IN THE MATTER OF AN APPLICATION TO
AN BORD PLEANÁLA
FOR PERMISSION FOR
STRATEGIC INFRASTRUCTURE DEVELOPMENT
(THE CHILDREN'S HOSPITAL OF IRELAND)

ABP Reg. No. PL29N.PA0024

AND IN THE MATTER OF AN ORAL HEARING

Submission by Dr Fin Breatnach
on behalf of The New Children's Hospital Alliance

1. Qualifications and Experience

1.1 My name is Dr. Fin Breatnach. I am a retired Consultant Children's Cancer Specialist having been appointed in 1981 as Ireland's first resident Consultant in this specialty with sessional commitments at St. Luke's Hospital, Rathgar (2), The Children's University Hospital, Temple Street (2) and at Our Lady's Children's Hospital in Crumlin (7). I remained as Ireland's only Children's Cancer Specialist for thirteen years and took early retirement in 2008.

1.2 I graduated from UCC (MB, BCh, BAO) in 1972 and interned in Cork. My paediatric training began at the Mercy University Hospital, Cork in 1974 and continued over the next seven years in the United Kingdom, the final three years of which were spent in the Hospital for Sick Children, Great Ormond Street, London as a Senior Registrar in Paediatric Oncology.

1.3 I successfully passed the Paediatric Membership examination of the Royal College of Physicians of the United Kingdom in 1978 and was elected as a Fellow of The Royal College of Physicians of Edinburgh in 1993.

1.4 During my working life I have been a member of the United Kingdom Children's Cancer Study Group, the Children's Cancer and Leukaemia Group, the Irish Paediatric Association, the Irish Association for Cancer Research, the Faculty of Paediatrics, Royal College of Physicians of Ireland, the Johnson & Johnson European Fund for Children's Health which I Chaired, the International Histiocyte Society, founder member of the European Neuroblastoma Study Group and Ireland's representative on the European Union Committee on Paediatric Oncology.

1.5 I acted, in a voluntary capacity, as Medical Director of the children's charity Barretstown from its foundation in 1994 until November of last year. I was appointed to the Board of Directors of Barretstown as Vice Chairman in 1995 and, following my retirement as a clinician, became CEO of Barretstown in October 2008. I retired from that position in December 2010.

1.6 At the invitation of Michael Martin, who was Minister for Health at the time, I became a member of the National Forum for Cancer Services from 2001 to 2007.

1.7 I built much of the infrastructure of the current National Haematology/Oncology Centre through fundraising over a twenty six year period and helped develop the national service.

1.8 In my current capacity, I am representing the New Children's Hospital Alliance and am pleased to have this opportunity to highlight some of the concerns of our group in relation to the current proposal. Our Alliance (NCHA) is a group of Health Professionals, parents, grandparents and other interested persons from all over Ireland who wish to ensure that the correct decisions are taken regarding the location of the New National Paediatric Hospital.

2. Choice of location:

2.1 In 1993, the Faculty of Paediatrics endorsed the concept of a single, tertiary Paediatric hospital for the Republic of Ireland, to be based in Dublin. Our Alliance wholeheartedly supports this concept. As there were no apparent initiatives undertaken in relation to this on the part of the then Government, Temple Street hospital entered into discussion with the Mater hospital with a view to transferring their hospital to the Mater site. Some years later, Our Lady's Children's Hospital began to look at the possibility of redeveloping their hospital on its current site. Following his appointment as CEO of the HSE in September 2005, Prof. Brendan Drumm, with the support of the Minister for Health, initiated a national review of Tertiary Paediatric services. In the following month, before the McKinsey report was commissioned, Prof Drumm addressed the Oireachtas Joint Committee on Health and stated that "while I cannot make a determination in advance of a detailed planning process, the centre (National Paediatric Hospital) should ideally be in the city centre or close to the Mater site"!

2.2 McKinsey were commissioned in Dec 2005 to prepare a report advising on the "strategic organisation of tertiary paediatric services for Ireland" and reported in February 2006 recommending the amalgamation of the services of all three children's hospitals into a single centre and suggested that the following assessment criteria be used to find the best location for such a facility:

2.3

PROPOSED ASSESSMENT CRITERIA

1. Space	• Ability to meet projected tertiary and secondary needs (including potential to accommodate research and education facilities)
2. Breadth and depth of services	• Centre should offer the following services: – Sub-specialist capability across the 25+ core sub-specialties: Medical - Anaesthetics, Cardiology, Endocrinology, General Medicine, Genetics, Haematology, Immunology, Infectious Diseases, Intensive care, Neonatology, Nephrology, Neurology, Oncology, Opthamology, Pathology, Radiology, Respiratory +/- allergology, Rheumatology, Microbiology and clinical chemistry; Surgical - Cardiothoracic surgery, ENT surgery, Gastroenterology/GI/ hepatobiliary surgery, General surgery, Neurosurgery, Orthopaedic surgery, Transplant surgery, Urology – A patient and family focused environment and services; including accommodation and schooling learning from recent best practice trends (e.g. parent and child rooms % single rooms)
3. Co-location	• The preferred option would be co-location. If so, needs to be specific about level of integration and sharing of services. If not co-located, need to be specific about how to address the challenges of isolation from adult services
4. Access	• Comprehensive outreach programme with other hospitals providing in-patient paediatric services in critical sub-specialties • National retrieval plan and ambulance diversion protocol for Dublin • Clear referral protocol and supporting liaison with Dublin A&E centres • Provision for "hospital hotel" facilities and family accommodation on site • Good public transport and road links
5. Efficient use of resources	• Parking for families and staff • Sufficient activity levels to support 24/7 cover in key sub-specialities and other multi-disciplinary support services
6. People - attract and retain	• Appropriate sharing of diagnostic equipment and other operational services • Attractive work environment and interesting career opportunities
7. Teaching and research	• Clear Children's Hospital 'brand' • Strong integration with under graduate and post graduate training programme, especially in medicine and nursing • Mandate to pursue clearly defined research agenda as part of child care mission, building upon the best of what is already ongoing and ensuring alignment with Ireland's long term research and innovation goals
8. Financial stability	• Brand and associated governance status to enable fundraising for research • Sufficient budget to manage complete services and range of sub-specialties within hospitals including necessary outreach and retrieval programme and additional sub-specialists as appropriate
9. Full project plan and role assessments	• Budget to reflect likely trend to higher case mix index • Credibility of proposal including ability to execute capital project and willingness to address roles, in particular with respect to cooperation with other providers (e.g. A&E) and to support integration with adult services where there are clear benefits

Beyond the above assessment criteria, further work will be required to define the mission and role of each of the non-Dublin hospitals as part of one integrated national paediatric service.

3. Selection of Site:

3.1 A Joint Task Force on Location was established in Feb 2006 and reported in June 2006. Its membership consisted of representative of the Health Service Executive and Department of Health and Children, with input from the Office of Public Works. All members of the Task Force were Civil Servants and **none** worked in a children's hospital. They selected the Mater site with **no** National Model of Care to guide site selection, **no** Cost-Benefit analysis performed (to this day!), **no** work-force planning and misinterpretation of the McKinsey report by insisting that co-location with an adult hospital was a non-negotiable criterion, thereby excluding certain sites from being considered. The priority of co-location with a maternity hospital, as exists at many locations worldwide, was not given any consideration. **No** scoring system was employed. There was **no** public consultation. There was **no** site visit. **No** paediatricians, children's hospital doctors or paediatric healthcare professionals of any kind were involved in the site-selection process which was strikingly different from the processes involved in selecting the sites for other children's hospitals e.g. the new Alder Hey Children's Hospital in Liverpool and the new Children's Hospital in Melbourne where one full year of discussion with staff and parents preceded the selection process. In fact, the process employed in selecting the Mater site totally lacked transparency. The only public consultation concerning the chosen site that I am aware of was by way of media polls – one was undertaken by Joe Duffy of RTE where, without advance warning, he offered a text poll over a ten minute period with a simple question "Are you in favour of the new National Children's Hospital being built on the Mater Hospital site"? The response was the largest he had encountered in this type of survey, indicating the enormous public interest in this issue. Over the allocated ten minutes, 15, 438 responded (25.73 texts/second) with only 11% in favour of the Mater site and 89% against. The Irish Times also conducted a poll which resulted in 83% of respondents voting against the chosen site. In another poll of medical consultants around the country, conducted by the Sunday Business Post, 70% opposed the Mater site, with only 13% supported it and with17% "Don't knows". In addition, letters published in the National Press have overwhelmingly rejected the site.

4. Radiation Oncology Report:

4.1 It is important to recall that before the Task Force selected the Mater site in June 2006, another report was presented just 17 months earlier in January 2005 to the Minister for Health Mary Harney and subsequently endorsed by her. That report was entitled **"Optimum Locations for the Development of Radiation Oncology Services in the Eastern Region of Ireland, North and South"**. The existing Radiation services at St. Luke's Hospital, Rathgar were to transfer to two sites, one in North Dublin and the other in South Dublin. The Department of Health were represented on this six member panel by the Chief Medical Officer, Dr. Jim Kiely and the Deputy Chief Medical Officer, Dr. Tony Holohan. The then Eastern Regional Heath Authority was represented by their Director of Planning, Ms. Angela Fitzgerald. The International members of the panel appropriately consisted entirely of Radiation Oncologists – Prof. Ann Barrett, Dean of Clinical Oncology at the Royal College of Radiologists, London (Nominee of the CMO, DoH, UK), Dr. Eli Glatstein, Consultant Radiation Oncologist (Nominee of the US National Institute for Health) and finally, Dr. Piet-Hein van der Giessen, Expert in Radiation Oncology Physics (Nominee of the European Society for Therapeutic Radiology and Oncology). The Panel was chaired by Prof. Barrett. To allow for full transparency regarding their decisions, they employed a scoring system. The expertise of this panel and the methodology of their approach are in stark contrast to that of the Task Force on Location.

4.2 In commenting on the strengths and weaknesses of Beaumont Hospital and the Mater Hospital, both of whom had submitted bids for the North City Radiation Centre, the Panel commented that it was their view that "the logistical capacity (in terms of space, lack of site constraints, parking and access) of Beaumont Hospital to deliver the model of radiotherapy requested would be greater than that of the Mater MUH". I would also like to draw your attention to the table below in which I have combined the scores concerning site suitability for both North and South Dublin.

4.3 In this, the Panel are scoring the:

Extent to which the hospital site can satisfactorily and efficiently accommodate radiation oncology and necessary support facilities (including linear accelerators, simulators, scanners, education and training facilities, parking, hostel and in-patient accommodation, catering etc.). Total Marks Available = 25

Tallaght	St. James's	St. Vincent's	Beaumont	Mater
23.5	**23**	**23.5**	**24**	**18.25**

As you can see, the Mater site received by far the lowest score. When informed of the decision to locate the National Paediatric Hospital on the Mater site by a Sunday Times Journalist on the 28th of August, 2010, the Chair of the Panel, Prof Barrett said she was "shocked" to learn this. She went on to say that "The issues that came up when we were considering a regional oncology site are even more relevant in the context of a national children's hospital. I'm talking about the shortage of space on the site and the difficulty of access. There are no open green spaces and it will be difficult for parents trying to get to it with sick children. When you're ill, you need to not have that stress of trying to find somewhere to park". I would like to remind you that the numbers of patients requiring radiation therapy is a tiny fraction of those requiring access to the proposed children's hospital.

5. Co-location:

5.1 McKinsey noted that :

- There are benefits from co-location in broadening services, making efficient use of resources and in teaching and research.
  - **Breadth of services**. A tertiary paediatric hospital co-located with an adult centre can share staff in those sub-specialties for which the caseload in the children's service does not by itself warrant a paediatric-only service, e.g., transplant surgery, neurosurgery and certain specialised orthopaedic surgeries (e.g. hand). This can lead to improved outcomes. For example, Edwards, Roberts , McBride, Schulak and Hunsicker, N. Engl J Med, 1999, noted in liver transplant the relationship between volume and lower mortality. They observed that low volume centres that were affiliated with high volume centres (e.g., paediatric programmes) had similar results to those of high volume centres.
  - Co-location also allows for enhanced patient care for chronic disease that traverse paediatric to adult care (e.g. for cystic fibrosis patients). These occur in various contexts, from consultants with joint accreditation in paediatrics and adult care who manage the care of children from childhood through adulthood, to clinics involving both paediatric and adult doctors as a child grows older. These centres typically also have the critical mass to develop distinctive adolescent-care programs

5.2 There certainly are potential advantages to sharing deep subspecialty expertise. Unfortunately, the Mater Hospital is not the National centre for Neurosurgery (Beaumont Hospital), or liver transplantation (St. Vincent's Hospital), or Bone Marrow Transplantation (St.James's), or Renal Transplantation (Beaumont), or Burns (St.James's), or Cystic Fibrosis (St. Vincent's), or Haematology/Oncology (St.James's) and, as is obvious from the result of the Radiation Oncology Panel findings, the Mater Hospital does not provide a Radiation Therapy service. The only National service at the Mater which might offer benefit to the children is cardiothoracic surgery. However, the current Paediatric Cardiothoracic service situated at Our Lady's Children's Hospital, Crumlin is the third largest in these islands and is sufficiently large to stand alone. Its cardiac service continues to expand and as it takes on more and more of the cardiac needs of Northern Ireland, whose population is too small to allow for continued paediatric cardiac surgery to continue there, it will soon become the largest service in these islands. It is interesting to note that children in Manchester who attend the Tri-located Children's Hospital there and who require cardiac surgery are referred to the stand alone Alder Hey Children's Hospital in Liverpool.

5.3 At a recent Mater Hospital conference entitled "Influencing Health Policy", Prof Brendan Drumm, former CEO of the HSE stated that the existing multiplicity of adult hospitals in Dublin with, for example, six cardiology intervention units and five oncology units" could not justifiably continue and that a single, large tertiary/secondary hospital, the size of the new Queen Elizabeth Hospital in Birmingham could alone meet all of Dublin's adult medical needs. Such a hospital would result in all National Specialties being available on the one site and would finally provide Dublin with a Level 1 Trauma Centre which it currently does not have.. It is not beyond the bounds of possibility that such a hospital might be built within the next ten to fifteen years. Such a facility, along with a co-located Maternity Hospital, would be an ideal partner for the proposed National Paediatric Hospital. However, it is clear that if the proposal before An Bord Pleanála is accepted, that a wonderful opportunity will be lost. According to McKinsey, the other potential benefit of co-location with an adult hospital lay in transitioning of adolescents in the NPH to the adult services. As outlined above, there will be few shared specialties if the NPH is co-located with the Mater Hospital and, in any event, most adolescent out-patients coming from outside Dublin will transition to adult services near their place of residence. Finally, potential cost savings resulting from economies of scale may be negated if, as proposed, the planned paediatric service is duplicated over 2 sites.

5.4 Given the broad spread of specialties throughout the Dublin adult hospitals, it would seem that McKinsey were aware that a suitable adult hospital for co-location did not exist when they stated that:

> ¶ International experience shows that it is important to weigh a decision to co-locate against pragmatic considerations, including: space and quality of access to potential sites; cultural and managerial fit with the adult hospital; and the quality of managed service provision on the adult site.

5.5 Are there any potential disadvantages to co-locating with adult services? Unfortunately, a growing problem, now ranked as a major public health threat by the World Health Organisation, the Centres for Disease Control in the United States of America and the European Centre for Disease Control, is the threat of antimicrobial resistance such as MRSA, which is endemic in adult institutions, affecting the Children's Hospital.

5.6 The absolute focus on co-location, insisted upon by the Task Force tends to create an impression that, in some obscure way, a large standalone Children's Hospital would be inferior to a co-located one. Nothing could be further from the truth. Many of the current Children's hospital's being developed or planned will be standalone e.g. Melbourne Children's Hospital, Alder Hey Children's Hospital, Liverpool. Our Lady's Children's Hospital, which provides more than 82% of all tertiary paediatric services in the Republic, has not been co-located since its foundation in 1956 and yet achieves excellent results by international standards. For example, in my own area of childhood cancer, a recent survival analysis carried out by the National Cancer Registry confirmed that our survival rates exceeded those found in both Europe and in the United States. In addition, Prof. Michael A. Berman, M.D., renowned pediatric cardiologist and an expert on faculty practice plans and clinical productivity issues and formerly Director of New York Presbyterian Hospital, was approached by the Task Force on Location to advise regarding Tertiary hospital services and, in a subsequent interview on RTE once the Task Force findings were made public, was quick to point out that he had no input into the site selection process and spontaneously added - "why co-locate with an adult hospital, surely the three Children's Hospitals together are big enough to be freestanding?" Despite this, our Alliance would see co-location with a maternity hospital as critical to allow for the safe transition of over 140 high risk infants per year from the maternity hospital to the neonatal surgical services in the National Paediatric Hospital. A model incorporating both a maternity hospital and a tertiary adult hospital which are adjacent, but structurally separate, on a large University campus would be most desirable. Such a campus would also be expected to have a medical school, schools of nursing and physiotherapy and schools for other allied health care specialties. The site would ideally also contain a large research facility and critically, would have ample room for future expansion.

6. Problems with Current proposal:

6.1 What are the disadvantages of the current proposal? Firstly, it is important to recall that this hospital will not just serve the needs of Dublin children. It will be the only tertiary facility for all the children of Ireland and, whilst the numbers of children with problems requiring tertiary care are outnumbered by those who will require secondary care, the workload generated by these children is enormous. An analysis of children with cancer, cardiac problems or haematological diseases alone attending the national services for these specialties at Our Lady's Children's Hospital shows that this relatively small cohort of patients account for almost 50% of all day cases attending the entire hospital and for over ⅓ of all admissions. In addition, an analysis of my oncology patients in 2007 showed that 75% of them lived outside the M50 and this is mirrored in all of the other tertiary services. By the way, the majority of day cases arrive and depart at peak hours.

6.2 The constrained nature of the chosen site has imposed numerous design limitations which cause us concern. Firstly, in order to accommodate the workload, it has to be a high rise building which is not recommended for a Children's Hospital with the majority I have viewed being between five and nine floors in height. The limitation of the footprint of the site does not allow for a surface car park. Instead, inadequate underground parking, with absolutely no room for future expansion, will be provided at enormous expense. In an attempt to minimise the final height of the building, Mr. Mahon, in his presentation, acknowledged that the floor to floor height at level 0, 1, 2, 3 and 4 were tight (e.g. floor to floor height of level 1, 2, 3 and 4 is 4.5M whereas in the USA a height of 5.5 to 6M is the norm). Mr. Mahon also conceded that the floor to floor heights in the upper floors, at 3.8M instead of the recommended 4M, is "very tight" – yet another site imposed constraint.

6.3 The RKW Executive Summary document, p20/21, describing the room size in the Inpatient Wards states that "A range of room sizes have been considered and exemplar layouts used to demonstrate functionality within a room of 24.5 - 28m2, including ensuite. It will be highly desirable that acute beds are capable of conversion to critical care beds over time. Our recommendation is therefore that the single room, plus ensuite should be planned at 26.5m2 which is in line with current UK Guidance for critical care single rooms and represents the mid-point from the exemplars. However, in her submission, Dr. Emma Curtis indicated that the standard room size would only measure 20m2 and that the intensive care rooms would only measure 25m2. I am uncertain if she has included the ensuite size in the room sizes. If she has, then the design will fail to meet RKW's recommendations – we would appreciate clarification on this issue.

6.4 The National Centre for Medical Genetics is currently located on the grounds of Our Lady's Children's Hospital. It provides an integrated national clinical and laboratory service for families affected by or at risk of genetic disorders. The clinicians in all three children's hospital support the need for an integrated service as part of the NPH. Sadly, again because of site constraints, such a service is not planned for the NPH Mater site.

6.5 The proposal before An Bord Pleanála is described as "a world class Children's Hospital". However, in an email regarding the Mater site received by one of our members in August 2006, the renowned Prof Roger Ulrich, Professor of Architecture and Health Facilities Design, Department of Architecture Texas A&M University stated that his impression was that "the Mater site selected in Dublin for the new children's hospital was so limited, tight and unsuitable that it would be unable to meet current best evidence-based design standards.

6.6 I am aware that the following paper by Prof. Ulrich was quoted on Tuesday, but I feel it bears repeating. Prof. Ulrich is considered to be the "Father" of evidence-based hospital design and his views carry significant weight internationally. In this paper entitled "**Elevator-dependent vertical hospital layouts may increase susceptibility to transport delays that worsen complications",** published in the Health Environments Research and Design Journal, Vol 1. No.1. Fall 2007, Prof. Ulrich drew attention to concerns relating to high-rise hospital layouts. In the paper he states that "Difficulty in accessing elevators was reported as one reason for transport-related complications in an Australian study. Another study identified elevator malfunction as a reason for delays in transport that worsened complications. In addition, elevators are especially vulnerable in emergency situations such as blackouts, fires, earthquakes. These findings should be taken into account when making such key architectural choices as between a high-rise building relying heavily on elevators and a low-rise horizontally dominant structure. The finding that elevators may worsen complications has implications for choosing between small infill sites within cities that require tall structures as compared to larger sites on the periphery of cities that permit lower-rise hospitals".

7. Concerns:

7.1 As a group, our Alliance continues to have serious concerns about many aspects of the current proposal. Over the last five years these concerns have been brought to the attention of the NPH Development Board and we were not in the least surprised to find almost identical concerns again being highlighted in the recent clinical review indicating that little in the way of solutions to these problems have been provided over the years. Many of these concerns are of critical importance and it is not unreasonable of us to ask at what point in this entire process will these problems be remedied.

7.2 For example, notwithstanding the evidence presented by Mr. Horan in relation to parking, our Alliance has not been reassured as to adequacy of the parking allocation for the NPH. Looking at recent hospital builds elsewhere, we consider this allocation to be completely inadequate. Dr. Duff will deal with this issue in his submission but I would ask - what options will parents have when the car park is full?

7.3 We also have serious concerns regarding the possibility of future expansion on this constrained site. If one visits the website of any children's hospital which is currently undergoing expansion or is contemplating this, the history of regular, continued expansion is a common denominator. Examples of this are shown below for two hospitals – the Hospital for Sick Children, Toronto and Our Lady's Children's Hospital in Dublin. As you can see, building on the current Toronto site began in 1951 with further large additions in 1964, 1972, 1986 and 1992. In May 2010, work began on an educational Research and Learning Tower. Due to the constraints imposed by the remaining available space, the Tower will be 21 storey's high.

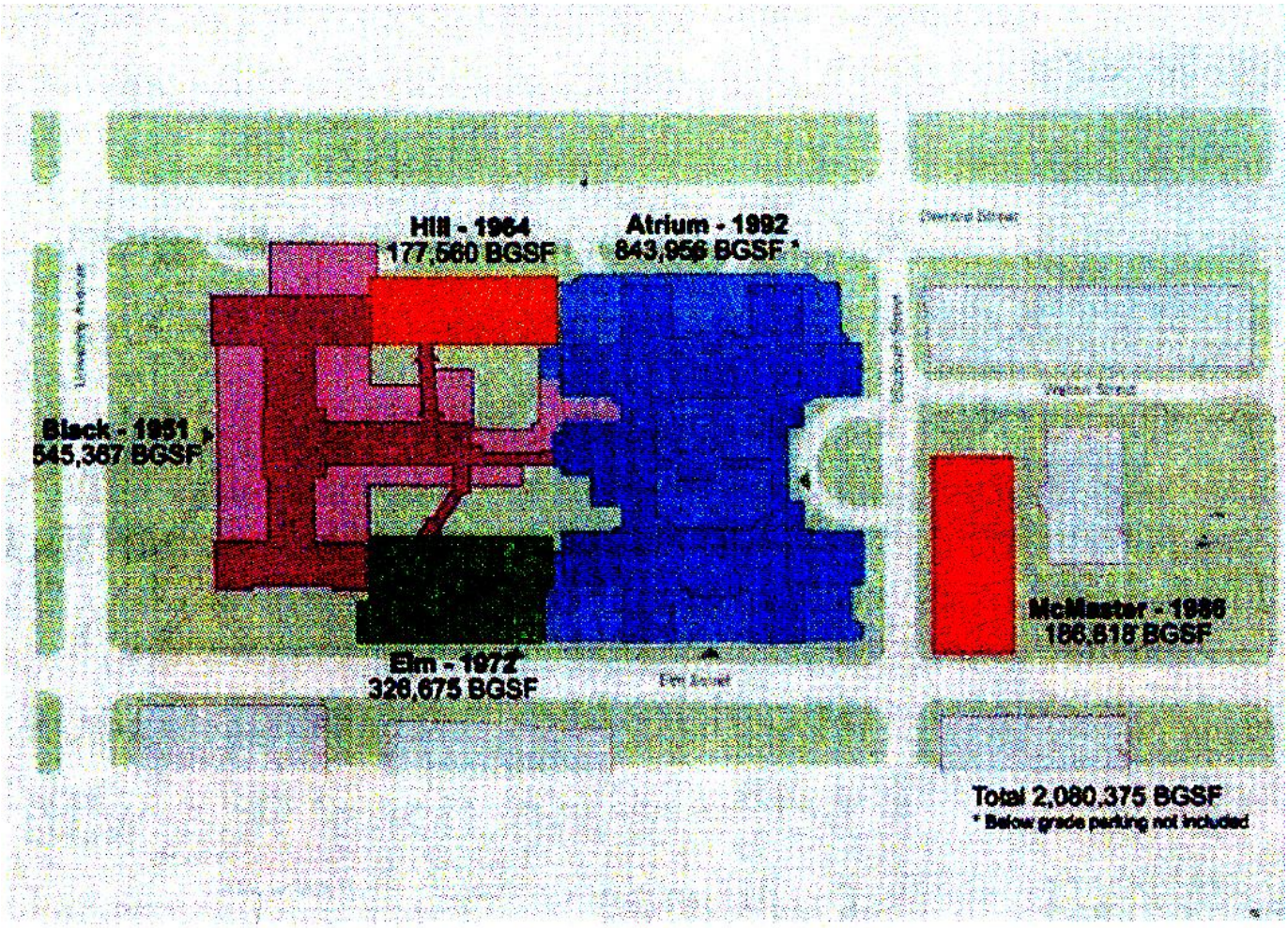

Diagram 1: *Growth and Change, Hospital for Sick Children, Toronto*

7.4 In the diagram below, the building in blue represents the original 1956 building footprint for Our Lady's Children's Hospital. The pink additions have mostly occurred over the last thirty years. Further significant expansion, not shown in the diagram, has occurred in the last five years i.e. extended Intensive Care Unit and New Cystic Fibrosis Unit. In fact, over just the last ten years alone, the available clinical space has increased by 46%! This would simply not have been possible on a constrained site.

7.5 Our Lady's Children's Hospital 1956 to 2006

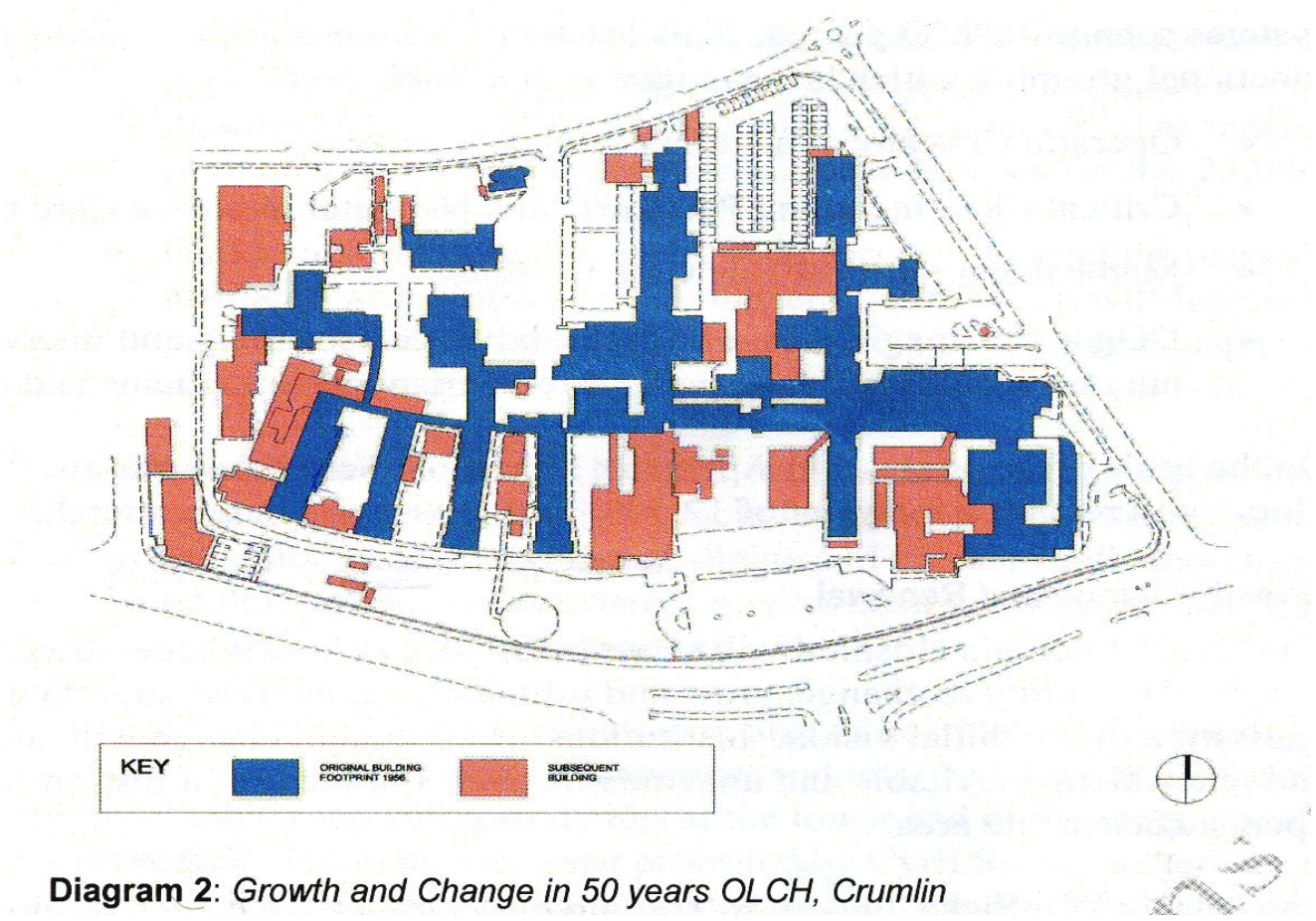

Diagram 2: *Growth and Change in 50 years OLCH, Crumlin*

7.6 The old military adage that "no battle plan survives the first contact with the enemy" also applies to any new hospital, especially in circumstances where there is an element of service reconfiguration and the building is not simply a replacement for an existing facility on the same site. No amount of planning, no matter how detailed, will obviate the need for flexibility in the new building to accommodate surprises. An example from the recent Manchester Children's Hospital reconfiguration was a substantial underestimate of the number of Emergency Department attendances in the new facility. This "magnet effect" where the large hospital attracts a disproportionate percentage of patients will be amplified in the NPH as there is also an expectation amongst the paediatricians in the country that the new hospital will provide

immediate transfer rights for their sickest patients. The cramped location provides less scope for flexibility to meet these challenges. Texas children hospital has been rebuilt not once, but twice in the last 20 years to accommodate expansion. In Ireland, as we have the highest birth-rate in Europe, we are very unlikely to run out of children any time soon and we must, for their sakes, plan for their future and for evolving clinical need. In Ireland, we do not build children's hospitals very often and expect such hospitals to function for at least 60 to 100 years. The site constraints imposed by the Mater site will severely limit the possibility of accommodating any new service or technology which will inevitably be required over the coming decades e.g. the new imaging technologies currently under development, which include molecular imaging, which may well alter the way patients are imaged into the future. The exact space requirements of these new technologies are as yet uncertain but they clearly will require additional space. It beholds us to allow for such new technologies to be absorbed. The large amount of available space on the site of Our Lady's Children's Hospital in Crumlin has allowed the hospital to introduce three entirely new imaging technologies in the last 15 years. It is very likely that PETCT or PETMR expansion space will also be required over time on the site of a National Paediatric Hospital. In addition, the range of bone marrow transplants currently offered at the national centre in Our Lady's is limited. The future appointment of an immunologist will certainly result in an increased demand as well as the likely future transfer of children from Northern Ireland for their transplant at the centre.

8. Conclusion:

8.1 Over the past 30 years I have learned much from working with children with life threatening illness and their families. On hearing the diagnosis of cancer or other life threatening condition, the lives of parents are utterly and irrevocably changed, regardless of the outcome. It is impossible for me to convey the levels of stress involved. Normal family life is lost through frequent, often prolonged, absences from home while their child is an inpatient, attending for day care or at out-patient clinics. Siblings are farmed out to relatives or friends and, as a result, often become distressed and fearful. Parents seem to pass each other in the night as they change shifts and, not surprisingly, the incidence of marital breakdown significantly increases. For such children and their parents, it is imperative that every effort be made to minimise their stress. The children with these tertiary illnesses and their parents will revisit this new hospital more than any other group and any deficiencies in its design or in the services provided will have the greatest negative impact on them. We are deeply concerned that the proposal before An Bord Pleanála today is simply incapable of meeting its intended purpose.

8.2 We have potentially produced a service configuration that will have patients from outside Dublin with complex diseases requiring tertiary care having to access the city centre for services while Dublin patients with less complex secondary care needs will be travelling to the periphery of the city to access their care. This is the reverse of the logical configuration that would have the tertiary facility for the country on the ring road accessible to all and the secondary facility for the city in the city centre.

8.3 The concerns raised in the recent review must be resolved. The attitude that "It will be alright on the night" is not an acceptable strategy for a project of this scale, expense and importance. It is vital that clear answers to the issues raised above are available to those planning the new hospitals if they are to deliver on their aspiration of providing a world class facility for Ireland.