Final Terms of Reference for Review of the Paediatric Orthopaedic Surgery Service at CHI

Contents

Version Control

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September 2023	V2	

1. Introduction

1.1 CHI

There are over 1.22 million children in Ireland under the age of 18 years (23.6% of the total population). Children's Health Ireland (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 three children's hospitals (Crumlin, Temple Street and Tallaght) and two urgent care centres in Dublin.

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, CHI commissioned two reviews, one internal and one external following the identification of patient safety concerns within the Paediatric Orthopaedic Spinal Surgery Service in CHI at Temple Street.

As part of the existing national patient safety governance process, the HSE were advised by CHI that a number of reviews relating to patient safety concerns within the CHI Paediatric Orthopaedic Surgery Service were being undertaken.

In July 2023, the HSE established an oversight group to monitor the management of the patient safety concerns identified by CHI.

The findings of the internal and external reviews were collated by CHI into a report - "Children's Health Ireland (CHI) Report on Spinal Surgery for Patients with Spina Bifida in CHI at Temple Street". This was provided to the HSE in August 2023.

Based on the complexity of the issues emerging, the Chief Clinical Officer (CCO) of the HSE took a decision to commission an independent, overarching external review by an international clinical expert.

2. Purpose

2.1 Aim

The aim of this work is to review elements of the Paediatric Orthopaedic Surgery Service at CHI and to provide independent assurance in regard to the current and future provision of the service. The principal focus of the review is on the service provided by an individual Consultant based at Temple Street and the environment in which they operate. However, it is acknowledged that any learning identified may have applicability for the wider CHI and other relevant sites and services.

2.2 Objectives

1. To conduct a risk assessment of the full range of domains of surgical practice associated with the findings of the completed review reports and to make recommendations in accordance with HSE Lookback Policy.
2. To review the completed review reports and evaluate controls and improvement plans developed in response to those reports.
3. To assess the governance of the Paediatric Orthopaedic Surgery Service and to make findings, and to make any necessary recommendations in regard to improvement in governance including quality, safety, outcomes and performance metrics.
4. To consider any implications for service capacity and access, including the delivery of the current agreed plans.

3. Methodology

The precise methodology will be agreed by the Commissioner and the independent external expert reviewer. All of the reviews (underway and completed) to date will be analysed in the first instance to inform their approach.

The work will be conducted in accordance with the principles of the HSE Incident Management Framework (2020) and includes consultation with relevant patients, families and staff members.

4. Timelines and outputs

A risk assessment will be completed by the independent external expert reviewer as soon as practicable but before the end of 2023. This will determine the specific timelines and milestones for the review process.

Monthly updates will be provided to the Commissioner and in turn submitted to the HSE Oversight Group.

A report will be submitted to the Commissioner, and published thereafter.

5. Roles and Responsibilities

5.1 Review team

This review will be conducted by an independent external expert reviewer, a clinician, who will be supported by a team comprising members from the HSE Quality and Patient Safety Directorate.

5.2 Ways of working

The HSE and CHI will provide any documentation and or information as is requested by the reviewer within a reasonable time

The HSE and CHI will provide full cooperation and assistance to the reviewer in order to carry out the review including access to sites, arrangement of accommodation for meetings and interviews with staff, patients, families and advocacy groups as required.

6. Governance and Accountability

The review team lead will report to the CCO as commissioner of the report. Updates will, in turn, be submitted to an Oversight Group. The TOR for the Oversight Group established by the HSE in July 2023 will be amended to encompass this work.

If, in the course of this review, it becomes apparent that there are reasonable grounds to believe that there are further or other serious risks to the health or welfare of any person or persons receiving services, the reviewer may recommend to the CCO that these terms be extended to include further investigation or that a new investigation should be undertaken, as appropriate.

The review team will provide interim reports to the CCO and escalate urgent concerns should they arise, pending the completion of a final publishable report.

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.

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7. Approval and Review Date

Name	Role	Date