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 Roisin Healy
on behalf of The New Children's Hospital Alliance

My name is Roisin Healy. I graduated from University College Dublin in 1970 with a degree in Medicine. After a year's internship in Dublin, I spent a year in paediatric medicine at the Hospital for Sick Children in Toronto. Returning to Ireland, I rotated through various hospitals on a training program in general surgery, rotating through Jervis St., St. Vincent's Elm Park, Portlaoise and Our Lady's Children's Hospital Crumlin. I had the privilege, as a member, albeit a junior one, of the renal transplant team in Jervis St. of being on the first helicopter retrieval of donor kidneys in Ireland in 1973, the helicopter using the Phoenix Park. In 1975/76 I worked in Zambia as a general surgeon, followed by a short locum in rural Swaziland. This was followed by an academic year at the School of Tropical Medicine in Liverpool where I obtained the Diploma in Tropical Child Health and during which I attended tutorials at the Alder Hey Children's Hospital. I returned to Toronto 'Sick Kids' hospital as it is affectionately called, in 1978, for further training in paediatric medicine. I rotated through the Indian hospital Sioux Lookout in northern Ontario, where I was involved in the emergency Medivac of sick newborns by air to Winnipeg.

I subsequently worked in Temple St Children's hospital over three years, St. Ultan's hospital for two years, with holiday locum Consultant Paediatrician experience in Castlebar and Portiuncula hospitals. I then returned for 12 months to Toronto Sick Kids as a full time Consultant in the Emergency Department. Toronto is recognised internationally as one of the leading children's hospitals in the world. I then accepted the position of Consultant in Paediatric Emergency Medicine at Our Lady's Children's Hospital Crumlin in 1987. I retired from Crumlin Hospital in 2008 after almost 20 years in charge of the Emergency Department. As part of Continuing Medical Education, I have participated in numerous international medical conferences and have visited many leading children's hospitals, including San Diego, Boston and Philadelphia Children's, Vancouver Children's, children's hospitals in Paris, and Birmingham, Edinburgh and Great Ormond Street in the U.K.

I hold the following professional qualifications – Fellow of the Royal College of Surgeons in Ireland, Fellow of the Royal College of Physicians of Ireland, Member (Paediatrics) of the Royal College of Physicians of London, Diploma in Tropical Paediatrics and Diploma of the Royal College of Obstetrics and Gynaecology.

Thank you, Inspector, for this opportunity to speak at the oral hearing of the application for planning permission for the National Paediatric Hospital (NPH) at the Mater site. I speak as a member of the New Children's Hospital Alliance. We are an advocacy group for children and their families nationally in the matter of the NPH. We wish as citizens to provide the highest quality of care for our children. The New Children’s Hospital Alliance does not believe it will be possible to achieve and maintain such standards in the tertiary level care of our children by building the proposed National Paediatric Hospital at the Mater site in the centre of Dublin.

The location decision was made in June 2006 behind closed doors and signed off as government policy by the cabinet without any participation from the public, child health professionals or our elected representatives.

We have extensively reviewed this flawed decision-making process in our submission of 14th of September 2011 to the Board. In that submission, NCHA also invited the board to agree with it that the applicant failed to discharge its obligation to assess alternatives and to deem the EIS, and indeed the application, invalid because it does not comply with the regulations. We have heard nothing in the current oral hearing to alter our position on this.

Comments on Independent Review

Inspector, in our submission of the 14th of September 2011 we noted that no clinical advantages to children of moving to the Mater site were identified. At the time, we were awaiting information from the Department of Health under the Freedom of Information Act before further commenting on the Independent Review. In the interim we have obtained answers to a few of our queries, but not many. For the others, we were told, on the 7th of October 2011, to redirect our enquiries to either the HSE or the Development Board. At this time, it is not possible to add comment on the Part One Financial Analysis because information is being withheld as "subject to ongoing key deliberative process".

Regarding the Part Two Clinical Analysis, I wish to make a few comments –

Expanding adult services

The Independent Review mentions that moving paediatric services to the Mater site will allow the Mater adult hospital to expand further. It states –

> "If the National Paediatric Hospital is built on the Mater site, this would provide a base for the further strategic planning of adult services." (page 8)

In an e-mail, released under the FOI act, discussing a draft of this review, this sentence read, "This would provide a base for further strategic and opportunistic planning of adult services (e.g. the eventual/early co-location of adult neuro-surgical services)."

In the concluding paragraph of the Independent Review (page 16), it states, "We recommend the Mater site. Given those services that are available and the plan to consolidate others at the Mater site, our recommendation is again reinforced."

In its submission to the Location Group in February 2006, the Mater hospital had listed its ambition to become a Level One trauma centre. The only Level One trauma centre in Ireland currently is in Cork. A Level One trauma centre handles the most complex trauma and requires all acute services on-site, including adult neurosurgery, which in Dublin is currently is in Beaumont. It also requires a helipad. The recent Independent Review e-mail raised this issue again, illustrating that the adult Mater hospital's ambition remains. It is conceivable that the acquisition of the NPH, which brings paediatric neurosurgery and a helipad on-site, is being used as leverage to achieve the adult hospital's ambition. Indeed, Mr deFreine has stated to this hearing that the helipad was more important for the adult hospital than for the children's.

The Children's University Hospital Temple Street, the Mater Misercordiae Hospital and the Rotunda have recently come together under a new forum as the North Dublin Hospitals Group. This group excludes Beaumont Hospital.

Alternative sites

The Independent Review (page 16) states in its conclusion, "of those [groups] who were critical of the site, none offered concrete alternatives... the reality is that no perfect site is available, and consequently the Review Team considered those options that were viable and achievable." However, at no point in the Review are any alternatives considered. The notional sites A, B and C were not to be considered as alternative sites, but were used purely for a costing comparison.

In an e-mail obtained under FOI, in which the reviewers are discussing a draft version of the Review, a reviewer comments –

> "I removed 'The ideal location would be located on green space, provide for unfettered access, accommodate research and educational activity, provide sufficient space to ensure the aggregation of all patient care services meeting current and future care requirements, and be tri-located with an adult tertiary care and a maternity facility. We agree that if there was a site and funding for such an aspirational location it would be a magnificent campus. Unfortunately, given the current challenge of funding the one children's hospital the perfect location is not possible. Consequently the team considered those options that were viable.'
>
> My concern here is that if the above text is included, the response will simply be that there is such an ideal site, and the issue will open up again."

The Independent Review committee was never presented with a list of alternative sites or options, nor was its function to assess such. Therefore, it is not valid for it to state that no ideal site exists.

The New Children's Hospital Alliance would not wish to pick a site, but it does wish that alternative sites now available should be identified and assessed according to the McKinsey criteria, the co-location of a maternity hospital and a weighted scoring system. The scoring system used for the Glasgow Children's Hospital was:

- Clinical Effectiveness: Weighting 40
- Access for Patients and Relatives: Weighting 20
- Research and Education: Weighting 10
- Staff: Weighting 10
- Physical Location: Weighting 20

Significant stakeholders such as parents, children and young persons must also be invited to participate in the decision-making process. According to *Consultation with Children and Young People Policy recommendations*, a 2009 report by the National Children's Advisory Council, participation, as distinct from consultation, "is the process by which individuals and/or groups of individuals can influence the decision making process and bring about change. The meaningful participation of children and young people can directly or indirectly address health inequalities and creates a platform to allow them to influence healthcare services and resource allocation."

Site and design issues

Expansion factor

Whenever hospitals were built in the past, the DoHC required that the potential for a one-third increase in capacity be provided for. This potential is not evident in the application for planning permission. In fact almost every possible square metre seems to be occupied and there is little or no scope for new additions within the plans for which permission is sought.

It is essential that the Board clarify where expansion can occur and include its impacts in the evaluation.

Whole site or part of site?

We note that in the first pre-planning application meeting of the Board with the NPHDB on November 5th 2010, "the Board reminded the prospective applicant that all impacts of the proposed development should be addressed. It stated that all impacts should be addressed within the context of the entire Mater block (including the Mater Private and Metro North)". However, at this oral hearing, the applicant has discussed only the proposed NPH, and not the other hospitals at the Mater site.

Although the whole Mater site of 7.2 hectares, including roads and footpaths, is put forward for consideration, little planning information is provided about the site as a whole. Without information on the whole site, it is difficult to place the application in context. The site for which planning permission is sought is 2.04 hectares (for a Children's Hospital and a separate Maternity Hospital). The NPH would seem to have a footprint of about 1.5 hectares, as judged by a level -2 drawing which fills the floor area out to the secant piling that surrounds the base.

It is difficult to assess the impacts the proposed building will have on the site as a whole, and vice versa the impact the other buildings on the site will have on the NPH, and yet it is vital that we are able to do so. Again on November 5th 2010, the Board advised that the prospective applicant should bear in mind the constrained nature of the site; it stated that from its perspective this would be a significant issue, as well as matters such as visual impact and overshadowing."

The impact of all buildings, including the height and impacts of the Maternity hospital to the west of the adult hospital, on the whole site as a unit of Strategic Infrastructure, need to be clarified for purposes of planning evaluation.

Impacts of design features

I will now deal with aspects of the building itself – aspects that I, as a "ragged non-engineer", to quote a CEO from the NPH 'Independent' Review, am little qualified to comment on – but which have been drawn to our attention by others more knowledgeable and which we wish to draw to the attention of the Inspector.

If a site comes with physical constraints or planning constraints that hinder the desired operation or functionality of the facility to be built there, then the site is by definition unsuitable.

Air Quality - internal

The NPH footprint area is approximately 11,500m^2. A high building therefore was the only solution. Given the city centre location, height is constrained by considerations of proper planning.

A consequence of this is the reduced height between floor levels, especially floors 10-15.
This may reduce the quality of air on the inpatient wards (levels 10-14) increasing the potential for airborne pathogens to cross-infect. (Staff of children's hospitals and their families are recognized as being at particular risk in this regard.) If the constraint on floor space can lead to diminished air quality in this way, then a less constrained site must be considered. We suggest that a review of the reduced height between floor levels 10-14 and its impact on internal air quality may be required.

Air Quality – pollutants

Hospitals pollute the atmosphere with emissions from car parks, energy centres, chemicals from laboratories, oncology drugs from special pharmacies (preparing individual treatments) radioactive diagnostic, laboratory and clinical agents, and micro-organisms from clinical areas and laboratories. Each of these sources of pollutants usually has its own individual air handling equipment for discharging to the atmosphere.

In the case of the NPH four hospitals are to be in very close proximity (Adult, Children's, Maternity and Private). Each may independently discharges to the air at multiple locations and levels.

The air quality of the NPH cannot be adequately evaluated in the absence of information on the discharges from the other hospitals on the site which have the potential to feed into its air intakes and interior both by natural ventilation and through mechanical air handling equipment and systems.

The location or locations of discharge from the laboratories on level 0 is/are not apparent. The research centre laboratories on level 6 are also an unknown quantity. So too is the oncology pharmacy on the 8th floor.

The energy centre is to exhaust at roof level. (Where is the centre located? Is it in the south west corner of the lower levels and if so is there a duct route to the roof at level 15+).

A particular concern has to be that the exhausts from one hospital could feed into the air intakes (natural or mechanical) of another. In particular if the exhausts from the Adult hospital are at its roof level, then they will feed directly into any intakes on the north face of the NPH ward block at levels 10-14.

ABP or Dublin City Planners may have past information on the air management of the Adult Hospital and the Mater Private and whether or not exhausts to the atmosphere exist at their roof level and pose a problem for the planned NPH.

Furthermore, there does not seem to be information provided on the air management of the car parks.

We request that the locations of the points of all air-polluting discharges from each hospital on or

planned for the whole site and from the Metro be made known and the potential for contaminated air from one to be recycled through other health care buildings on the site be studied and taken into account.

Air flow/wind

The airflow/wind studies provided with the application explicitly deal only with discomfort impacts on pedestrians passing and using the site. The test used appears not to have considered potential wind loading effects on either the proposed development (cladding or structural) or on neighbouring buildings. However, given the nature of the design put forward in the application airflow other than for pedestrians need attention.

The external shape of the ward blocks, levels 10-15 is such that it will have, depending on the direction and speed of the wind, the same characteristics as an aircraft wing (although in a vertical plane) The effect is to create difference in air speeds and pressures between the north and south sides of the building. (In aircraft this gives lift.)

The extent of the difference has at times potential to supercharge the natural ventilation that is planned for the single ward rooms. Flow through the rooms into the ward corridors areas would negate the gains provided by single rooms to confine air borne infections and odours. The plans for natural ventilation may be frustrated as vents may be kept closed.

The air quality management plant situated on the north face of each ward level may permit back draughts when differentials are considerable.

ABP needs to be assured that studies on the nature of wind effects associated with the external design shape of levels 10-15 are known at this stage and take them into account. We further note that DCC suggested vertical fins to lighten the perception of horizontal bulk . Effects on ventilation may in such a case require further examination.

Light and glare

In the application documentation there is an analysis of glare that may be produced by the glass encased ward block at levels 10-15. This analysis is on the basis that the whole façade is convex. It concludes that at most a sparkle effect will be appreciated from isolated panels of fritted yellow glass.

However, on the South side there is a concave section (centred directly opposite Nelson Street) which in its reflection of solar energy acts in the manner of a parabolic reflective surface. The analysis of glare production may need to be revisited and the point(s) at which the concave area will focus reflected energies identified for the range of sun altitudes and positions. Where is the focus of reflection when the sun is shining directly along Nelson Street? It is possible that a “hot spot” will be identified that will have consequences for whatever is at that point. The focus needs to be identified for all sun positions over its annual cycle.

Light and overshadowing

Considerable information is provided on some aspects of overshadowing of surrounding properties by the high NPH building planned for the HSE owned part of the site. However there seem to be significant omissions with regard to over shadowing of properties on the parts of the site owned by the MMUH and on which the new Adult Hospital and the older phase one Mater Hospital are built.

The podium part of the NPH structure will be very close to the whole of the South façade of the Adult Hospital. Levels 10-15 overlook the Adult Hospital. The effect of the proposed building will be to block out direct sun light from the south face of the adult hospital dramatically changing the natural light available to it particularly its south-facing aspects which we understand have some inpatient wards. While we understand from the applicant that the Mater administration has no problem with this, we are concerned that no Family or Patient Advisory Committee in the Adult hospital has made a statement on it. In this era when, world-wide, families and patients are recognised as partners in Health Care Facility design, has the adult Patient Advisory Committee been made aware of the NPH plans? Has its participation in the design process been encouraged?

Steps to determine the extent of the adverse impact of overshadowing of the Adult Hospital both by the NPH and the Maternity hospital are essential.

In tertiary paediatric care, the most important facility to co-locate with is a maternity hospital. Yet the NPH is proceeding without planning clearance for such a hospital at the Mater site. Without that the NPH should not proceed. Co-location with an adult hospital comes way down the list of priorities for children.

Access

Access via North Circular Road (NCR)

The application includes a dedicated car ramp from NCR to the level -2 car park under the NPH.

If the car ramp from NCR is to be built excavation is needed. It would appear that this excavation involves the planned service yard and part of the site owned by the HSE that has been designated for a maternity hospital. This excavation does not appear to be included in the information on excavating and removing 269,000 cubic metres of soil from the footprint area of the NPH.

Further, there is a block recorded on the demolition of some buildings (old pathology and mortuary) on the maternity hospital part of the site. Could this hinder the provision of the ramp?

Due to the need to access the underground car park, the access ramp from NCR must be available from day one.

Also, as regards the NCR itself, arrangements for traffic (particularly for that approaching from the West) need to be reviewed. What will happen when cars attempting to turn onto the ramp are

delayed? What consequences will this have for other traffic? There is also need to review the impact of a 'car park full' sign.

Emergency Department Access (from Eccles St.)

There is an important human factor in regard to access arrangements to the Emergency Department. Many of the car drivers at this location will be under enormous stress. They will be transporting what they fear is a very sick child with an urgent problem. These children will come from the whole of the GDA, and will need immediate unhindered access. (For example, consider a parent transporting a convulsing child, or a toddler potentially poisoned having swallowed granny's tablets).

The nature of these pressures on drivers taking children with emergency events from home to the NPH, through city centre traffic, needs to be recognized and provided for in planning. It is wrong to dismiss them as just a minority of drivers, as has been done. Access arrangements should minimize the stress, not exacerbate it, and should avoid triggering road rage or the inappropriate parking and abandonment of cars.

An unobstructed, obvious and intuitive access path is required. Immediately obvious dedicated drop-off spaces are a *sine qua non* for any world-class Emergency Department.

Parents driving from Dorset Street will have nowhere to pull in, except on the far side of the street. This is unacceptable, especially in an emergency. And, once the entrance at the street has been reached, it opens not into the Emergency Department, but into a lobby with lifts, stairs and a ramp leading to the Emergency Department in the basement. This is hardly a patient-centred arrangement and is significantly inferior to what currently exists in all three children's hospitals.

There is no pull-in bay outside the ED – indeed the footpath appears to widen, narrowing the road. The footpath entrance is made more complex by the large volume of pedestrian traffic across the access route that will arise from the Metro entrance also planned for this same location on Eccles Street. Pedestrians to and from Dorset St direction will have to negotiate cyclists, cars and ambulances using the multi-purpose ramp to both Adult and Children's hospitals. It seems likely that at times Eccles Street itself will be congested and somewhat chaotic.

We note that a disabled parking space for the private hospital is to the west of the children's ED entrance, at a significant distance from the Mater Private Hospital. It is difficult to see how its use will be protected for the Private Hospital.

It is notable too that the parking facilities for the Mater Private have not been addressed within the context of the entire Mater block. We understand those facilities to consist of twelve spaces underground. It is self-evident that patients and visitors to the Mater Private will use the public hospital's car park. As the car park of the adult, maternity and children's hospitals are integrated, parking will become a free-for-all.

Ambulances and emergency access

The NPH Independent Review states the following –

> Page 10 –
> "there is already significant emergency paediatric traffic in Dublin's city centre. The busiest children's Emergency Department in the city – the CUH at Temple Street – is situated 400 metres from the proposed development at Eccles Street. No information which we have received or presentation we have attended has identified that access to Temple Street is of major concern. CUH Temple Street currently deals with 45000 attendances per year. The proposed volume of activity at the new NPH on opening will be around 65,000 attendances per year i.e. an increase of 45% on existing levels."
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> Page 11 –
> "There has also been comprehensive planning and coordination with local councils and ambulance services."
>
> Page 16 –
> "In addition, we were satisfied with the Emergency Transport representative's assurance that 'blue light' access onto the Mater site did not pose an issue."

The reviewers state that no information they have received indicates that access to Temple Street is of major concern. Perhaps this is because the analysis has never been carried out. It is our understanding that there has been no analysis of ambulance access times. A bland reassurance that the 45,000 children who attend the Emergency Department at Temple Street every year have no problem accessing it shows a grave misunderstanding of the fundamental difference between a local paediatric hospital and what is to be the sole National Paediatric Hospital for all of Ireland and the only Paediatric Emergency Department for the GDA. One should not underestimate the 'magnet' effect of the children's Emergency Department. It is our understanding that Emergency Department attendances may be as high as 80,000 a year.

> Page 10 –
> "The traffic studies looked at journey times for emergency patients from inside and outside the Dublin conurbation using the M50 and established the travel times along the major radial routes from the orbital motorway to the Eccles Street site at various times of the day. They identified, not surprisingly, that the longest journey times are in the morning peak period. The majority of paediatric attendances at Emergency Departments take place between 12.00 and 20.00, when the journey times are at their shortest."

We know of no such study looking at Emergency patients. A study described in the Review looked at travel times for cars, as distinct from emergency travel times for ambulances. We are concerned that the problem of emergency access during the morning rush-hour is dismissed simply because it involves a minority of patients. A child who falls gravely ill during the morning rush-hour and urgently needs medical attention must be provided with proper access. As we have stated in our submission of the 14th of September 2011, "every child is precious, not a statistic caught in a traffic jam". Furthermore, we know of no "comprehensive planning and coordination with local councils and ambulance services". Therefore, unlike the Independent Review consultants, we are not "satisfied with the Emergency Transport representative's assurance that 'blue light' access onto the Mater site did not pose an issue." We submit that An Bord Pleanala require that an analysis of

ambulance access times be conducted by an independent organisation such as HIQA.

Medical Issues

Emergency Department (ED) Design

Concern is expressed about the two separate entrances to the Emergency Department, one on ground floor level and one on lower ground/basement level, the latter being for ambulances. These entrances are at opposite ends of the department. This design issue will require two separate areas for triage (initial assessment) of patients and is unsatisfactory. A unified triage is considered a safer and more efficient use of resources.

A further concern is expansion space within the department. According to Dr Curtis's statement of evidence, the central light-well area is designated as a garden area, a play area, or an open waiting area. We understand that this area has been mooted for future possible clinical use. The fact that such 'soft areas' might be sacrificed to meet the need for clinical space is unacceptable and clearly demonstrates the shortage of adequate space on the site.

Genetics

The problem of capacity identified above is aptly illustrated by the limbo in which the National Centre for Medical Genetics (the NCMG) finds itself.

The NCMG was set up in 1994 in response to the Tierney report, to provide an integrated National clinical and laboratory service for families affected by or at risk of genetic disorders.

Although the NCMG is based in Our Lady's Children's Hospital, Crumlin, 50% of the patients seen in clinic are adults, and genetic testing is available for both adults and children. Only about 30% of the genetic tests carried out are for patients of Crumlin hospital. The NCMG also runs outreach clinics in Cork, Galway and Limerick. The NCMG provides an inpatient consultation service in both Crumlin and Temple St for the many children with complex disorders who require multidisciplinary clinical input. The NCMG in Our Lady's Crumlin has a floor area of 1800m^2, and a current staff of 58. With major advances in the understanding of genetic disease and of genetic testing, it is seeing a 20% year-on-year increase in requests for genetic tests.

The clinicians in all three Dublin children's hospitals are very supportive of the need for the integrated genetics service to be part of the National Paediatric Hospital. Furthermore, the European Rare Disease Directive, which has been adopted by Ireland, comes into force in 2013. This directive emphasises the need for integrated centres nationally for patients affected by rare diseases. Eighty per cent of such rare diseases are genetic, and the NCMG is already fulfilling such a role for patients.

A meeting was held with the HSE Steering Group in September 2010, at which the HSE agreed that the NCMG would be part of the NPH, but that it would be sited adjacent to, rather than within the NPH. The subsequent decision, whereby the NCMG is no longer part of the NPH planning process, nor funded as part of the NPH build, was made without its involvement.

The NPH Development Board has indicted that 4 outpatient clinic rooms will be available in the

NPH for the NCMG clinical staff to see children. However, there is no provision for the NCMG laboratories, which need to be integrated with the clinical service.

If the decision of the HSE is left to stand, the NCMG will no longer be able to provide its existing service, and families with genetic conditions will be left without an integrated service. Likewise, it will be unable to continue to provide adult services, which it has done so successfully for the past 17 years.

It is self-evident that it is lack of space that has resulted in the NCMG being evicted at this late stage from the NPH plan. Cost may also be a factor. The NCMG is no longer within the NPH €600 million budget. There is no capital allocation in the HSE plan for building a new NCMG close to the NPH, and the NPHDB is not providing any planning support for it.

In the section on Genetics (page 15) in the recent NPH 'Independent' Review, the reviewers state

> "While historically Genetics as a clinical specialty emerged from the paediatric setting, the recent explosion of the genetics knowledge base, and its application, has seen an increasingly broad engagement of genetic services across the full range of clinical disciplines, in particular Oncology. However, the *rapidly evolving neuro-genetics and equivalent developments across every medical and surgical discipline and subspecialty mean that Genetics is becoming an increasingly academic discipline. As such, it requires a very solid laboratory and research base, and will be based less and less solely within the realms of child health.* [my emphasis]
>
> So while the decision not to plan for the National Genetic Service in the NPH *may* [my emphasis] be correct, clarity about the presence, availability and engagement of genetics clinical services within the tertiary facility is critical."

Elsewhere in the Review they state – "Research and education are critical elements of the mission of a tertiary children's hospital" (page 13), "the greatest concern of researchers was that their space was potentially disposable and hence at great risk" (page 13).

For Genetics at the NPH, that fear has already been realised. The Review appears to argue that because genetics is "an increasingly academic discipline" it should be removed from the children's hospital. The truth is it has to be removed simply because there is no space for the research laboratories. The absence of research laboratories in the adult hospital compounds the problem. If genetics is an "academic discipline" that straddles "every medical and surgical discipline" then surely its place is in in a Academic Health Sciences Centre containing clinical (hospital), research and teaching (medical school/university campus) facilities. The Mater site has now failed capacity testing for such. It is a nonsense that HSE Estates, as this hearing was earlier informed, is currently looking for a site adjacent to the Mater in which to house the NCMG. This does not fit easily with the comments in the Review. The case for planning a comprehensive Academic Health Sciences Centre for Dublin grows.

It is truly said that Research is the engine that drives excellence in a hospital. Contrast the NPH to the following –

The new Queensland Children's Hospital (QCH), Brisbane. I quote from their website

> "Four levels of the QCH Academic and Research Facility will be dedicated to research space, including wet and dry laboratories. The remaining levels will house pathology services, retail shops (in foyer), and car parking. There will also be a service tunnel link to the QCH. While the facility will house more than 450 researchers, the design has been future-proofed to allow for expansion. This flexibility to grow will ensure Queensland's children's health research needs are met now and well into the future."

The Royal Melbourne Children's Hospital's website states,

> "The Murdoch Children's [Research Centre] is well-positioned to make major discoveries to improve child health. The Institute's team of 1200 passionate researchers conducts innovative and internationally recognised research to improve the health and wellbeing of children."

The Research Institute is in the same building as, and integrated with, the children's hospital and the University of Melbourne Department of Paediatrics.

The Hospital for Sick Children, Toronto – more than 2000 researchers work in a dedicated research building linked by corridor to the children's hospital.

Yet the decision to locate the NPH on the Mater site decouples it from the engine of genetic research. If there is no space for genetic research, the future looks equally bleak for other on-site research laboratories.

Caring for human beings

Caring for Staff

The absence of a staff crèche is noted, though it is mooted in the Phibsboro/Mountjoy LAP as a facility that could be provided on the Mountjoy prison site.

A children's hospital I visited in Paris has a 24-hour staff crèche and accommodates the needs of breastfeeding working mothers. Our Lady's Children's Hospital Crumlin has a staff crèche that accommodates 45 staff members' children.

We repeat what was said in our submission of the 14th of September 2011 – that what staff appreciate is choice regarding mode of transport, that many work 12-hour shifts, that staff dropping off children at crèches or schools en route to work may need to use cars, and that a 13% staff car parking provision is totally inadequate.

Staff may have duties that call them away during the working day, such as attending child protection meetings in community care offices, lecturing at universities, etc. We appreciate that the planning authority does not wish to increase vehicular traffic into the city. This is a strong argument against locating the NPH in the city centre.

We wish to know what facilities such as showers, lockers and changing rooms are being made available for staff, and if they are available to all staff.

It is unclear whether a fully-equipped canteen, able to serve hot meals, will be available to staff at the new NPH, as is the case at the existing children's hospitals. We would like reassurance that canteen facilities will be available to staff both on day and night work.

We note in the landscape report that there are no outdoor facilities provided specifically for staff. As staff, often quite junior, have to cope with highly emotional and stressful situations, they may need short periods of downtime, and a private garden would be welcomed, in line with other all other world-class hospitals around the world.

Is there a residence or recreation lounge provided for non-consultant hospital doctors? Are there on-call or duty bedrooms for staff who are required to be available on-site through the night? Without entering the debate over the safety of long 12-hour shifts, with which the literature on emergency medicine is replete, a room in which to 'power nap' is considered essential in many countries for doctors on night shift.

Doctors need space to think. It has been said that if you want a consultant to remain on-site, you give him (or, nowadays, her!) an office. It is common in North America to have a Faculty block on the campus of major hospitals, with offices where medical staff can work on patient files, lecture notes and research papers, have telephone communications with parents and colleagues, and interview and counsel junior staff. Will such facilities be available at the new hospital?

Caring for parents

I just wish to comment on one aspect of the social support for patients' families. It is suggested that a 2310m^2 hostel currently used by adults might become a Ronald McDonald 'home away from home' for parents of sick children. Given that Ronald McDonald homes are about 60m^2 per apartment, and factoring in kitchens, corridors, lounges, library/ common room and other communal spaces, this could accommodate a maximum of 30-35 units for a the NPH 392 bed hospital.

This compares with 86 such units at the New Chicago Memorial Hospital and 70 at the Alder Hey in Liverpool. Though these are smaller hospitals the the proposed NPH, they have more than twice as many apartments for parents. Again, a lack of space seems to be interfering with the provision of necessary facilities.

At Our Lady's Children's Hospital Crumlin, there are 16 family suites at the Ronald McDonald house on the grounds of the hospital and 12 further units in houses on the Crumlin Road. Our Lady's Hospital currently has one double bedroom in the new intensive care unit and 44 single bedrooms with kitchenette and laundry facilities on the parents' corridor in the converted nurses' home, which is in a wing of the main hospital.

Caring for the bereaved

Ideally, the configuration of the mortuary should meet the guidance notes set out in the Hospice-Friendly Hospitals' “Design and Dignity Guidelines”. The following are noted as the ideal configuration for the mortuary –

- It should have a a dedicated entrance separate from the ambulance yard
- It should be separate from other clinical areas

- There should be joined up family/hearse egress

Unfortunately, the NPH design falls short of these ideals in several ways –

- Proximity of the adult ED (pedestrian and ambulance) to the children's hospital mortuary yard. An access controlled gate will be located at the entrance to the children's hospital ambulance and mortuary yard.
- Sharing of access to mortuary yard with ambulances for both the children's hospital and the adult hospital
- Sharing of car park entrance and exit with adult car park entrance and exit, with regard to egress of the funeral cortège
- If two or more removals occur at the same time, there will not be enough space available for parking in the mortuary yard
- High activity on the entrance ramps to serve adult & children's ambulance yards and the integrated adult, maternity and children's car park

The mortuary yard is designed to accommodate one hearse and two cars for the immediate family. It is unclear how families of the deceased can get from the public car park to the mortuary without going through the public concourse area.

It is difficult to see how the hearse and other cars exiting from the car park can converge to form a cortège.

Currently, Our Lady's Children's Hospital Crumlin has approximately one hundred funerals per year. The needs of traveller families, who, sadly, suffer more death in childhood than the settled community, and by tradition have very large funerals, often with some hundreds coming to the hospital, must be catered for. It is our belief that the location of the mortuary is not sensitive to the needs for the needs of grieving families and is a deterioration of what is currently available at the children's hospitals.

National issues

Economic impacts

In deeming the NPH to be Strategic Infrastructural Development within paragraph (a) of section 37A(2) of the Act, the Recommending Inspector stated "the proposed development would be of strategic *social* [my emphasis] importance to the state and region, providing national tertiary paediatric care and secondary paediatric care for the Greater Dublin Area". As a children's advocacy group, we commend the Board's recognition of the *social importance* nationally and regionally of this development, highlighting that the needs of our young citizens, not economic drivers, are its prime consideration.

If the NPH is to fulfil the aspiration to enhance efficiency by consolidating the three current paediatric hospitals into one (and by sharing non-clinical facilities on the site of an adult academic teaching hospital) there will be fewer staff.

The application's claim that jobs will be created is not valid. In consolidating the location of hospitals, jobs are simply being moved about. The gain for the Eccles Street area is a loss for other areas within the GDA. A beggar-my-neighbour policy is being promoted.

Equally, construction jobs are not unique to the Mater site. Equivalent capital development and expenditure at any location would provide a comparable volume of jobs.

Research and teaching activities too are not an additional economic gain but are a translocation of present arrangements.

The applicant has stated that a new medical district and health care hub in the Dublin City Centre will provide opportunities and attract private medical practitioners, consultants and specialists to the area. This is not compatible with current public hospital contracts of employment for such practitioners, nor with the recently revised Health Policy. This policy states that a single tier of practice and a system of Universal Health Insurance will be introduced.

Health Policy

We find it surprising that no member of the Department of Health, the department that defines health policy, has given evidence at this hearing or been called upon to give a witness statement.

The current application for planning permission does not appear to be part of a National Strategic Infrastructure for acute hospitals and services. It seems to be a pre-emptive development driven by institutional rather than patient interests.

Recently, Government policy has changed, with priority being given to provision of services near to home and at the optimum level of complexity. In the main, this is being delivered through a system of 'Primary Care'. This primary care system will also be the gateway to and from hospitals.

The role and nature of public and other hospitals will change as a result of this policy (as well as in response to developments in medical sciences). Most hospitals will become independent corporate entities and will be funded for services provided through a Universal Health Insurance system. This is the 'Dutch' system, but also that of Germany (since the time of Bismarck) and many other European countries.

The Health Strategic Infrastructure needs to be viewed in this future context. Other countries have evolved Academic Medical Centres based on comprehensive hospitals and associated University Schools of Health Sciences. In the Dutch case new comprehensive hospitals were built on large sites adjacent to cities. If this pattern and scale of hospital provision is to emerge as a plan of Strategic Infrastructure there would be at most two such hospitals in the Dublin area. The pattern of progressive development of hospitals is somewhat similar in the UK, with developments at Birmingham often given as an example. There are similar strategic developments in Northern Ireland.

From such a strategic viewpoint, the site available at Eccles Street has not the capacity to fit the needs of the future. It is difficult to understand how a development can be strategic and not be working to a long term development plan. The development control plan (DCP) should be made public. An overall strategy is needed to guide wise development and commitment of public resources. This tri-location is an arrangement conceived in the Celtic Tiger years under a different administration. It is not part of a National Strategy for major comprehensive hospitals. Will the NPH building be a white elephant in the not-too-distant future? It is time to pause, to allow the

Minister and Department of Health to publicly articulate the future planning for the hospital division of the health service.