Report of Second Stage of Urgent Review

- In March 2013, a set of unverified mortality figures released by the Director of the National Institute for Cardiovascular Outcomes Research (NICOR) along with some unsubstantiated complaints were used as justification by Sir Bruce Keogh to order the immediate suspension of children's heart surgery at Leeds. Co-incidentally, this came the day after NHSE was defeated in the High Court. An immediate review led to surgery being resumed after a short time but a second stage review would look at mortality and family experience.

- After nearly a year, on Thursday 13th March NHS England released the *Leeds Children's Heart Surgery Services Review.* The length of time taken to publish this report caused significant uncertainty and frustration for staff and families.

***Mortality Case Review*:**

- The purpose of the mortality case review was to examine the quality of medical and surgical care provided to those children who died following surgery during between 2009 and 2013, to give an opinion on the care provided and to identify any relevant learning or recommendations for further improvement in the quality of care provided. The results were:
- The first part of the conclusions state that the Leeds unit is safe and is running well.

- The 35 cases which were reviewed found no new or additional findings; concerns or recommendations.

- Clinical management of the cases examined showed medical and surgical care to be in line with standard practice.

- A set of recommendations was made for ongoing quality improvement and they have been graded in the opinion of the review team as "high" or "medium" or "low" priority.

- NHSE states that many of these recommendations could apply more widely across other children's cardiac units in the NHS.

- The review team added that a range of further audits should be undertaken in order to facilitate the on-going quality analysis and development of the unit. Audits would allow organisational issues such as timing of procedures, staffing, cardiological and surgical expertise to be further evaluated.

Family Experience Review:

- CHSF is disappointed that the *Family Experience Review* focuses on a very small number of unsubstantiated complaints.

- It is right that any family who wishes to detail a genuine complaint should be allowed to express their concern; however CHSF believes that NHS England should have fully investigated these complaints rather than just detail them in the report.

- What is especially regretted is the fact that the unit was not given the opportunity to respond to these complaints resulting in a highly unbalanced account of the experiences the families received at Leeds.

- The Leeds Teaching Hospitals Trust has already made changes to ensure that complaints are now handled differently, and that families feel that they are treated with sensitivity and compassion at all times.

- In order to provide context to the reviews findings, the 16 complaints are set against more than 40,000 patient cases, and 1,500 surgical procedures which have been carried out since the earliest complaint in 2009. Leeds' success rates in this speciality stands at 98%.

Moving forward:

- No other children's heart surgery unit in the country has faced anything like the same level of scrutiny as Leeds. We would like to see any continuing audits of Leeds, as recommended by the review, also conducted at all units across the country in order to ensure equality of assessment and ending Leeds being targeted in isolation.

- CHSF is concerned that the third part of the review, focusing on 'Concerns expressed by another NHS Unit in relation to patient pathways and referrals to other units' has been omitted and a report will come later. Clarification of the release date in addition to allowing adequate time for the unit to provide a reply would be an appropriate way to move forward. This would guarantee a balanced and fair account of the concerns than have been expressed.