surgery would have major implications for its neighbouring paediatric cardiac surgical centres, and for the reputation of both the children's hospital and the Trust. This situation demands the Trust Board's full attention.

APPENDIX 3

Review of cases of concern by Mr Andrew Parry, Consultant in Congenital Cardiac Surgery

When concerns were raised about the paediatric congenital cardiac surgery service in 2023, members of the team specifically raised concerns around the outcomes of a number of children that had been operated on by an individual surgeon. As a direct result of those concerns, the individual surgeon has had their practice restricted and is being provided with support whilst the matter is investigated.

Mr Andrew Parry, a paediatric cardiac surgeon in Bristol, completed a review over a six-month period, of seven cases. These cases had been selected for review by the paediatric surgical and paediatric cardiology teams.

Although the review was completed in May 2025, an eighth case has subsequently been shared with Mr Parry. It is anticipated that the review of that child's care will be available in the next two months.

Parents were contacted prior to the review commencing, with all families being given an opportunity to speak to the expert if they felt that would be helpful.

Of the seven children whose care has been reviewed, two have sadly died. The remaining five children continue to receive care from various specialties including congenital cardiac surgery.

Mr Parry concluded following his review that in three of the seven cases, the surgeon performed well in what were described as complex cases. Complications occurred in four cases and in two of those, the surgeon's familiarity with the procedure was called into question, particularly in highly complex surgery in very small children. In two cases, the expert was critical of the surgeon's documentation.

The individual surgeon's practice remains restricted and any concerns around their practice are being managed in a separate confidential process.

APPENDIX 4

Interim Action Plan:								
	Safety action description	Safety action owner	Target date for implementation	Date Implemented	Tool/measure	Measurement frequency	Responsibility for monitoring/oversight	Planned next review date
1.	Submission of business case for funding to increase PICU nursing establishment to match PCCS standards.	Laura Whelan Bridget Sutton (CSU) Rabina Tindale (Chief Nurse)	31 October 2025	TBC	WTE nurses in PICU Business case submitted to increase nursing establishment to PCCS standards	Monthly review of progress	Laura Whelan Bridget Sutton (CSU) Rabina Tindale (Chief Nurse)	31 October 2025
2.	Adequate PICU nurses trained to deliver ECMO on PICU.	Laura Whelan Bridget Sutton (CSU) Rabina Tindale (Chief Nurse)	31 December 2025	TBC	WTE nurses trained to deliver ECMO ECMO commissioned for LTHT PICU	Three monthly review	Laura Whelan Bridget Sutton (CSU) Rabina Tindale (Chief Nurse)	30 September 2025
3.	Appointment of a new lead congenital cardiac surgeon	Children's CSU LTHT Exec team	01 January 2026	Complete	Consultant AAC panel	Complete	Children's CSU and LTHT Exec team	Complete
4.	Adult patients no longer to be treated in the paediatric hybrid catheter lab	Andy Hogarth (CRS CSU)	30 November 2025	TBC	Adult patients treated in the paediatric hybrid catheter lab	Two monthly review of progress	Andy Hogarth (CRS CSU)	31 September 2025

5.	Ensure mortality in congenital cardiac surgery in line with peers	Children's CSU Mortality Improvement Group LTHT Execs	31 December 2025	Ongoing	Continuous review of unit and individual surgeon outcome data. Review of cases in specialist governance forum	Three monthly review	Children's CSU MIG LTHT Execs	31 October 2025
6.	Ensure positive and collaborative working relationships between all key clinical groups.	Children's CSU Tri Team LTHT Medical Directorate LTHT Execs	30 June 2026	Ongoing	Regular feedback meetings with key stakeholders from the team. Staff survey	Three monthly review	Children's CSU LTHT Medical Directorate LTHT Execs	31 December 2025
7.	Ensure formal process of mentorship and professional development of junior consultant surgeons	Lead cardiac surgeon CD Children's Hospital LTHT Responsible Officer	30 June 2026	Ongoing	Opportunities for dual operating formally discussed and agreed at MDT preoperative planning stage Feedback at consultant appraisal Audit of dual operating	Six monthly review	Children's CSU LTHT Responsible Officer	31 December 2025

8.	External review of cases of possible concern	CD Children's Hospital Deputy CMOs	30 September 2025	Ongoing (seven of eight cases complete)	Completion of case reviews by external expert Feedback offered to parents	One monthly review	Children's CSU Deputy CMOs	31 August 2025
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