Children’s Hospital Group

The clinical case for the new children’s hospital, its satellite centres and tri-location
I. The new children’s hospital; why is the new children’s hospital necessary and important?

By 2020, the new children’s hospital will have replaced Dublin’s three children’s hospitals – Our Lady’s Children’s Hospital Crumlin, (OLCHC), Temple Street Children’s University Hospital, (TSCUH) and the National Children’s Hospital at Tallaght Hospital, (NCH). TSCUH, built in 1872 and OLCHC, built in 1956, both have an infrastructure which is no longer fit for purpose. The National Children’s Hospital, Tallaght, is small, particularly in terms of delivery of specialist services and potentially isolated. The new children’s hospital will provide national paediatric specialist (tertiary and quaternary) care for the island of Ireland and secondary general paediatric care for children in the greater Dublin area. In numerical terms, and in terms of service volume, secondary general paediatric care services make up the greater part of the clinical services to be provided.

The new children’s hospital will be built on the campus at St James’s Hospital. The Government determined that St James’s Hospital was the most suitable adult partner hospital for the new children’s hospital. This decision followed the deliberations of the Dolphin Group which identified St James’s Hospital as the most appropriate adult partner for the new children’s hospital with which to co-locate because it had the broadest range of national adult specialities and an excellent and well established research and education culture and infrastructure. St James’s Hospital and the new children’s hospitals are both Model 4 hospitals. (A Model 4 Hospital provides acute surgical care, acute medical care, critical care, tertiary care (specialist care) and in certain locations supra-regional care whereas a Model 3 Hospital provides 24/7 acute surgical care, acute medical care and critical care. Source HSE).

St James’s Hospital has the widest range of subspecialities and the highest level of clinical complexity of all the adult hospitals in the country and provides a number of national services. The new children’s hospital will have a similar profile. The skill and expertise of the clinical staff in the co-located new children’s hospital and St James’s Hospital match appropriately and these shared skills and expertise are precisely what is required for the care of the most complex and life-threatening conditions with which children from all over Ireland will present to the new children’s hospital. There are many specialists who work between both hospitals already. Having these specialists on the one campus will enhance joint working. It is likely that the number of joint appointments will increase once the new children’s hospital opens.

This paper will explain why a new children’s hospital is needed in Ireland. The paper will describe the model of care for the hospital and explain how the two new children’s hospital satellite centres will function and how they are a necessary and integral part of the project.
Thirdly, the paper will explain how the tri-location of a major adult teaching hospital, a maternity hospital and a major children’s hospital is essential for the promotion and protection of the health and wellbeing of the sickest infants, children, young people and high risk mothers.

In 2005, the HSE commissioned McKinsey & Company to prepare a report advising on the ‘strategic organisation of tertiary paediatric services for Ireland’ that would be ‘in the best interests of children’. In early 2006, McKinsey produced their report ‘Children’s Health First’ which demonstrated that a population of c. 3.5 - 5 million people – like Ireland – can only have one large public tertiary children’s hospital (consisting of over 400 beds). A key clinical benefit of the merger of the three children’s hospitals relates to the principle of ‘improved clinical outcomes with scale and critical numbers of sub-specialists’. International evidence demonstrates that clinical outcomes are better in units in which higher volumes of complex care is delivered. This is driven by improved access to and availability of key sub-specialist clinical teams, as well as the utilisation and viability of medically advanced and expensive diagnostic machines and supplies. This was quantified by McKinsey & Co in their example of the mortality rate in Swedish heart hospitals which decreased from 9.5% to 1.9% one year after this merger, despite taking on more complex cases. This improvement in outcome can be attributed to the fact that specialist teams improve in their management of complex cases when they physically do more of them and when they are surrounded by the required sub-specialist team members and resources.

The existing three Dublin children’s hospitals have 432 beds. Approximately 53% of the inpatient rooms are single rooms. There are 12 theatres and the three Dublin children’s hospitals cover a cumulative space of c.75,000 Sq. m. of building space. This will be replaced with the new children’s hospital on the campus at St James’s Hospital of c. 124,000 Sq. m. with 380 inpatient beds, 100% of which will be single en-suite rooms each with a parent bed, 93 day care beds and 18 in-patient and day-care theatres as well as cardiac and interventional radiology suites and two endoscopy suites. Out-patient care and urgent care will be provided both in the hospital on the campus at St James’s Hospital and in two new children’s hospital satellite centres on the campuses of Tallaght and Connolly Hospitals. There will be 111 outpatient examination rooms in the hospital on the campus at St James’s Hospital and 6 each in both satellite centres. Emergency care will be delivered in the new children’s hospital Emergency Department on the campus at St James’s Hospital. Emergency and urgent care will be described in section 2 of this paper.

The fact that there are three stand-alone children’s hospitals in Dublin results in splitting of specialist care across the city as well as duplication and triplication of some clinical services within a 14Km distance. This might mean that a child with a single condition which affects different body organs might have to attend different specialists in more than one hospital.
This does not lead to optimal ‘joined-up’, holistic care and adds to the family’s burden of care. Having all of the specialists working together under one roof means that the child’s care can be co-ordinated and integrated resulting in safer, higher quality clinical care and a reduction in stress and inconvenience for the child’s family. By bringing all the specialists together there is also the opportunity for sub-specialisation within a specialty. This is what happens in all of the major international children’s hospitals where subspecialisation allows for expertise to develop even in rare conditions. This could reduce the need for Irish children to travel to seek such expertise in other countries. This travel incurs cost to the state and cost and inconvenience for the family. This level of subspecialisation is not possible with specialists split across the city.

By integrating the three existing Dublin children’s hospitals into a single large hospital and co-locating with a major adult teaching hospital on the campus at St James’s Hospital, the new children’s hospital will operate the system proven to deliver better clinical outcomes in most leading children’s hospitals across the world, that is scale and critical mass combined with adult co-location (as used by 15 of 17 major children’s hospitals identified as relevant by global consultants McKinsey & Co. in major cities in the US/Canada, UK, Australia/New Zealand and Scandinavia).

In June 2015, it was announced by the Department of Health that the Coombe Women and Infants University Hospital will be re-developed on the campus at St James’s Hospital resulting in the tri-location of a major adult (St James’s), maternity (Coombe) and a major children’s hospital. For major public tertiary children’s hospitals scale (i.e. the highest volume of the most complex cases), critical mass and tri-location demonstrably improve clinical outcomes and save more children’s lives by optimising the utilisation and effectiveness of multiple clinical teams of specialists and subspecialists and expensive equipment. McKinsey & Co. showed critical mass, and adult co-location is common to all of the new children’s hospital builds they assessed in several jurisdictions.

As a new facility, the new children’s hospital plans to use an operating model (Model of Care) regarded as most effective in modern public hospitals. While there is minimal change in the total number of beds, the type of bed will change. There will be more critical care / high dependency beds [currently 39 in number increasing to 60] and more day-care beds [number increasing to 93]. The inpatients rooms are all single rooms with ensuite facilities and overnight parent accommodation. The single room is crucial from an infection control

2 US/Can (Stanford, Texas, Pennsylvania, Cincinnati, Toronto, BC), UK (Ormond St., Guys & Thomas/Evelina, Manchester, Bristol), Australia/NZ (Sydney, Melbourne, Auckland), Scandinavia (Helsinki, Oslo, Stockholm, Ulleval)
viewpoint but also enhances privacy and the dignity of the patient experience. The infrastructure supporting these beds will have a significant impact on productivity and clinical outcomes. Modern healthcare is not solely about the quantum of beds but how the skills and resources of the multiple clinical teams are best leveraged. When St James’s Hospital leveraged its scale and clinical operational model to create an Acute Medical Admission Unit in 2003, hospital mortality decreased from 12.6% (2002) to 7.0% (2006), saving an estimated 300 lives per year⁴.

The three Dublin children’s hospitals have always worked to provide high quality secondary clinical care to the children of the greater Dublin area and specialist care to all the children of Ireland. The National Children’s Hospital, located in Tallaght since 1998, was founded in 1821. Known as the "Pitt Street Institution" it was the first hospital in Ireland and Britain established specifically for the care and treatment of children and they "sought to improve child and family centred care." Dr Charles West who worked in the hospital went on to found Great Ormond Street Hospital for Sick Children in 1852. In 1875 the National Orthopaedic and Children's Hospital was established and it was formally joined with the Pitt Street Institution in 1884. They both moved to "Harcourt Street" in 1887. The stated objective of the hospital at that time was, "to educate mothers and nurses regarding the proper management of children in both health and disease." Tempel Street Children’s University Hospital, was founded as a charitable infirmary in Dublin 1 in 1872. Thomas Moore Madden, one of the hospital’s founding doctors, spoke on its behalf at the Spencer Commission presenting the case that Irish children deserved to be treated in a special environment of the their own rather than in an adult hospital. Our Lady’s Children’s Hospital Dublin opened in Crumlin in 1956. It was specifically designed to care for and treat children.

The National Children’s Hospital moved from Harcourt Street in to Tallaght in 1998 and therefore is a relatively modern build. One of its three wards has 100% single bedrooms with parent accommodation provided in the room. However, the other two wards have a mixture of multi-occupancy rooms and single rooms and the majority of rooms do not have en-suite provided. There is a paediatric Emergency Department which sees approximately 33,000 children annually however access to the paediatric emergency department is through the adult emergency department. While there are three high dependency beds, there is no intensive care provided and children, who are critically unwell and require more intensive care must be transferred to either Our Lady’s Children’s Hospital, Crumlin or to Temple Street Children’s University Hospital. The hospital provides a secondary general paediatric service to the local community and also has specialists in respiratory medicine, cystic fibrosis, diabetes and endocrinology, gastroenterology, developmental medicine and


The Children’s Hospital Group consists of Our Lady’s Children’s Hospital, Crumlin, Temple Street, Children’s University Hospital & the National Children’s Hospital at Tallaght Hospital
neuro-disability. However, children with complex, multi-organ problems need to attend one of the other two Dublin children’s hospitals for any other specialist care.

Temple Street Children’s University Hospital, has continued to modernise and develop over the 143 years since it was founded. In 1966 the national newborn screening programme was established there. In 1993, the national metabolic service was set up. In 2003, the national paediatric haemodialysis and kidney transplant service moved to Temple Street from Beaumont as did the national neurosurgical services for the under sixes and the national paediatric cochlear implant programme in 2010. The facilities have been upgraded with a paediatric intensive care unit being installed in 2006 and a neonatal high dependency unit in 2009. However, the hospital continues to function from the building to which it moved in 1879. The infrastructure is not optimally suited to the delivery of modern clinical care. Most patients are in multi-occupancy rooms and their parents sleep on the floor beside them at night. Clinical adjacencies have developed rather than being planned for optimal clinical care and efficiency. The children currently treated in Temple Street Children’s University Hospital, will benefit from the planned clinical adjacencies in the new children’s hospital, the access to a wider range of specialist and multi-disciplinary care and a vastly improved physical infrastructure.

Our Lady’s Children’s Hospital Crumlin is the largest children’s hospital in Ireland and provides the majority of tertiary and quaternary (specialist) paediatric care in Ireland. Again, the hospital has been committed to developing and improving its infrastructure over the decades. However, it was not designed for the delivery of modern paediatric care or for optimal efficiency. While historically the infant ward has had single rooms for infants, these are small and allow parents to sleep overnight in only a chair. Some recent ward upgrades have provided single rooms with parent accommodation but this is not yet uniform. There are many multi-occupancy rooms which mix children of different ages and genders and where parents sleep on the floor beside their child’s bed overnight. The floor to ceiling heights are compliant with standards of a different era. Clinical adjacencies have developed rather than being planned for optimal clinical care and efficiency. The children attending Our Lady’s Children’s Hospital, Crumlin will also benefit from the planned clinical adjacencies in the new children’s hospital and the availability of the full range of clinical specialist which will be available there. In both Our Lady’s Children’s Hospital, Crumlin and Temple Street Children’s University Hospital the commitment of the staff to the delivery of excellence in clinical care shines through but many elements of the physical environment remains a challenge.
Ireland needs a new, national children’s hospital where all specialist paediatric care is provided by multi-specialty and multi-disciplinary teams. This new model will result in improved delivery of care to the child and an enhanced experience of the child and his/her family. The establishment of a department of secondary paediatric medicine in the new children’s hospital will co-ordinate and improve that care for the children of the greater Dublin area. The new children’s hospital has been planned as a large unified children’s hospital. It has been designed to facilitate optimal clinical care, efficiency and the patient and family experience. The Emergency Department, Paediatric Intensive Care Department, Operating Theatres and the Helipad are all stacked one above the other, vertically adjacent, and facilitating rapid, safe transfer of the sickest children. Every standard inpatient room is single with en suite facilities and a bed for accompanying parents. The orthopaedic outpatient service, a high user of X Ray facilities, is located beside the Radiology Department. The outpatient departments have been designed with the clinical consulting examination rooms and the multi-disciplinary support facilities in the same area to reduce patient movement and inconvenience and deliver a cohesive multi-disciplinary service in one place. The new hospital is specifically designed to deliver high quality, specialist, efficient, effective and safe clinical care in a manner in which it cannot be delivered in the current three Dublin children’s hospitals. The proposed facility promises a new era in the delivery of excellent healthcare to the children and young people of Ireland.
II. The new children’s hospital: what is a model of care and why are the new children’s hospital satellite centres an essential and integral part of the new children’s hospital model of care?

Introduction

The model of care for the new children’s hospital has been developed and a copy of this is available in Appendix 1. This document describes the model of care for the new children’s hospital satellite centres and describes how these are an essential and integral part of the new children’s hospital model of care. The aim of the new children’s hospital satellite centres is to promote and guarantee the provision of high quality, safe clinical care to every child, every time, s/he attends the new children’s hospital satellite centres.

Definition of Model of Care

A Model of Care is a clinical and organisational framework for how and where healthcare services are delivered, managed and organised. The term model of care covers both methods of care at the individual patient level and the clinical and organisational framework at a unit, hospital and state-wide level. This model of care is based on current best practice and evidence but, as these are organic and respond to the emergence of new evidence and standards, the model of care will continue to change and develop in the future. There must be a programme of review and ongoing innovation allied to an institutional framework which ensures the involvement of clinicians and users at all stages. The model of care constitutes one of the fundamental elements of the operating model of a healthcare facility.

National Model of Care for Paediatrics and Neonatology

A model of care for the delivery of paediatric and neonatal care nationally has been developed by the HSE National Clinical Programme for Paediatrics and Neonatology. The new children’s hospital has a central role in this national model of care. The new children’s hospital will provide specialist tertiary and quaternary services for children from all over Ireland and will engage in shared care arrangements with local paediatricians in regional paediatric units. This shared care arrangements already happens. The specialists in the new children’s hospital will also provide outreach clinics in regional centres thereby bringing their expertise closer to the patient. The hospital model of care is consistent with the national model of care and, as paediatric care providers, we are working together towards a uniformly agreed quality and standard of safe and reliable care for all the children of Ireland.

Current Situation and Rationale for the proposed hub (new children’s hospital) and spoke (new children’s hospital satellite centres) model:

As described in Section 1, there are currently three children’s hospitals in Dublin which fulfil local and national functions. The new children’s hospital will merge these three existing
children’s hospitals (Our Lady’s Children’s Hospital, Crumlin; Temple Street Children’s University Hospital; The National Children’s Hospital at Tallaght Hospital) and they will all close. The remit of the new children’s hospital has two separate but linked service delivery responsibilities. It will provide tertiary / quaternary (highly specialised, small volume) services on an all-island basis and secondary paediatric care (higher volume but less severe and less complicated conditions) to the greater Dublin area (counties Dublin, Wicklow, Kildare and parts of Meath). National and international evidence shows that children with complex, rare and life-threatening conditions do best by centralising highly specialised and complex tertiary / quaternary services. Secondary care, by its nature less complex and requiring less specialised equipment and staff, can and should ideally be delivered as close to the child’s home as possible.

This is a model which is well established internationally.

‘At Cincinnati Children’s, we believe every tri-state family should have easy access to the care offered by our pediatric experts. That’s why we provide a number of neighborhood locations in addition to our Main Campus (Burnet).’

(U.S. News & World Report ranked Cincinnati Children’s No. 3 in the nation in the magazine’s 2015-2016 list of the best children’s hospitals.)

Reasons for having the two new children’s hospital’s satellite centres working alongside the new children’s hospital:

1. To provide secondary general paediatric care closer to home to children and young people in the greater Dublin area.

The largest volume of the child population in the greater Dublin area is based within the limits of the M50 motorway (Central Statistics Office). The Central Statistics Office also projects that future growth in the child population will take place in the south-west and north-west areas of Dublin, close to, but outside of, the M50 motorway. The proposed model fulfils the core objective of bringing paediatric services closer to the local populations of the greater Dublin area by providing the hub in the city centre (providing secondary paediatric services to the city centre, Dublin north-east, Dublin south-east and East Wicklow populations) and the two spokes in the south-west and north-west, outside the M50 motorway, on existing hospital campuses. The new children’s hospital satellite centres will provide paediatric services to the child population of the north, north-west, south and south-west areas of Dublin, Kildare, West Wicklow and parts of Meath. As a speciality, the majority of paediatric services are ambulatory, which are outpatient, emergency/urgent care and/or day-case based. The vast majority of children who attend the three emergency departments are discharged home to the care of their
parents. This population based understanding of health care provision supports the proposed hub and spoke model.

2. To provide safe emergency and urgent care to the children and young people of the greater Dublin area.

Each year, approximately 117,000 children attend the emergency departments of the current three children’s hospitals. Within this number, there is a mixture of emergencies and urgent care. The vast majority (approximately 85%) of children attending the existing three Emergency Departments are assessed, treated, observed and discharged home (Urgent Care). The projected clinical activity for emergency/urgent care department visits for the new children’s hospital in 2020 is approximately 126,340. There is no paediatric Emergency Department in the world which sees as many as 126,340 children annually in a single unit. Most large specialist children’s hospitals would see between 50,000 – 90,000 children in their Emergency Departments annually. The provision of urgent care in the two new children’s hospital satellite centres addresses this issue by providing urgent care to approximately 25,900 children in each of the two satellite centres to meet the needs of the local population. The Emergency Department in the children’s hospital on the campus at St James’s Hospital is designed to treat 74,540 children. This includes the local population in the city centre, the north and south east areas of the Dublin and East Wicklow as well as critically ill and injured children and young people from all parts of the greater Dublin area.

3. To provide a safe, local secondary paediatric service which will meet the local community’s needs and which will reduce inconvenience for children, young people and their families.

The new children’s hospital satellite centres will provide ambulatory services. Ambulatory care refers to paediatric healthcare services provided on a scheduled outpatient, day care or rapid access basis and includes diagnosis, observation, treatment and rehabilitation services. The local catchment area for the greater Dublin area is a densely populated area. It includes counties Dublin, Kildare, Wicklow and parts of Meath and has a large child population. The two new children’s hospital satellite centres will provide daily OPD services (Monday to Friday) including rapid access, general paediatric, developmental, fracture and chronic disease clinics and will work closely with local primary care and community health services. Access will be close for the local population and those with access to the M50 and will involve less interruption of the educational day for children and young people and of the working day for their parents.

Who will deliver clinical services in the new children’s hospital satellite centres?

The Children’s Hospital Group consists of Our Lady’s Children’s Hospital, Crumlin, Temple Street, Children’s University Hospital & the National Children’s Hospital at Tallaght Hospital
The new children’s hospital satellite centres are an integral part of the new children’s hospital. There is a single staff complement planned for the new children’s hospital and the two satellite centres. Clinical care will be delivered at both the new hospital and its satellite centres by consultant led teams, supported by paediatric nurses and paediatric multi-disciplinary health care professionals. Clinical staff will work in both the new children’s hospital on the campus at St James’s Hospital and the new children’s hospital satellite centres. Staff will be assigned, on a rotational basis, to work in either the hospital or satellite centres.

**What is the planned governance model for the new children’s hospital satellite centres?**

The Chief Executive Officer and new children’s hospital Board will be responsible for the management, delivery and quality of clinical care in the new children’s hospital and its satellite centres. The new children’s hospital satellite centres will be managed as part of the organisational structure of the new children’s hospital, within a Clinical Directorate structure. The requirement to comply with clinical audit, research activity, staff training and education, outcome measurement and staff, child and family satisfaction rating will be the same for both the new children’s hospital and its satellite centres.

**What is urgent care and how does it differ from emergency care?**

Emergency care involves life-saving and limb-saving treatment, the provision of timely pain relief and the psychological care of patients and their families. It is available all of the time and is delivered by an emergency medicine team of clinical and support staff.

Urgent care is for the diagnosis and treatment of injuries or illnesses requiring medical review in a dedicated facility but not serious enough to require emergency department attendance or inpatient admission. Currently 85% of attendances to the three children’s hospitals Emergency Departments are treated and discharged on the same day.

(Source of definitions: Model of Care for Paediatric Urgent and Ambulatory Care Centre produced by the HSE National Clinical Programme for Paediatrics and Neonatology and the National Clinical Programme for Emergency Medicine. 2015)

**What care will be provided in the new children’s hospital satellite centre urgent care services?**

Urgent care, as described above, will be delivered in the new children’s hospital satellite centres. Clinical care in the satellite centres will be consultant led and delivered. It will provide care for most common acute illnesses and injuries, such as, an ear infection, a urinary tract infection or a broken limb. In addition to this, the consultant led clinical staff at the urgent care unit will have the skills, knowledge and expertise to stabilise any child who presents to the satellite centre urgent care services and to prepare and support the critically
or injured child for transfer to the new children’s hospital. It is expected that the vast majority of children who attend the new children’s hospital satellite centres will be discharged home following assessment, observation, investigation and treatment. It is estimated that between 8-12% of those attending the new children’s hospital satellite centre urgent care units will require transfer to the new children’s hospital on the campus at St James’s Hospital. This translates into 5-8 children requiring transfer from each new children’s hospital satellite centre daily. A similar unit, the Panda Unit in Salford, England transfers only 4% of the children it sees to the Royal Manchester Children’s Hospital.

**How will children be transferred to the new children’s hospital if they require further treatment there?**

The method of transfer will depend on the child’s clinical condition. A child may be clinically well and stable but have, for example, an injury, e.g. a broken arm which has been stabilised and pain relief addressed. This injury may require an operation. All operations will be performed in the new children’s hospital and not in the satellite centre. Such a well-child might be transferred to the new children’s hospital in their parent’s car. If this child’s parent does not have transport, the well child will be transferred by ambulance or by the new children’s hospital transport service. Any child who is ill or severely injured will be transferred from the new children’s hospital satellite centre to the children’s hospital on the campus at St James’s Hospital by ambulance.

**Will ambulances bypass the new children’s hospital satellite centres?**

Children who require ambulance transfer to hospital are likely to require the specialist investigative facilities and treatment provided in the new children’s hospital. Therefore, if an ambulance is called for a child, the ambulance will bring the child straight to the Emergency Department in the new children’s hospital.

**How will families know where to bring their child?**

There will be an intensive education and information programme for the public and health care providers in the areas local to the new children’s hospital satellite centres. This information will be made available in paper form in primary care and health centres, on the new children’s hospital website, as an app to be used on a smart phone, to attendees to the new children’s hospital and to new parents in the maternity hospitals. This will spell out clearly, in lay-man’s language, those conditions which are suitable for the urgent care centre and those which require that the child should be brought to the emergency department.

This model of care functions successfully in many other countries. In Appendix 2, we provide examples of the webpage information which is provided by some of the international centres providing this model of care. The aim of the webpage information is to indicate clearly to parents where they should bring their child with a particular condition. As
mentioned above, the satellite clinical team will have the skills, knowledge and expertise to stabilise and prepare for transfer any child who requires this to the new children’s hospital on the campus at St James’s Hospital.

**What will happen if parents bring a child who is critically ill to one of the new children’s hospital satellite urgent care centres?**

The clinical care at the new children’s hospital satellite urgent care centres will be led and delivered by consultants, the most senior and experienced health care staff. At all times, the clinical staff at the urgent care centre will have the skills, knowledge and expertise to stabilise any child who presents to the satellite centre and to prepare and support the child for transfer to the new children’s hospital. Ambulances will bypass the satellite centres.

**Will the new children’s hospital satellite centres be open 24 hours?**

The satellite centres will have restricted opening hours. They will be open during the known busiest daytime and evening hours and closed during the night when the current Emergency Departments are at their quietest. At the moment, approximately 10 children attend each of the three Dublin children’s hospitals emergency departments between the hours of twelve midnight and eight am.

**How will parents know when the new children’s hospital satellite urgent care centres are closed?**

Part of the education campaign will be to inform primary and community health care providers and the local population about the opening hours of the new children’s hospital satellite urgent care centres. The opening hours will be clearly posted on signage to the facilities.

**What would happen if parents arrive at the new children’s hospital satellite urgent care centre when it is closed?**

Parents will be re-directed to the Emergency Department at the new children’s hospital during the hours that the new children’s hospital satellite centres are not open. If the parents, and/or the staff member at the satellite centre, are concerned about the child’s well-being, the staff member will call an ambulance to transport the child to the new children’s hospital Emergency Department.

**How will the new children’s hospital satellite centres operate in advance of the new children’s hospital at the St James’s Hospital campus opening?**

It is planned that the satellite centres will be operational for two years before the new children’s hospital opens. They will operate in conjunction with the three existing children’s hospitals until such time as the new children’s hospital on the St James’s Hospital campus...
becomes operational. This means that parents, families, local communities and General Practitioners served by the two new children’s hospital satellite centres will have used the facilities and will have developed well established patterns of use before the new children’s hospital is opened. The Children’s Hospital Group have established a Children’s Services Strategy Working Group to implement the model of care for the new children’s hospital satellite centres in advance of the opening of the new children’s hospital. This working group has already met and is engaged in planning more than two years ahead of the proposed opening date of the new children’s hospital satellite centres.

**Will the new children’s hospital Emergency Department also provide urgent care?**

Yes. The new children’s hospital Emergency Department will provide urgent care for its local population in the city during the hours of opening of the new children’s hospital satellite centres and for all children in the greater Dublin area during the hours of closure of the new children’s hospital satellite centres. The new children’s hospital Emergency Department will provide emergency care to all the children in the greater Dublin area 24 hours a day, 365 days a year.

**How will clinical information about children be shared between the new children’s hospital on the St James’s Hospital campus and the new children’s hospital satellite centres?**

The proposed model includes an electronic healthcare record so that clinical information about a patient is available to the staff of the new children’s hospital in whatever clinical location the child is seen.

**Philosophy and principles supporting the new children’s hospital and the new children’s hospital’s two satellite centres**

- Senior clinicians will provide clinical leadership in all three locations.
- The quality of care for the same condition will be the same across all three locations.
- Clinical staff will rotate between the new children’s hospital on the St James’s Hospital campus and the new children’s hospital satellite centres on the Tallaght and Connolly Hospital campuses.
- There will standardisation of care with one set of clinical protocols used across the three locations.
- There will be one set of values underpinning care delivery across the three locations.
- There will be one set of standards across the three locations.
- The new children’s hospital, at all sites, will have a very clear brand both for those who attend the hospital for clinical service and also for those who work within it – this is the brand of the new children’s hospital.
- All three facilities will be governed and managed as one healthcare organisation.
The Children’s Hospital Group consists of Our Lady’s Children’s Hospital, Crumlin, Temple Street, Children’s University Hospital & the National Children’s Hospital at Tallaght Hospital
III. The new children’s hospital: What are the reasons for tri-location of a major adult, maternity and children’s hospitals?

A primary mission of the new children’s hospital is to ensure that the children of Ireland are provided with a level of healthcare that meets international best practice. Above all, it must offer highly developed tertiary and quaternary services across a broad range of sub-specialities, so that children and young people with life-threatening and complex chronic medical and surgical conditions can have the best possible therapeutic interventions which will deliver the best clinical outcomes. Such excellence in modern paediatric clinical practice can only be provided with the centralisation of paediatric specialties in one location supported by a large academic adult hospital with a broad range of sub-specialities that supports the delivery of acute paediatric healthcare and provides support for basic science research-led discovery and its translation into clinical practice. From a clinical and academic perspective the Dolphin Group identified St James’s Hospital as the most appropriate adult partner for the new children’s hospital with which to co-locate because it had the broadest range of national adult specialties and an excellent and well established research and education culture and infrastructure.

Co-location with a Model 4 Adult Hospital

There are many reasons why the co-location of the new children’s hospital with a major adult academic teaching hospital was also the model recommended by McKinsey (2006). The new children’s hospital will provide secondary clinical care to the children and young people of the greater Dublin area and tertiary (specialist) and national care to the sickest children and young people throughout Ireland. St James’s Hospital and the new children’s hospitals are both Model 4 hospitals. (A Model 4 Hospital provides acute surgical care, acute medical care, critical care, tertiary care (specialist care) and in certain locations supra-regional care. A Model 3 Hospital provides 24/7 acute surgical care, acute medical care and critical care. Source HSE).

St James’s Hospital has the widest range of subspecialities and the highest level of clinical complexity of all the adult hospitals in the country and provides a number of national services. The skill and expertise of the clinical staff in the co-located new children’s hospital and St James’s Hospital match appropriately and these shared skills and expertise are precisely what is required for the care of the most complex and life-threatening conditions with which children from all over Ireland will present to the new children’s hospital. There are many specialists who work between both hospitals already and this is likely to increase once the new children’s hospital opens.
Tri-location
On the 30th June, 2015, the Department of Health announced that the Coombe Women’s and Infant University Hospital would be redeveloped on the campus with St James’s Hospital. This decision will allow tri-location of adult, paediatric and maternity services, a model considered optimal in terms of maternal and child health. Welcoming the announcement, Dr Sharon Sheehan, Master of the Coombe said “The tri-location model of maternity, paediatric and adult services will, I believe, enhance the quality of care provided to women and children across the country and as such, we fully endorse the development of the new children’s hospital at St James’s and we welcome the opportunity to be the maternity hospital within this tri-located model.” The Department of Health said that the tri-location of adult, children’s and maternity services at St James’s will create a campus of healthcare excellence for patients across the age span. Children and young people receiving complex treatment and care, young people transitioning to adult services, as well as the sickest new-borns and mothers, will greatly benefit from providers of these services being on one campus. Improved clinical outcomes for the sickest new-borns, children, young people and mothers will be realised through all three links – children-adult, maternity-children and maternity-adult.

At present the timeline for the development of the Maternity Hospital on the St James’s Hospital campus has not been established. No work on the planning of the Maternity hospital has commenced. Should the Maternity Hospital not proceed for any reason new-born children will be transferred to the new children’s hospital by ambulance for treatment. This is the current operational procedure within the existing children’s hospitals.

Tri-location clinical synergies
Children-Adult Link:
For children and young people receiving care in the new children’s hospital, co-location with St James’s Hospital ensures access for children to adult specialists in conditions which are more common in adults. Joint management of these conditions by specialists who work with both children and adults provides better quality of clinical care to the children and young people concerned. This is particularly true in the area of specialist surgery e.g. ophthalmology, plastic surgery, ENT, cardiac surgery, burns and maxillofacial surgery. In Ireland because of our population, these cases are better managed by those surgical specialists who work across the adult-child age range developing and maintaining their skills through their work in the greater number of adult patients they see and applying that skill and expertise to the care of children with similar problems.

The new children’s hospital will be the national paediatric oncology (cancer) centre. St James’s Hospital is the largest provider of adult cancer services nationally. There is a radiotherapy centre on the site of St James’s Hospital that will facilitate children and young
people with cancer directly accessing this service, as opposed to having to travel to St Luke’s Hospital from the children’s hospitals for this treatment as they currently do. Young adult survivors of cancer will transition into the cancer survivorship (late effects clinics) clinical programmes at St James’s Hospital and the complex chronic haematological disorders, such as, sickle cell disease, haemophilia and related inherited bleeding disorders will transition to the National Centres for these conditions at St James’s Hospital.

Thankfully, survival in children with complex conditions is continually improving. For that reason, a growing number of patients with chronic conditions need to be managed across their lifespan from childhood to adulthood. Examples of these are children with congenital and acquired cardiac conditions, cystic fibrosis, chronic skin conditions, epilepsy and diabetes mellitus among others. While as a child, they may need to attend the new children’s hospital, development of a structured transition protocol between the children’s hospital and its adult partner on the St James’s Hospital campus will lead to an improvement in the quality of transitional care nationwide. Young adults with chronic conditions such as diabetes mellitus, epilepsy and Crohn’s Disease from the population served by St James’s Hospital will transition to those specialist services within St James’s Hospital. Young adults with these and other similar conditions from elsewhere will transition, using the same model of transitional care, to their local or regional adult specialist service.

Examples of other conditions which transition into adulthood include respiratory conditions, kidney failure and other chronic renal conditions, rheumatological disorders such as arthritis, endocrinology [hormone] disorders, neurological disorders other than epilepsy, gynaecological disorders and immuno-deficiencies. Many of these conditions are life-long and a formal, well-structured transition will allow the young person to take over responsibility of their condition from their parents and enhance their disease management during the transition period and in the long term.

There are outstanding examples internationally of good transition care. There are examples of very good practice in Ireland but there is room for improvement. The co-location of the new children’s hospital and St James’s Hospital will facilitate the development of such models in Ireland and allow dissemination of good practice throughout the country.

In the three Dublin children’s hospitals, the majority of surgical subspecialists work with both adult and paediatric populations. Currently, much of the specialists’ time is spent in travel between the adult and children’s hospitals and the specialist is not always readily available in one hospital while in the other hospital. For this reason, co-location on one campus facilitates ease of movement for specialists between the two hospitals enabling the
neonatologists for transfer commonly seen by paediatricians. Shared management of these young people by paediatricians and adult doctors will provide the optimal level of care to them.

Over half of the children’s hospitals’ consultants already work in central Dublin adult hospitals (St James’s, Mater and Beaumont Hospitals).

**Children-Maternity Links**

The draft site capacity study undertaken for the St James’s Hospital campus involves the location of a new maternity hospital with physical links to both the new children’s hospital and to the adult hospital. Once the planning team for the new Maternity hospital is established a more detailed analysis of its location and it physical links to both the new children’s hospital and the Adult will be undertaken.

Tri-location, having an adult, children’s and maternity hospital together on the same site is the optimal situation. Sick new-born babies can be transferred easily to the children’s hospital. The proposed design of the new children’s hospital plans a corridor access between the new children’s hospital and the new, redeveloped Coombe Women and Infants University Hospital on the St James’s Hospital campus. The clinical conditions which require transfer of new-born infants from a maternity hospital to a specialist paediatric hospital are often known about before delivery. Women from all over Ireland with a known high risk pregnancy can be booked for delivery in the redeveloped Coombe Women and Infants University Hospital on the St James’s Hospital campus in order to facilitate the smooth transfer of the new-born infant with a congenital condition to the new children’s hospital for treatment. The delivery and transfer of the infant can be planned by the obstetricians, neonatologists and relevant paediatric consultant specialists who work in both the children’s and maternity hospitals.

The maternity hospital will have a neonatal intensive care unit where care is provided to very premature and ill new-born infants. During their time in the maternity hospital neonatal intensive care unit, these infants can develop conditions which require their transfer to the critical care services in a specialist children’s hospital. This can be facilitated via the corridor access to the new children's hospital and the infants can return to the maternity hospital neonatal intensive care unit following intervention and treatment. The recent announcement of the redevelopment of the Coombe Women and Infant’s Hospital...
on the St James’s Hospital campus is a hugely important development in the guaranteeing of the best level of care for vulnerable, unwell new-born infants.

**Maternity-Adult Links**
A maternity hospital requires proximity to an adult hospital for the care of the ill mother. Often, unlike in the conditions affecting the new born infant, those serious conditions affecting the mother develop with little warning and can place a previously healthy, often young, woman and new mother in a critical condition. The conclusion of the KPMG Report on maternity services (2008) was that the three stand-alone maternity hospitals in Dublin should be co-located with a major adult hospital. The reason for this is to enhance the medical and surgical care of very ill women.

There will be further synergy between maternity and adult services through the shared care of gynaecological cancers. St James’s Hospital is one of the eight national cancer centres providing oncology, radiotherapy and specialist surgical services on site. There are already many joint consultant appointments and shared services between St James’s Hospital and the Coombe Women and Infants University Hospital across surgical and medical specialities.

**Tri-location Research Synergies**
Excellence in modern paediatric clinical practice cannot be provided except in the context of basic science research-led discovery and its translation into clinical practice. From a clinical and academic perspective the Dolphin Group identified St James’s Hospital as the most appropriate adult partner for the new children’s hospital with which to co-locate because it has the broadest range of national specialities but perhaps more importantly it has very strong, internationally recognised, clinical, research and education culture and infrastructure. This will be of huge benefit to the new children’s hospital and the redeveloped Coombe Women and Infants University Hospital and, from the perspective of the new children’s hospital will make it a place where the best child and adolescent healthcare professionals will want to train and work.

**Summary**
The development of the new children’s hospital and the re-development of a new Coombe Women and Infant’s University Hospital on a campus shared with St James’s Hospital provide the optimal model of care for the sickest children, new-born infants and women. This model will enhance the care and clinical outcomes of children attending the new children’s hospital from all over Ireland and that of infants born at the Coombe Women and Infants University Hospital and their mothers. It is universally welcomed by all the hospitals involved and it is extremely exciting that this model has been approved by Government. From a primary focus of doing what is right for the sickest children, new-born infants and
women, this model of tri-location is fully acknowledged by healthcare providers to be the optimum model of service delivery to achieve the best clinical outcomes.

Conclusion
The decision to build the new children’s hospital, a single hospital providing secondary general local care and all-island specialist care provides a unique opportunity to improve paediatric care and clinical outcomes for all the children of Ireland. The new children’s hospital satellite centres provide the opportunity to deliver secondary, general care close to the local populations in the greater Dublin area. Tri-location of the new children’s hospital with St James’s Hospital, a Model 4 adult hospital with a strong education and research base and the Coombe Women and Infant’s Hospital provides the best possible modern environment for the delivery of excellent clinical care, education of clinical undergraduates and postgraduates and the opportunity for important clinical research. This is one of the most positive developments in child health in the history of the State.
APPENDIX 1: MODEL OF CARE FOR THE NEW CHILDREN’S HOSPITAL

The Model of Care for the new Children’s Hospital and the Hospital Satellite Centres at Tallaght and Blanchardstown

March 2015
SECTION 1

Introduction

In 2009, the National Paediatric Hospital Development Board (hereafter referred to as the Board) established the Model of Care Committee with the terms of reference as outlined below. The committee produced the Model of Care for the hospital and for the proposed ambulatory and urgent care centre at Tallaght. This was presented to the Board, the RCPI, RCSI, ICGP, College of Anaesthetists, the Faculty of Paediatrics and the children’s hospitals. Following the refusal for planning permission for the new children’s hospital on the site of the Mater Hospital, and the subsequent re-location of the proposed new children’s hospital to the site of St James’ Hospital, it is necessary to produce an updated model of care document which reflects this and incorporates the two hospital satellite centres on the sites of Tallaght and Connolly Hospitals.

Relationship to the Statutory Instrument No. 246 2007

Development of the Model of Care for the hospital and satellite centres is necessary in order that the Board might appropriately plan, design, build, furnish, equip and commission them. The development of this Model of Care is also necessary in order for the Children’s Hospital Group Board to plan the transfer of services and to prepare a human resource strategy for transfer to the new hospital and the hospital satellite centres at Tallaght and Blanchardstown.

Key Stakeholders

The staff of the three children’s hospitals, and clinicians nationally who work with children, are key stakeholders in the development and implementation of the proposed Model of Care. The Model of Care is informed by current good practice in the three children’s hospitals, which is incorporated into the document, and by international developments in the delivery of high quality, safe paediatric clinical care. The Health Service Executive, the Department of Health and Children and the Faculty of Paediatrics are critical partners in the delivery of paediatric health care in Ireland and their engagement will be crucial to the successful implementation of the model of care.

Relationship between the Model of Care for the new children’s hospital and the National Model of Care

The National Paediatric Programme was established by the HSE in 2011. The national leads are Professor Alf Nicholson and Dr John Murphy (neonatology). The programme will produce a National Paediatric Model of Care in 2015. The Board facilitated the development of a National Model of Care for Paediatric Healthcare in Ireland in 2010. The national model of care will establish the role of the new children’s hospital in a network of paediatric care delivery throughout Ireland.
Age cut-off for access to the new children’s hospital

The cut-off age for access to the new children’s hospital was approved by the HSE, the Faculty of Paediatrics, RCPI and the Department of Health and Children. Access is planned for:

1. Care of all children up to their 16th birthday;
2. Care of children between the ages of 16-18 years who are already patients of the hospital and support of them during their transition to adult services and;
3. Care of children aged 16-18 years, not already patients of the children’s hospital, where there is a clinical indication that they should be treated in a paediatric hospital.

There are specific areas where flexibility in the above criteria is in the best interests of young people. This applies in particular to young adults with severe disability who often continue to attend paediatric units into their third decade. There is a requirement for the development of more appropriate facilities for these young people in adult hospitals. Another area is in relation to inpatient child and adolescent mental health care, for children between the ages of 16 and 18 years. The 20 bed child and adolescent mental service inpatient unit in the new hospital will form part of a national network of inpatient units. Access to this specialised inpatient unit is governed by mental health legislation.

Implementation of the new children’s hospital model of care

An implementation guidance document will be developed identifying the specific actions required, the agency / role responsible for implementation and a proposed timeline.
SECTION 2: MODEL OF CARE for the new children’s hospital

Introduction
The new children’s hospital offers a unique opportunity for the people of Ireland to develop a hospital that will define what is best in health care provision for children and will contribute to the care of children in the community as well as those who need to be in hospital.
The new children’s hospital is formed by the merging of the existing three Dublin children’s hospitals to provide national tertiary care for the whole of Ireland including and secondary care for the greater Dublin region across two sites. The new hospital will provide service to, and care for, the children and young people of Ireland.

Definition of Model of Care

A Model of Care is a clinical and organisational framework for how and where healthcare services are delivered, managed and organised. The term model of care covers both methods of care at the individual patient level and the clinical and organisational framework at a unit, hospital and state-wide level. This is based on current best practice and evidence, but as this is organic, may change and develop further in the future and should involve a programme of ongoing innovation and an institutional framework which ensure the involvement of clinicians at all stages.

Principles underpinning the model of care

The following principles will underpin child health service delivery in the new children’s hospital and the hospital’s satellite centres:

- Child-centred and family-focused care;
- Patient safety and quality of clinical care; and
- A rights-based service.

Child-centred and family-focused care means that the service delivery must:

- Involve families/carers in the care of the child or young person;
- Value user’s feedback; and
- Involve children, young people and their families in service planning and development.

Patient safety and quality: means that the service will provide high quality, equitable and safe care to children, young people and their families that will be benchmarked with comparable best international and national services, including adult services where appropriate.

A rights-based service will respect the rights of children and young people under the UN Convention of the Rights of the Child. In accordance with Article 19 of that Convention, the service will take all appropriate measures to protect the child from all forms of physical and mental violence, injury and abuse, neglect and negligent treatment, maltreatment and
exploitation, including sexual abuse. The service will develop its policies, procedures and practice in accordance with Children First – National Guidelines for the Protection and Welfare of Children.

The new children’s hospital will:

- Treat children and young people in an age-appropriate manner;
- Transfer young people from paediatric to adult services, where required, in a structured and planned manner;
- Recognise and respect diversity in the children and young people it treats; and;
- Ensure equity of access for all children and young people.
SECTION 3

This section describes the overall vision for the hospital, the principles underlying the model of care and the model of care for the different areas of service (in-patient, day Care, OPD, emergency and urgent care) planned for the hospital and A&UCC.

Overall Vision for the Hospital

- That the hospital should rank among the best children’s hospitals in the world in terms of the quality of care delivered. This quality will be defined in terms of:
  - Safety of care
  - Clinical outcomes
  - Quality of care
  - Patient experience
  - Staff experience
  - Research
  - Teaching, training, learning and development
- That the service will provide value to patients, their families and the health service.
- That the service will be a caring service with the child and family at the centre.
- That each child should receive the highest quality of care every time, from the first time, in the new children’s hospital.
- An ability to educate and train paediatric specialists of all disciplines in Ireland
- The hospital being able to attract and retain excellent and committed staff.
- The hospital setting standards and leading the way in paediatric health care delivery in Ireland in a transparent manner committed to safe, high quality care
- The people of Ireland being proud of their new national children’s hospital.

Overriding Principles

1. Plan, Design and Build for the future
   Not on how we deliver care now which may be out of date by the time the hospital has been built.
2. Provide a 7 day hospital service
   There should be an equal opportunity of receiving the highest standard of care every day of the week. The quality of care should not decrease at the weekends.
3. Embed quality and safety in the design and aim for high reliability
   There must be a drive to improve quality based on the six domains of quality (Institute of medicine 2001: Safety; Effectiveness; Efficiency; Patient-Centeredness; Timeliness; Equality).
4. Transparency supports change and improvement. The hospital must demonstrate to the public what is being measured and how the hospital is performing in relation to its stated aims. Productivity and safety will improve as a result of improvement in quality.
5. Reliability is required in order to work to zero harm.

Reliability means that the child gets the treatment needed, when it is needed, how and where it is wanted – every time. There is a balance between what is wanted and what is needed.

6. **Appropriate use of ICT**
   
   Data is the most important driver of change. Data should be used for quality improvement. Standardisation of care processes across the health care system is critical to drive safe and efficient care. A successful IT based system depends upon standardisation of clinical processes. A modern IT system is required to deliver safe care across the three sites and to optimise the delivery of safe, high quality clinical care in the new children’s hospital and in the new children’s hospital satellite centres. This IT system must include a comprehensive electronic patient record system, order communications and electronic prescribing.

7. **Apply Management Operations Theory**
   
   The new children’s hospital must work towards reduction in, and where possible, the elimination of variation. Variability methodology, inventory control and queuing theory will be used. (Reference Litvak)\(^6\)

8. **Build general secondary care paediatrics**
   
   A high quality, safe children’s hospital requires a comprehensive secondary care service with high quality secondary care clinicians working with nursing colleagues and health and social care professionals within multi-disciplinary teams. Secondary paediatric issues are not referred to specialist tertiary paediatricians.

9. **Standardised care will be essential to improve reliability**
   
   This is facilitated by agreed protocols and integrated care pathways, based on best available evidence, for the wide range of secondary and specialist paediatric conditions.

10. **Long term conditions**
    
    There is an increasing demand for care for children with complex long term conditions. We shall use the principles of the chronic care model and medical home\(^7\). This involves the expansion of the role of community based paediatricians and outreach programmes with specialist nursing and health and social care professionals that support children with chronic illnesses and their families in their home.

11. **Education and Training**
    
    We must train the healthcare students for the future.

12. **Research**
    
    Child health care research is a crucial element within a high quality hospital and will be co-ordinated and supported from the new children’s hospital.

13. **Advocacy**
    
    The hospital will act as an advocate for the right of the child to equity in access to healthcare and good outcomes.


\(^7\) [http://www.improvingchroniccare.org](http://www.improvingchroniccare.org) or AAP website [http://www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)
**In-Patient Care**

The responsibility of the hospital is to provide acute and chronic, secondary general and specialist tertiary and quaternary care.

**Inpatient Care Principle 1: Do what is best for the child**

- Services are arranged around the needs of the child and family.
- Age appropriate services are delivered to all children and young people
- Transition to adult services for young people with long term conditions is carried out according to established protocols.
- The needs of the older, young person with disability are identified, and met, within this hospital while promoting the development of appropriate services in the adult hospitals.

**Inpatient Care Principle 2: Consultant delivered care on a daily basis**

- Every child in a hospital bed is seen by a consultant every day (the minimum standard).
- Children with complex, multi-system conditions may benefit from the inclusion of a secondary general and/or community paediatrician in their care. Criteria for such involvement will be established.
- Within clinical specialities, there is team of consultants working to agreed protocols and pathways, i.e. one consultant, within the same team, can discharge another consultant’s patient to assist with the prevention of delayed discharge among other efficiency gains.
- The responsibility to train future paediatricians must not compromise patient care. Trainees are supported and supervised by consultants in their clinical work.

**Inpatient Care Principle 3: No delay in discharge**

- A child who is ready to go home goes home without delay.
- Discharge planning starts before admission, for all planned admissions, and on admission for emergency, unplanned admissions providing a date and time for planned discharge. Clinicians of senior decision-making capacity must be in the hospital every day. The team working described requires integrated care pathways, agreed discharge criteria and empowerment of all members of the professional teams including pharmacy, HSCP’s and nursing. This enables smaller sub-specialties to be covered at all times.

**Inpatient Care Principle 4: Actively work to eliminate waste – (Management Operations Theory)**

- Emergency beds and elective planned beds will operate separately so that planned admissions and emergency admissions do not compete for the same resource and this is established in the bed management policy for the new children’s hospital.
- Emergency bed utilisation will be at a lower rate than that of elective bed utilisation.
- Secondary care will work closely with the Emergency Department with decision making being made by appropriately trained front line staff.
- Smaller tertiary subspecialties will be supported by merging to form larger teams working to agreed guidelines and pathways.
- Acceptable and sustainable on call rotas are required.
- Service and training require attention so that trainees are supported in their development of clinical decision making while patients continue to receive consultant level care.
- Trainees are taught leadership skills, business skills and performance monitoring.
- Support for a 7 day hospital will be determined by the dual aim of providing consistent quality and value for money, e.g. cost benefit analysis of the availability, or not, of weekend diagnostics e.g. MRI.
- The service will aim to allow for the use of standardised care delivered by an appropriately trained professional.

**Inpatient Care Principle 5: All patients to have documented daily care plans**

- In order to enhance flow and safety, as well as clinical outcomes, every patient in the hospital will have a documented daily care plan.
- Central oversight is essential – the Chief Operations Officer must know what is happening at all clinical levels within the hospital and hospital satellite centres.

**Inpatient Care Principle 6: Ward configuration**

The configuration of the inpatient units in the new children’s hospital is based on clinical activity and on the following principles: of emergency and planned care:

- The separation of children with acute, secondary general medical and surgical illnesses and those with complex tertiary/quaternary conditions.
- The acuity of the child’s illness will be the chief determinate of the level of care they receive.
- Recognition of the vulnerability of the child.
- The need to accommodate children with complex conditions together because of their requirement for specialist medical/nursing care and/or equipment and,
- Co-location of children, where possible and appropriate, based on the age of the child.

**Inpatient Care Principle 7: Avoidance of need for emergency resuscitation**

- Paediatric clinical early warning systems (PEWS) will be in place in order to prevent the need for unexpected emergency resuscitation.
- A rapid response or outreach team will serve to intervene to prevent deterioration.
- A team will be assigned to attend and manage resuscitation events within the hospital.

**Planned Ambulatory Services**

Almost 90% of the clinical care delivered in the three children’s hospital is ambulatory care, both planned and unplanned. Planned ambulatory care, out-
patient clinics and day care procedures, account for the greater part of this service.

**OPD Care Principle 1: Matching demand for services with provision of clinical services to decrease delays - Use of Advance Access Methodology**

The aim is to improve access so that referred children are seen within an appropriate, and patient acceptable, wait time. This method is very patient-centred and very referrer-centred with the aim of all referrals being are seen promptly. There are standards set and monitored by the HSE in relation to this quality criterion. The new children’s hospital intends to match and where possible improve on the national standards.

**OPD Care Principle 2: Care as close to home as possible**

The hospital “front door” should be as close to the patient’s home as possible. The new children’s hospital satellite centres will provide ambulatory secondary care close to patients’ homes in the greater Dublin area. Out-reach and shared care will be standard. This includes both the physical presence of the specialist in regional clinics and/or direct electronic engagement with patients and their families. Home-based care will be actively pursued so as to support the child and family in their own home.

**OPD Care Principle 3: Specialist clinics embrace shared care**

There will be shared care arrangements with secondary general paediatricians, both within the new children’s hospital and in the regional hospitals in order to reduce return attendance at specialist clinics. A complete pathway and/or a shared care system will be in place on discharge from a specialist service back to the community.

**OPD Principle 4 Equity of access and care**

Referrals to tertiary care will come only from secondary consultant paediatricians in new children’s hospitals and in the regional hospitals. Nationally, general paediatricians see and treat most children and determine which children should, following assessment, be referred to tertiary specialists. On occasion, for specific conditions, direct referral to tertiary care will be appropriate as per agreed protocols.

**OPD Principle 5: Outpatient services are delivered by consultant led teams**

There will be sharing of care within the specialist teams thereby demonstrating to the family that their child is under the care of a multi-disciplinary team including consultants, nurses and HSCP’s thereby teaching trainees and students a new, improved way of working.

**OPD Principle 6: Outpatient services are delivered by the MDT**

The multi-disciplinary team under the governance of a team of consultants, will allow children and families access medical, nurse-led and health and social care professional clinics and services as appropriate in OPD.

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Emergency Paediatric Medicine

The new children’s hospital will provide emergency care and urgent care at the new children’s hospital on the St James’s Hospital campus and urgent care in the new children’s hospital satellite centres at Tallaght and Blanchardstown Hospital campuses. The clinical care delivered at each location will be safe and of high quality and delivered by appropriately trained health professionals. The care delivered at new children’s hospital on the St James’s Hospital campus Emergency Department will be more specialised because of the larger numbers attending and because of the agreed bypass policy for ambulances carrying children who are critically ill and/or victims of significant trauma directly to the new children’s Hospital Emergency Department on the St James’s Hospital campus. The hospital’s Emergency and Urgent Care Policy will outline the conditions suited to treatment at the urgent care centres and will identify those children who should proceed directly to the Emergency Department. There will be clear protocols and pathways for these conditions. There will be an intensive education programme to indicate to parents and to health care professionals where they should attend with different clinical conditions. There will be information available in paper form and on the new children’s hospital website at all times. Should children who are seriously ill or injured self-present to the new children’s hospital satellite centres at Tallaght and Blanchardstown Hospital campuses, they will be stabilised and transferred to the base hospital for ongoing care.

Philosophy of care

1. There will be cover at a senior decision making level on all sites at all times.
2. There will be no delay in assessing the acuity of the child and no unnecessary delay in the treatment of any child.
3. The decision to admit a child from the emergency department and the satellite urgent care centres is the responsibility of the emergency teams at which time care is transferred to the acute inpatient teams.
4. Children, acutely unwell, requiring admission from the emergency department and/or the urgent care centres will be guaranteed admission to the appropriate unit at the new children’s hospital on the St James’s Hospital campus.
5. When required, a specialist second opinion will be provided to the emergency department and the urgent care centres without delay.

Effective care

1. It is acknowledged that the emergency department and the urgent care centres will deliver different levels of care based on clinical need.
2. Effective emergency management is the ability to provide the child with the care s/he needs, when s/he needs it, every time.
3. The clinical staff will have the skills required to stabilise any child who presents to the emergency department or the urgent care centres.
4. There will be a competent decision maker present in the units at all times. A competent decision maker is someone who can make the correct clinical decision and provide the appropriate treatment at that time.
Efficient care

1. Severely ill children will not compete for clinical attention with children who are less ill. There will be separate streams for children who are critically ill and for those who are less seriously unwell.
2. No child, whatever the severity of his/her illness, will have an unnecessary wait. Clinical care at all units will be timely, efficient, safe and transparent. A child will be seen by a decision making clinician without a delay which might affect clinical outcome.
3. There will be appropriate access to timely diagnostics (lab and radiology) on all sites. Emergency patients will not compete with inpatients or outpatients for access to these facilities or vice versa.

Training

There will be an active skill maintenance programme at both departments with regular assessment of competence.

Transport

There will be clinically appropriate transport for transfer of patients from the new children’s hospital’s satellite centres at Tallaght and Blanchardstown Hospital campuses to the base hospital at the St James’ campus.

DAY CARE PROCEDURES

1. Children requiring a longer recovery time are scheduled for procedures earlier in the day allowing for same-day discharge and avoidance of unnecessary admission.
2. Emergency surgery will not displace elective, planned surgery (through the provision of emergency theatres and a rules based theatre booking system).
3. Following day surgery, or a medical day procedure, the patient/family is phoned when clinically appropriate, according to protocol.

Philosophy and principles supporting the new children’s hospital and the hospital’s two satellite centres

1. Senior clinicians will provide clinical leadership on all sites.
2. The quality of care for the same condition will be the same on all sites. There will be standardisation of care with one set of protocols, one set of values and one set of standards.
3. There will be equal status for equivalent management posts at both sites
4. The hospital, at all sites, will have a very clear brand both for those who attend the hospital for clinical service but also for those who work within it – this is the brand of the new children’s hospital.
Patient Centred Care

1. The aim is to provide high quality care close to the patients’ home for all specialties.
2. Care will be provided based on clinical need.

Safety

1. In order to maintain skills, and to enhance team working, there will be rotation of staff between the new children’s hospital at the St James’s Hospital campus and the new children’s hospital satellite centres at Tallaght and Blanchardstown Hospital campuses. Skills and team-working are central to maintaining high standards of care. This will involve scheduled rotation of staff, including physicians, as well as maintaining some permanent (non-clinical) staff at each site.
2. Clinical staff will not be expected to do two jobs or have competing clinical responsibilities – i.e. be in two places at once. ICT will assist with communication between all sites to ensure communication with the right person at all times.

Outpatient Service Delivery on 3 Sites

1. There will be a consistent clinical standard and quality of care and safety on all sites.
2. The quality of facilities will equal on all sites.
3. There is a commitment to the provision of high quality care close to the patients’ home for all specialties.

EDUCATION

1. The hospital will be the main site for specialist paediatric training in Ireland.
2. All staff will be committed to teaching and training.
3. Education is key at all levels – there is a need to educate/train primary care; families and patients and try to keep children out of hospital.
4. Improvement and safety methodology training will be core modules in the education programme.
5. Senior members of staff will participate in simulation exercises alongside trainees.
6. Paediatricians (and clinical support staff) from across Ireland can utilise the facilities at the children’s hospital for CPD.
7. The learning and development strategy will produce skilled staff competent in the areas of leadership, business training, and will support directorate teams.
8. Regular use of simulation is essential.
RESEARCH

1. To rank as a world class paediatric institution the new children’s hospital must foster a culture of research to evaluate the care it provides, to develop new treatments for children, and provide insight and understanding into paediatric disease and in so doing advance the health and welfare of the children of Ireland.

2. The new children’s hospital must be proactive in encouraging research in all aspects of the care it provides and across all care pathways.

3. All models of care at the new children’s hospital need to be underpinned by systematic clinical enquiry, which is research based, in order to improve the understanding of the disease process and the factors which contribute to the health and happiness of children.

4. Clinical practice is a dynamic, ever changing, ever-improving process. In this environment it is important that new children’s hospital can, and is able in the future, to effectively evaluate the quality of care it provides for children. The new children’s hospital will be in a unique position to evaluate these new models of healthcare in paediatrics, and provide peer-reviewed research evidence which will inform and benchmark best practice internationally for the care of children.

5. Providing the best, most efficient and compassionate care for the children of Ireland requires an overarching research philosophy which will combine translational and clinical enquiry, treatment/technology improvements and effectiveness evaluation and health services research.

6. There is significant overlap in the infrastructure and expertise required to develop these three strands of clinical research but with appropriate support, the outcomes will exceed the sum of the parts. Health services effectiveness research will drive the quality of all aspects of care at the new children’s hospital which in turn will facilitate systematic observation which is the hallmark of new insights into the disease process.
APPENDIX 2: International examples of web-based advice to parents on whether to attend an urgent care centre or emergency department

Children's Hospital Colorado

1. When it’s okay to go to urgent care

(These are guidelines; if at any point you believe your child needs immediate emergency care, take him or her to the emergency room or call 911):

- Anything that does not appear to be life threatening
- Any routine acute illness or injury
- Simple lacerations
- Your child has sustained a head injury but is acting normally and not vomiting
- Your child has swallowed something and is not having difficulty breathing
- Normal headaches or migraines (without numbness, tingling or weakness)
- Sprains, strains and fractures (unless bone is sticking out)
- If your child has ingested something you believe is dangerous, call Poison Control first. They can oftentimes direct you where to go and might be able to alert the urgent care facility or emergency room of your arrival.
# Seattle Children's
## Emergency or Urgent Care?

When your child needs medical care and can’t wait until your doctor’s office opens, where should you go?

This chart will help you know whether a visit to Urgent Care or the Emergency Department is best. UrgentCare is not intended for emergencies, but is appropriate for minor illnesses and injuries.

**Remember, if your child's illness or injury is life-threatening, call 911.**

### Have Billing Questions?
Seattle Children's bills a facility charge for hospital-based clinics. Effective July 1, 2013, Seattle Children's reduced the urgent care facility fee associated with visits to any of our Urgent Care Clinics. By choosing urgent care, you will likely have lower out-of-pocket expense than a visit to the Emergency department. Learn more about your bill at www.seattlechildrens.org.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Urgent Care</th>
<th>Emergency Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Urgent Care</td>
<td></td>
</tr>
<tr>
<td>Asthma attack (minor)</td>
<td>Urgent Care</td>
<td></td>
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<tr>
<td>Asthma attack (severe)</td>
<td>Urgent Care</td>
<td></td>
</tr>
<tr>
<td>Bleeding that won't stop</td>
<td>Urgent Care</td>
<td></td>
</tr>
<tr>
<td>Broken bone (bone sticking out of skin)</td>
<td>Emergency</td>
<td></td>
</tr>
<tr>
<td>Broken bone (not sticking out of skin)</td>
<td>Urgent Care</td>
<td></td>
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<tr>
<td>Bronchitis</td>
<td>Urgent Care</td>
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<tr>
<td>Burn (severe)</td>
<td>Urgent Care</td>
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<tr>
<td>Burn (minor)</td>
<td>Urgent Care</td>
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<tr>
<td>Cast problem (soiled or wet)</td>
<td>Urgent Care</td>
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<tr>
<td>Colds</td>
<td>Urgent Care</td>
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<tr>
<td>Cough</td>
<td>Urgent Care</td>
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<td>Cut (severe)</td>
<td>Urgent Care</td>
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<td>Cut (minor)</td>
<td>Urgent Care</td>
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<td>Dehydration</td>
<td>Urgent Care</td>
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<tr>
<td>Dizziness</td>
<td>Urgent Care</td>
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<tr>
<td>Earache and ear infection</td>
<td>Urgent Care</td>
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<tr>
<td>Fainting</td>
<td>Urgent Care</td>
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<tr>
<td>Fever (infants less than 2 months old)</td>
<td>Emergency</td>
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<tr>
<td>Fever (children over 2 months old)</td>
<td>Urgent Care</td>
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<tr>
<td>Headache</td>
<td>Urgent Care</td>
<td></td>
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<tr>
<td>Head injury (minor and without loss of consciousness)</td>
<td>Urgent Care</td>
<td></td>
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<tr>
<td>Head injury</td>
<td>Urgent Care</td>
<td></td>
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<tr>
<td>Insect or minor dog bite</td>
<td>Urgent Care</td>
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<tr>
<td>Migraine headache</td>
<td>Urgent Care</td>
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<td>Nausea</td>
<td>Urgent Care</td>
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<td>Pink eye</td>
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<td>Pneumonia</td>
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<td>Poisoning</td>
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<td>Rash</td>
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<td>Seizure</td>
<td>Urgent Care</td>
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<td>Shock</td>
<td>Urgent Care</td>
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<tr>
<td>Sunburn</td>
<td>Urgent Care</td>
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<tr>
<td>Sprain or strain</td>
<td>Urgent Care</td>
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<tr>
<td>Stitches</td>
<td>Urgent Care</td>
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<tr>
<td>Stomach pain (mild)</td>
<td>Urgent Care</td>
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<tr>
<td>Stomach pain (severe)</td>
<td>Urgent Care</td>
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<tr>
<td>Swallowed object</td>
<td>Urgent Care</td>
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<tr>
<td>Trouble breathing</td>
<td>Urgent Care</td>
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<tr>
<td>Urinary infection</td>
<td>Urgent Care</td>
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</tbody>
</table>
Urgent Care

Urgent Care Locations

Liberty Campus – Now Open!
7777 Yankee Road
Liberty Twp., Ohio 45044
513-636-7774
Mon – Fri: 6 pm – midnight
Sat, Sun & holidays: Noon – midnight

Burnet Campus (Main Hospital)
3333 Burnet Avenue
Building B, 3rd Floor
Cincinnati, Ohio 45229
513-803-1191
Mon – Fri: 3 pm – midnight
Sat, Sun & holidays: Noon – midnight

Anderson
7495 State Road, Suite 355
Cincinnati, Ohio 45255
(In Mercy Center for Health & Wellness)
513-636-6111
Mon – Fri: 6 pm – 11 pm Closed holidays
Sat – Sun: Noon – 7 pm

Green Township
5699 Harrison Avenue
Cincinnati, Ohio 45248
513-803-8271
Mon – Fri: 6 pm – 11 pm Closed holidays
Sat – Sun: Noon – 7 pm

Mason Campus
9660 Children’s Drive
Mason, Ohio 45040
513-636-5790
Mon – Fri: 6 pm – 11 pm Closed holidays
Sat – Sun: Noon – 7 pm

Cincinnati Children’s Hospital Medical Center offers Urgent Care services at locations all over town to provide families with easy access to the pediatric expertise provided by our world-class hospital.

Contact Your Doctor First:
Because your child’s primary care provider knows your child best, we do encourage you to see your child’s primary care physician whenever possible for the types of illnesses and injuries we treat in Urgent Care — that’s why our Urgent Cares are open during evenings and weekends only.

Our Urgent Care Facilities Offer:
• Walk-in service: no appointment needed
• Expert pediatric care for a wide variety of minor illnesses and injuries for children and adolescents
• Five locations for easy access
• Lower costs than traditional emergency visits (with lower co-pays)

How We’re Different
• Our Urgent Care doctors and nurses are specially trained in pediatrics and are the same experts who treat children at our main hospital’s Emergency Department (recently ranked #2 in the nation for emergency care by Parents Magazine).
• We report back to your child’s primary care physician after your visit.

24-Hour Emergency Services
For more serious or life-threatening injuries or illnesses, 24-hour emergency care is available through the Emergency Department at the Burnet (Main) and Liberty Campuses.

For wait times at all of our Urgent Care locations, TEXT “ccurgent” to 437411.
# Where Should I Go?

**Contact Your Doctor First**

We co encourage you to see your child’s primary care provider whenever possible for the types of illnesses and injuries we treat in Urgent Care—that’s why our Urgent Cares are open during evenings and weekends only.

<table>
<thead>
<tr>
<th>Urgent Care/Primary Care Provider</th>
<th>Emergency</th>
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<tbody>
<tr>
<td>Allergic Reaction (Severe)/Anaphylaxis</td>
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<tr>
<td>Allergies</td>
<td>●</td>
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<tr>
<td>Asthma Attack (Minor)</td>
<td>●</td>
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<tr>
<td>Bleeding That Won’t Stop</td>
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<tr>
<td>Broken Bone (Skin Intact)</td>
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<tr>
<td>Broken Bone (Bone Sticking Out of Skin)</td>
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<tr>
<td>Burn (Minor)</td>
<td>●</td>
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<td>Burn (Severe)</td>
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<td>Cest Problems (Wet or Soiled)</td>
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<td>Colds</td>
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<tr>
<td>Insect or Minor Dog Bite</td>
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<td>Nausea/Vomiting</td>
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<td>Pink Eye</td>
<td>●</td>
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<td>Shock</td>
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<td>Sore Throat</td>
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<tr>
<td>Vomiting</td>
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</tbody>
</table>

These are general guidelines to help parents make healthcare decisions for their children. Please contact your primary care physician to receive personalized guidance for your current situation.

For wait times at all of our Urgent Care locations, TEXT “ccurgent” to 437411.
The PANDA Unit (Paediatric Assessment and Decision Area) provides dedicated emergency and short stay care for children less than 16 years of age.

This is a consultant-led service within which children can be assessed, investigated, observed and treated within 24 hours and without recourse to inpatient areas. The unit also provides a Tier 2 Paediatric referral service for residents of Salford, or those patients with a Salford GP.

Gate-keeping by Paediatric and Emergency Medicine Consultants ensures that over 96% of attendees are currently discharged home direct from the Panda Unit.

Early discharge is supported by a dedicated team of children’s community nursing staff that support integrated care between Panda and primary care services.