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Terms of Reference for Review of the Paediatric Orthopaedic Surgery Service at CHI and Dublin Hospitals

November 2023, version 2

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1 Introduction

1.1 Childrens Health Ireland ("CHI")

There are over 1.22 million children in Ireland under the age of 18 years (23.6% of the total population). CHI is the primary specialist healthcare provider for this population. CHI is constituted under statute Children's Heath Act 2018; it has its own Board and the Chairman of the Board reports to the Minister of Health. It is HSE-funded under a Service Level Agreement, and as such is required to comply with HSE policies and procedures including the Incident Management Framework 2020 and Open Disclosure Policy 2019.

Whilst providing a wide range of services and care, CHI also provides tertiary services nationally and secondary paediatric services to the greater Dublin area. CHI comprises two hospitals where Paediatric Orthopaedic Surgery is provided (Crumlin, Temple Street) and two urgent care centres in Dublin. Paediatric Orthopaedic Surgery is also provided for at the National Orthopaedic Hospital at Cappagh which is not under CHI.

The new children's hospital on the shared campus at St. James's Hospital, will provide services for children and young people in need of specialist and complex care. It will provide tertiary care on a national basis (including on an all-island basis for some specialties) and secondary care for the greater Dublin region. CHI has 39 different clinical specialties and has merged the three Dublin children's hospitals, combining clinical and research expertise to improve clinical outcomes. The new hospital will be digitally enabled.

Currently Spina Bifida services for children are delivered primarily in CHI at Temple Street through an established Multi-Disciplinary Team (MDT) catering for patients with Spina Bifida from birth to transfer to adult services. Spinal surgery is one element of this service.

An action plan to address waiting times for scoliosis and spina bifida surgeries was agreed in April 2022 and further developed in 2023. Implementation of the actions were continuously progressed over the past 15 months.

1.2 Background to Review

In 2022, following the identification of patient safety concerns in the Paediatric Orthopaedic Spinal Surgery Service in Children's Health Ireland at Temple Street, CHI commissioned two reviews. The first review, which was conducted internally, is entitled the *Children's Health Ireland Spines Clinical Review Report (May 2023)*. The second review was conducted by external reviewers and is entitled *Children's Health Ireland at Temple Street Spinal Surgery Programme for Patients with Spina Bifida (7th July 2023)*. The reports are listed at (i) and (ii) in the attached list of reports at Appendix 1.

In line with the requirements of the national patient safety governance process, the HSE was advised by CHI that a number of further specific reviews relating to patient safety concerns in the CHI Paediatric Orthopaedic Surgery Service were in the process of being carried out. Those

reviews are listed at (iii), (iv), (v) and (vi) in Appendix 1. A further review to assess outcomes of spinal surgery at CHI Crumlin was also undertaken to provide a basis for comparison - (vii) in Appendix 1.

In addition to the above, the Department of Health has directed the Health Information and Quality Authority ("HIQA") to conduct an inquiry pursuant to the Health Act 2007 (the report relating to this Inquiry (which has no specific title as yet) is listed at (viii) in Appendix 1).

In July 2023, the HSE established an oversight group to monitor the management of the patient safety concerns identified by CHI. Based on the complexity of the issues emerging, the Chief Clinical Officer (CCO) of the HSE ("the Commissioner") made the decision to commission an independent, overarching external review ("the Independent Review") to be carried out by an international clinical expert ("the Independent Reviewer").

2. Purpose

2.1 Aim

The Independent Reviewer will review the practice of an individual Consultant ("the Consultant") and the environment in which they operated and will prepare a risk assessment. The 'environment' to be reviewed in the context of the risk assessment will be determined by the Independent Reviewer but may include, for example, the physical environment where clinical activity occurs; the availability of appropriate support staff; access to theatre and engagement with multidisciplinary working.

The Independent Reviewer will also review the service, including the governance, being provided by the Paediatric Orthopaedic Surgery Service at CHI Temple Street, CHI Crumlin, the National Orthopaedic Hospital, Cappagh and other relevant sites in Dublin ("the Service") for the purposes of providing independent assurance with regard to the current and future service delivery.

2.2 Objectives

The Independent Reviewer will:

(a) review the Paediatric Orthopaedic Surgical practice of the Consultant and the 'environment' (see 2.1 above in relation to the meaning of 'environment') in which they operated and prepare a risk assessment and make any necessary recommendations;

(b) consider the findings of the completed reviews and reports listed at (i), (ii), (iii) and iv) in Appendix 1 and, if completed prior to the completion of the risk assessment,

the findings of the reviews and reports listed at (iv), (v), (vi) and (vii) in Appendix 1 and compare to the findings of the Independent Review.

(c) evaluate the procedures (and/or any actions to be taken for the purposes of enhancing quality, safety and outcomes of clinical practice) and any improvement plans proposed in response to the findings in any of the completed reviews and reports listed at (i), (ii), (iii) and (iv) in Appendix 1 and, if completed prior to the completion of the risk assessment, the findings in any of the reviews and reports listed at (iv), (v), (vi) and (vii) in Appendix 1.

(d) review the Service, including the governance, and make any necessary recommendations for improvement including on matters such as quality, safety, outcomes, and performance metrics;

(e) consider the implications of the findings of the Independent Review on the Service including on matters such as service capacity, service access, and delivery on current service plans and make any necessary recommendations.

3. Methodology

The Commissioner acknowledges that this is a complex Independent Review. Accordingly, the Independent Reviewer will determine the methodologies for the approach to be taken in order to achieve the objectives set out at 2.2 above.

In addition, the Independent Review will be conducted in accordance with the fair procedures principles set out in the HSE Incident Management Framework (2020).

4. Timelines and outputs

The Independent Reviewer will complete the risk assessment referred to at 2.2(a) above and will submit the risk assessment report to the Commissioner as soon as practicable. The completed risk assessment report will inform the methodology and timeline for the remainder of the review process referred to at 2.2(b) – (e) above.

The Independent Reviewer will provide monthly status updates to the Commissioner who, in turn, will advise the HSE Oversight Group on the status of the Independent Review.

A final report will be submitted to the Commissioner at the conclusion of the Independent Review and published thereafter.

5. Roles and Responsibilities

5.1 Review team

The Independent Reviewer will be provided with administrative support for the purpose of the Independent Review.

In addition, the Independent Reviewer may, with the approval of the Commissioner, engage the services of experts with specialist expertise, for example, in the fields of anaesthesia, nursing, physiotherapy, spinal surgery and infection control ("Specialists Experts") for the purposes of the Independent Review. Where Specialist Experts are engaged, their expert opinion (where it is relied upon) will be clearly identified in the draft report of the Independent Review for the purposes of fair procedures.

5.2 **Ways of Working**

The HSE, and the Service (which for the avoidance of doubt is defined in 2.1 above and includes CHI Temple Street, CHI Crumlin, and the National Orthopaedic Hospital, Cappagh and any other relevant Dublin hospitals) will provide any documentation and/or information requested by the Independent Reviewer within a reasonable period of time.

The HSE, and the Service will also provide full cooperation and assistance to the Independent Reviewer in carrying out the Independent Review. Such assistance may include, for example, accessing various hospital sites, arranging accommodation for meetings and interviews with staff, patients, families, and advocacy groups as required.

6. Governance and Accountability

The Terms of Reference for the Oversight Group established by the HSE in July 2023 will be amended to encompass the oversight of the Independent Review.

If, in the course of the Independent Review, it becomes apparent that there are reasonable grounds to believe that there are serious risks to the health or welfare of any person or persons receiving a service, the Independent Reviewer must immediately notify the Commissioner and may recommend: (a) a variation or extension to the Terms of Reference of the Independent Review or (b) the commencement of a new investigation in relation to the issues identified.

In addition, in the event that the Independent Reviewer considers it necessary to seek an extension, variation, amendment or clarification to the Terms of Reference he may make such recommendations to the Commissioner as appropriate.

6.1 HSE Oversight Group

The Commissioner of this Review, the Chief Clinical Officer of the HSE, co-chairs the HSE Oversight Group. Membership of the Oversight Group includes:

- Chief Clinical Officer, HSE (Co-Chair)
- Chief Operations Office HSE (Co-Chair)
- National Clinical Director for Quality and Patient Safety
- National Director HSE Communications
- National Director, Acute Operations
- QPS lead Acute Operations

In attendance
Members of the CHI Executive
The CCO will report on progress of the review to the National Patient Safety Office (NPSO) and Department of Health through the existing oversight arrangements and meetings between the CCO and Chief Nursing Officer/NPSO.

7. Approval and Review Date

Name	Role	Date
Dr Colm Henry	Commissioner	November 2023, version 2
Mr Selvadurai Nayagam	Independent Reviewer	November2023, version 2

Appendix 1

i. Internal Report - Children's Health Ireland Spines Clinical Review Report (including a review of the spinal surgery outcomes for patients with Spina Bifida at Temple Street), dated May 2023 (completed).

ii. External Report - Children's Health Ireland at Temple Street Spinal Surgery Programme for Patients with Spina Bifida, dated 7th July 2023 (completed).

iii. Systems Analysis Review 1 dated September 2023 (completed)

iv. Systems Analysis Review 2 (as yet not complete, anticipated completion date is 20 December 2023.)

v. Children's Health Ireland Clinical Case Reviews (as yet not complete, anticipated completion date is end November 2023.)

vi. Children's Health Ireland Internal (Non-Spinal) Case Reviews dated May 2023 (as yet not complete, anticipated completion date is end November 2023.)

vii. Internal Report - Spinal Surgery Clinical Outcomes Review CHI at Crumlin, dated September 2023 (completed)

viii. HIQA Inquiry (as yet not complete, anticipated completion date is not currently known.)