COMMENTS BY C4KH ON THE NPHDB PRESENTATION TO THE JOINT OIREACHTAS COMMITTEE ON HEALTH, 27th OCTOBER 2016

Submitted to the Oireachtas Joint Committee on Health, 8th November 2016

Having listened to the National Paediatric Hospital Development Board (NPHDB) presentation to the Joint Oireachtas Committee on Health (October 27th 2016), Connolly for Kids Hospital (C4KH) was shocked at the number of false and misleading statements made. C4KH is very disturbed that the Committee would be presented with incorrect information on such an important matter. In an effort to appraise you of the extent of the misinformation, we have, in this document below, made relevant comments in clear and short additions to the abbreviated transcript of the presentation. Our comments will be easily identified as they are printed in RED immediately following the inaccurate statement.

Ms Eilísh Hardiman: I thank the Chairman, Deputies and Senators for inviting us to present to the committee this morning. The Children's Hospital Group consists of the three children's hospitals at Crumlin, Temple Street and Tallaght, and we have been working for the past three years with the National Paediatric Hospital Development Board to develop a hospital that will meet the requirements of our sick children and the children whom we serve locally. It is a project that the staff in the three children's hospitals fully support. This does **not tally** with the information we are getting from hundreds of staff who have never been consulted.

It is a badly-needed project that must be delivered in a timely manner.

As Mr. Pollock mentioned, the hospital is just one part of our plan for paediatric services in Ireland. This plan is called the new model of care for paediatrics, which has been developed over four years of extensive engagement with parent representative groups, general practitioners, doctors, nurses and health and social care professionals in every paediatric service unit on the island of Ireland.

It is led by Professor Alf Nicholson and Professor John Murphy. It has concluded, but it has been working for the past four years and central to that work was the development of the new children's hospital. This statement is **false.**

The model of care to which she refers was first published as recently as July 2016 so it cannot have been working for the past four years.

The new children's hospital at St. James's Hospital and the paediatric outpatient department and urgent care centres at Tallaght and Connolly hospitals will provide services to children and young people to ensure that the right care is given by the right team at the right time. It is important for us to be clear about the primary functions of these new facilities. First, **the vast majority of work we undertake, which is 78% of the inpatients** currently in the three children's hospitals, comes

from the greater Dublin area, that is, Dublin, Kildare, Wicklow and part of Meath. It is **grossly misleading** to quote these statistics for the GDA.

By quoting the figures of the entire Secondary catchment area, and not the distribution within that area, we gain no further insight into where, within that catchment area, the hospital should be located. These numbers are meaningless and misleading if there is no consideration of duration of stay and complexity of child's illness. We have argued that it is much more appropriate to have the hospital at the M50 - two thirds of children in the GDA live outside the M50 and a significant proportion of the remaining third that live inside' live close to the M50. Nine out of ten children in the country live outside the M50.

The future plan is to undertake those services through the hospital and the two satellite centres at Connolly and Tallaght hospitals.

Our second objective has the national remit, which is the highly specialist tertiary-quaternary care, for children across all of the island. Currently, that comprises **22%** of the workload undertaken by the three children's hospitals. Again a **misleading and meaningless** figure.

However it is important to understand that 60% of admissions to the new children's hospital will be day cases and over half of those are the sickest "tertiary" patients. This will be the only tertiary hospital in the entire country. This should not be the second objective; it must be the first objective. This national remit is what distinguished the NPH from other units around the country and has to be the first priority.

I fully support the previous group in its strong support for tri-location. We in the Children's Hospital Group and the three children's hospitals fully believe that tri-location on this campus with St. James's Hospital and the relocated Coombe Women and Infants University Hospital is the optimal configuration of services from a clinical perspective.

In terms of the three children's hospitals, the clinical directors, the medical boards and the nursing leaders believe it is best for us to co-locate with St. James's Hospital, This is **very misleading**.

The current Group Clinical Directors were appointed only in 2015, years *after* the site was chosen as were the nursing leaders. The medical board of our Lady's Hospital Crumlin was never consulted regarding the choice of St James and did not endorse the decision. Tallaght's Children hospital does not have a Medical Board. These appointments obviously would not have been made if the candidates did not support the site already chosen.

which is the largest hospital and the leading adult teaching hospital, because it offers unparalleled opportunities for our paediatric services to be supported by the breadth

and depth of sub-specialties that best support paediatrics. This is **misleading**.

The top subspecialties identified by the Location Task group and McKinsey are not available at St James's. There is no evidence to support improved clinical outcomes with adult co-location. All required specialist care will be provided from within the Children's Hospital.

Also, as a campus, it fits in with our vision for research and innovation. Between its facilities already on the St. James's campus and the new children's research and innovation centre, it will drive advancements and treatments that will improve clinical outcomes for our children. This is **misleading**.

The National Children's Research Centre will be with the Children's Hospital irrespective of location. Furthermore, the space allocated for the research centre is smaller than requested at the St James's site with no room to expand.

What we are about, however, is more than the building, albeit it is an important catalyst.....

We have heroic, talented staff that we value highly. Despite their surroundings, they are doing great work but in sub-optimal conditions. We support our colleagues, who have presented previously to the committee, in the absolute need for a new children's hospital. It is, however, broader than that. We also rely on multiple arrangements with several adult hospitals to support paediatrics This statement is **false.**

A Children's Hospital does not rely on any adult hospital to care for sick children. The arrangement is with individual consultants, determined by their contract, Not with hospitals.

and we need to move to position where that is much more co-ordinated with a large teaching hospital. This is **not relevant**.

When completed the Children's Hospital itself will be one of the leading children's teaching hospitals in Europe. For example the dual-trained orthopaedic surgeons in Temple Street and Crumlin would continue to work in their adult hospitals Cappagh and Tallaght respectively when patients transition into adult care. St James adult hospital does not have the inpatient bed capacity, theatre time and outpatient facilities to absorb any new cohort of patients.

The ability to work collaboratively across all of the clinical specialties in paediatrics is hampered and limited by the fact that the specialties are on different sites particularly between Our Lady's hospital in Crumlin and Temple Street Children's University Hospital. This means that our children and their families need to move across the city, our charts need to move across the city, our x-rays need to move across the city and it is not helping us in delivering optimal care. Tonight, parents will be sleeping on the floor of a children's hospital beside their sick child's bed because we do not have the

facilities to accommodate them appropriately. This statement is **irrelevant.**

This will be resolved by the amalgamation of the three children's hospital irrespective of location. It has nothing to do with an adult hospital.

There is limited car parking at Our Lady's hospital in Crumlin and there is none at Temple Street. This is **grossly misleading.**

The parking provided at St. James's is the lowest parking allocation of any recently built children's hospital anywhere in the world with fewer parking spaces per bed than were available in Crumlin in 2010.

Our children deserve more.

In making progress, we have identified that there are 39 specialties within our existing services. These specialties have mapped out, over the last year, what they are going to do and undertake before they move to this new hospital. This is essential because while the building offers the opportunity to come together, fundamentally as a service we need to be working effectively before we transition to these new centres. There is extensive, daily collaboration between the three children's hospitals; between the nurse, the clinical and the management leaders, on optimally getting the best from a clinical and operational perspective in designing this hospital. This statement is **irrelevant.**

Collaboration will continue irrespective of location. It has nothing to do with an adult hospital. It is not dependent on an adult hospital.

We are on track for our programme and we will work with our colleagues in the development board to support this build. We are already making changes in how we are delivering paediatric services such as introducing new beds and new types of beds into children's hospitals. The new building will be a significant catalyst for positive change and it will afford us the vision that we want to deliver, as do all of us here, with what is right and best for our children. This statement is **irrelevant**.

The new building will be a catalyst for positive change irrespective of location. It has nothing to do with an adult hospital.

Chairman: I thank Mr. Pollock and Ms Hardiman for their opening statements. I am going to bank questions in groups of three, due to time constraints, and the witnesses may make notes of the questions. I invite Deputies O'Reilly, O'Connell and Kelleher.

Deputy Louise O'Reilly: Good morning, or good afternoon now, and I thank the witnesses for their presentations. A number of questions arise which are not specifically based on the presentations we have just heard, but are related to it.....

Deputy O'Reilly asked three questions. **NONE** were answered

Deputy Kate O'Connell: I thank the witnesses very much for coming in to speak with us this afternoon. To follow on from Deputy O'Reilly's questions, I would like to speak about the tri-location model..... **THREE** of the questions asked by Deputy O'Connell were **not answered,** others were not answered fully.

Deputy Billy Kelleher: I thank and welcome the witnesses..... **FOUR** of the questions asked by Deputy Kelleher were **not answered**.

Senator Rónán Mullen: I welcome the members of the hospital development board and thank them for coming before the committee today. **TEN** of the questions asked by Senator Ronán Mullen were **not answered**.

Chairman: I thank the Senator. I am conscious that there is a vote in the Dáil at about 12.50 p.m. that we had not calculated into our timing. I wish to make the witnesses aware of that.

Mr. John Pollock: There are quite a few questions there. I will start with the St. James's campus. There is a big vision for the St. James's campus that people probably do not always fully understand.

C4KH fully understands that the NPHDB's 'big vision' is for the St. James's campus. This is the problem. The big vision should be for the development of a world class Children's Hospital as per their brief. Mr. Pollock has confirmed our belief that they have overstepped their brief (SI 246/2007) to build the Children's Hospital and are more interested in furthering the aims of the adult hospital.

It has come out of all reports that were written for Government on which the ultimate decision to co-locate was made. Fundamentally, having co-location is the optimal solution. This statement is **absolutely shocking.**

It is acknowledged by everyone that tri-location is ”the optimal solution”, not co-location. Again, it appears that the NCHDB is more interested in furthering the aims of the adult hospital.

That comes out clearly in all of the reports, whether it is the McKinsey report, the Dolphin report or the Clear and Martin report. Co-location is fundamental. Mr Pollock is **misrepresenting** these reports. Yet again, it appears that the NCHDB is more interested in furthering the aims of the adult hospital.

It is notable that he also fails to mention The Independent International Expert Review Report of 2011 which stated that tri-location was "imperative".

What St. James's has as a campus is specialties and sub-specialties. What does that mean for people who come to the hospital? It means it has radiation treatment services. This statement is **misleading.**

Only a tiny number of children receive radiotherapy and the vast majority would be treated as outpatients. Due to its potential to cause severe side effects in children, it

is likely that proton beam therapy will replace it. There is no space for proton beam therapy at St James's.

Obviously, Connolly does not have a radiation treatment service so we would have to duplicate a service like that out in Connolly. This statement is **false**.

Duplication of this service at Connolly would not be required.

St. James's has access to the blood transfusion service. Again, that is obviously a service that paediatrics requires. This statement is **ridiculous and seems meant to mislead.**

Every hospital in the country has access to blood transfusion services.

I will ask my medical colleagues to elaborate on why these specialties are so important.

St. James's has 50 acres of land in the middle of the city centre. It is going to undergo a radical change over the next number of years. I invite the committee to come and visit the site. It is currently made up of many single and two-storey buildings. The development plan now permits the building of six and seven-storey buildings. The children's hospital construction works are now under way. This statement is **false**.

Construction work will not start for approximately 12 months. The site is being prepared but construction is not underway. We too urge the Committee to visit the St James's site to see just how crowded and inaccessible it is, and then to visit the Connolly site.

Adults are already there. Yes, St James's is an adult hospital!

It has blood transfusion services. Every hospital in the country has access to blood transfusion services.

On the issue of maternity services and the Coombe, I will ask Dr. Sharon Sheehan to talk about her support for the site from the maternity side of things. The Coombe will be delivered in the next number of years. When asked for a timeframe Mr. Pollock failed or was unable to answer.

We hold that it is not possible for a fully serviced Coombe hospital to be built on the site.

On this campus, there will be services from cradle to grave: there will be maternity services, children' services and adult services.

It is our strong belief that the site simply cannot accommodate these services.

St. James's recently opened the Mercer's institute for successful ageing, MISA, building for the aged. There are services for maternity, children, adults and the aged.

We also have access to radiation oncology services. There are the blood transfusion services.

There is research carried out there. There is the institute for molecular medicines and the Wellcome institute. We are going to put the children's research centre right beside that. **It is too small.**

We refer to the letter you all received from Dr Joseph McPartlin (26 October 2016), Head of the Institute of Molecular Medicine and the Wellcome Institute, where he expressed serious concerns about the viability of the campus if this project goes ahead.

They will share a mass spectrometer. This statement is **ludicrous**

It is a laboratory machine which does not require co-location

Buildings will be physically linked and staff will move from building to building. They will share their research. People ask, "Why is research important?". Research is important because it is the future of treatment. The research we do today is the treatment of tomorrow.

We wish to inform the Committee that the most productive medical institution in terms of research for the past 40 years has been the National Children's Research Centre on the campus of Our Lady's Children's Hospital Crumlin.

There is a big vision piece happening on this campus. Out of that, we will get a campus that will rival anything in Europe. It will be one of the great health care campuses and will compete with any in Europe. What we get from that is the best staff and the best people wanting to work on this campus. People automatically think of Great Ormond Street Hospital and they want to work there.

Great Ormond Street Hospital is in no way not comparable to the National Children's Hospital. It has no emergency department or secondary care beds. It is a national and global quaternary referral centre.

This is what we are creating: a health care campus across cradle to grave that people want to come to and have access to research in. If we get the best people and staff, we get the best treatment for our children.

We welcome the admission that staffing will be a major problem at St. James's. Ms Hardiman has said "recruitment of highly qualified staff would be a challenge for the hospital". We have been warning her of this for years. Her totally unrealistic solution that staff at St James's should be paid more and that local housing should be provided by Dublin City Council and the HSE indicates just what a major problem it will be.

That is the big vision piece that might not always be communicated on our behalf. I will ask Dr. Peter Greally to talk about why St. James's is so suitable from the clinical

perspective.

Dr. Peter Greally: It is great to have the opportunity to present the vision for the new children's hospital. As a bit of background....., Last year, in 2015, I became the group clinical director. I was appointed in open competition.

I was involved in the appointment of the other three clinical directors. These are the site clinical directors for Temple Street, Tallaght and Crumlin. One of them is a specialist in neonatology and is very much an intensive care doctor. Two of them are emergency department consultants. That involves front-of-house, very acute medicine. These are not people who are hiding from the coalface. They see the problems that arise in trying to provide services for children in the current set-up on a daily basis. These people were appointed in open competition and on the merits of their experience and training. We find this **misleading** in the context of a debate on the choice of site.

All the Clinical Directors were appointed in 2015 - their appointment depended on their support for the site.

I just want to clarify that.

This project has received the wholehearted support of the medical boards of the three children's hospitals, as well as the boards of management of the three children's hospitals, the Coombe Women and Infants University Hospital and the faculty of paediatrics. This statement is **false.**

The Faculty of Paediatrics has NOT supported the project. The St James's site was not endorsed by paediatricians. In fact the choice of location was never discussed by the membership of the Faculty of Paediatrics or debated at their AGM. The claim of support from the three medical boards is also false. There is no paediatric medical board at Tallaght. The medical board of Crumlin Hospital was never consulted about the choice of St. James's.

Therefore, people whose main interest is the best care for children all endorse this project and location because we recognise that an integrated, tri-located campus has the capacity to care for the sickest of newborn children, older children, very ill mothers and adolescents with chronic diseases who will need to transition to adult care. As Mr. Pollock mentioned, it is an academic campus that has the capacity to care for people from cradle to grave. We therefore have great ambitions for this campus, and I envisage that the children's hospital, over time, will become a magnet hospital where the scale of our activities becomes such that we will attract medical and nursing trainees from all over the world who will want to work in our institution. We re-iterate the acknowledgement that the choice of location will create a major staffing problem.

We will become a flagship hospital of international renown and will be a rival to hospitals such as Great Ormond Street Hospital. This statement is **utterly**

ridiculous.

Great Ormond Street is a global referral hospital with the remit to also serve a national population of 64 million.

I will say a few words on the evidence for tri-location. I think we have all agreed that tri-location is a good thing. The lack of evidence does not mean that there is a lack of benefit. The lack of evidence means that no one has done a clinical trial or a trial that examines the outcomes of patients who have been treated in one system versus another, so that argument does not hold. **Ridiculous** statement.

You don't need to do a clinical trial! All you need do is look at outcomes as has been done in demonstrating improved clinical outcomes in relation to maternity co-location.

Many clinical interventions in medicine have occurred which have not been scrutinised by clinical trials but which we know to be beneficial to patients.

The modern trend, when building a new children's hospital, is to tri-locate it on a campus with maternity services and an adult academic centre. These days, new builds of stand-alone hospitals are rare. We have heard about Alder Hey but, in fact, Alder Hey wanted to tri-locate with the relevant hospitals in Liverpool but they were unable to cater for the scale of activity that Alder Hey was providing on a suitable campus. I can give the committee plenty of examples of tri-located hospitals in the UK and elsewhere. The most analogous to our proposal in the UK is in Manchester, but Glasgow Children's Hospital is also tri-located, as will be the soon-to-be-completed Edinburgh children's hospital. The Lady Cilento Children's Hospital in Brisbane is also tri-located on an adult campus, so the evidence is that international best practice is tri-location. Dr Greally's presentation is **confused and incoherent**.

We all agree that there is ample evidence to support the benefits of tri-location. There is however no evidence whatsoever of improved clinical outcomes through co-locating a children's hospital with an adult hospital.

Why St. James's Hospital? The authors of the Dolphin report were asked to carry out an appraisal of the Dublin academic teaching hospitals. They chose St. James's Hospital on its clinical and academic strengths, This statement is **shocking.**

Dr Greally's lack of knowledge of the content of the Dolphin Report and the site selection process is difficult to fathom and raises very serious questions over his evidence. The Dolphin Report did not choose or recommend any particular hospital nor was it in its brief to do so.

which I will go into in a moment, but it was also chosen because it has excellent public transport links. Six bus routes serve it, there are three Luas stops near it, it is adjacent to Heuston Station and is closely adjacent to the N4 and M50. No other hospital has such links. The medical sub-specialisms available there, as we have heard, include blood transfusion, radiation oncology and PET scanning. It is also the

national or regional centre for haematology and coagulation disorders and oncology and provides craniofacial and maxillofacial surgery, immunology, vascular surgery, orthopaedics, plastic surgery and burns treatment, cardiology, respiratory treatment, renal treatment - the list goes on. Unfortunately, none of the other sites had such a breadth of specialties. These specialties are important because many children who are regular users of our service will require care in adulthood, and while not all of them will be catered for on the adult site, many can be. This statement is **misleading**.

The references to all of the specialties in James's suggests a claim to improved clinical outcomes which we repeat cannot be substantiated.

I am not involved in defining strategy over the next 50 years,

Defining strategy is not the job of a Clinical Director. It is the job of politicians.

but I imagine that national centres will relocate to the St. James's Hospital site to facilitate that transitional care to adulthood. This statement is **misguided**.

His reference here is to the development of the Adult Hospital. There will be no capacity to relocate additional centres to the St.James's site if the Children's Hospital is built there. We have explained what will happen to transition of care as children progress to adult services. The various national specialties are scattered throughout the city e.g. cystic fibrosis (St Vincent's); neurosurgery (Beaumont); young adult congenital heart disease and metabolic disease (Mater hospital); kidney transplant (Beaumont); heart transplant and lung transplant (Mater), liver and pancreatic transplant (St Vincent's). And the majority of those who need to transition will have their needs met by the Regional University Hospitals of Cork, Limerick and Galway.

We feel that Dr Greally's evidence should be discarded. Such flawed "evidence" from the Children's Hospital Group Clinical Director reflects an extraordinary lack of understanding of the issues and the fabrication of arguments used to justify what is unjustifiable. This is what we have faced over the past four years.

A particular example of the importance of the transition to adult care is children who survive childhood cancer. They are at risk of developing new cancers because of the chemotherapy used to treat their primary cancers. Some children will have received radiation therapy, particularly to the brain area, and are therefore at risk of pituitary growth-type problems. Children who have undergone palliative treatment for complex congenital heart disease require long-term follow-up and often follow-up procedures in adulthood. Children who have chronic conditions of the kidney or joints will also require long-term follow-up.

None of the above is specifically relevant to St. James's

An academic environment is extremely important as well. I hold an academic appointment in Trinity. Teaching and research is very important. It should be remembered that today's medical and nursing students are tomorrow's clinical

leaders and that current research leads to tomorrow's cures.

Chairman: We put Dr. Greally under time pressure there but we have devised a means by which we can continue so that he is not under time pressure later.

Deputy Billy Kelleher: Is that a cunning plan of the Chairman for us to come back after the vote?

Chairman: Yes.

Deputy Billy Kelleher: Okay. Are the witnesses are available to hang on, then? Will we suspend for a number of minutes and then come back, or does-----

Chairman: Two Senators wish to contribute. We will continue.

Deputy Billy Kelleher: I see.

Chairman: The Deputy can come back with further questions.

Deputy Billy Kelleher: That is perfect.

Mr. John Pollock: One of the concerns of the members of the committee is the capacity of the site for maternity services. I will ask Dr. Sharon Sheehan in a minute to talk about the relocation of the Coombe, but one thing that demonstrates how we handle maternity services is that as part of our planning application to An Bord Pleanála, we did not lodge a planning application for maternity services. That was not what we were asked to do by the Government. That decision was only made in May of 2015, and we lodged our planning application in August of 2015. However, what we did do is produce a master plan for the campus. This statement is **false.**

No master plan has been produced despite being requested to do so by An Bord Pleanála.

Just to clarify for the Committee what a Master Plan involves - it generally shows a development concept for the entire land holding which would include layout landscaping, infrastructure service provision, circulation, present and future land use and built form. It would generally consist of images, text, diagrams, statistics, reports, maps and aerial photos that describe how the site can be developed. What was presented to An Bord Pleanála instead of a Master Plan was a document titled " DRAFT Site Capacity Study" dated August 2015. The date of the draft indicates that all the plans for the children's hospital were drawn up in the absence of any detailed assessment of what would fit on the St James's site.

The people who know this campus best of all are now us. We were told we would not deliver a children's hospital in this campus and that it was too cramped and too small.

We delivered a planning application and An Bord Pleanála adjudicated on it and made no changes to it. We understand this site. We understand how we need to stay

within the Dublin City Council development guidelines regarding height and access to the sites. We understand all the planning issues about overlooking and protecting residents. We applied the same strategy as we applied for the children's hospital to do an outline design of the maternity hospital.

This is most surprising! To our knowledge there is no outline design for a Maternity Hospital. If it exists it is remarkable that it hasn't been produced.

We have identified the site. It is three acres. Much of it is made up of a car park, which is the outpatients department of St. James's Hospital. The other portion is a single-storey building, the outpatients department, which would need to be demolished. That building was erected in the 1970s. This is **incorrect.**

The building opened in late 1989.

That three-acre site will be a full maternity hospital, and we have physically plotted all the connections, whether underground, for servicing it and for materials, or corridor links above ground for moving patients and staff from the maternity hospital to the children's hospital. I am therefore extremely confident that we will deliver a maternity hospital on the site. What our site capacity plan demonstrated is the 50 acres of land we have on St. James's Hospital site, and because of the fact that heights will go up as permitted under the Dublin City Council development plan, our building will be seven stories. There will be more seven-storey buildings in St. James's Hospital.

Our outline master plan demonstrated that we can have the St. James's adult campus and the children's and the maternity hospitals, and on top of that we could build another children's hospital, This statement is **unbelievable.**

As stated above there is no master plan for the site. It is our strong view that the site is too small for the children's hospital, that it cannot accommodate a full service maternity hospital as well as the adult hospital. It is simply preposterous to suggest that a second children's hospital could be accommodated there as well.

so we could triple the development on the 50 acres at St. James's Hospital.

That is while protecting the listed building and the residents. This campus of 50 acres can therefore triple in capacity, so we will comfortably deliver the maternity hospital. Would Dr. Sharon Sheehan like to talk about why it is so important from her perspective?

Dr. Sharon Sheehan: Yes. I thank Mr. Pollock.

Deputy Louise O'Reilly: Before Dr. Sheehan begins, will the witnesses specifically address the issue of timing? My understanding is - and I ask the witnesses to correct me if I am wrong about this - that planning permission has not yet been received for the maternity hospital. I ask the witnesses to factor in an assumption of planning permission. We are all speaking about tri-location, but what is

being proposed in the short to medium term, from what I can see as a layperson, is co-location, which we all agree is not ideal. I apologise for the interruption but I must go and I want to be very specific about this. This question was not answered in the following response by Dr Sheehan.

Dr. Sharon Sheehan: I thank the committee for giving us an opportunity to speak. I am here at the master of the Coombe Women and Infants University Hospital. I am also a consultant obstetrician and gynaecologist. Like Dr. Greally, I have worked the three Dublin maternity hospitals as well as in Limerick and in the UK. I bring a range of perspectives to this.

Tri-location is absolutely essential. It is really simple as to why we should tri-locate. It improves outcomes and efficiencies across our services. What is very important, and I would like to take this opportunity to dispel many of the myths circulating, is we are not talking about moving a high-risk maternity unit onto the campus. We are talking about bringing the full breadth and depth of women and infant services that operate in the Coombe Women and Infants University Hospital onto the St. James's Hospital campus site to tri-locate with St. James's Hospital and the new children's hospital. Any misconceptions about a high-risk maternity unit are ill-founded. It is very important that it is the full breadth and depth. For us, in our hospital, it is about looking after maternity services. It is also very important to remember how much gynaecology service we deliver in our hospital. It is essential this is catered for on the St. James's Hospital campus and this has been allowed for.

The full breadth and depth of women and infant services is very important and it has been raised previously regarding the national maternity strategy. I had the great pleasure and privilege of sitting on the national steering group for this strategy. It fully endorsed the tri-located model, which is very important. Yes, it endorsed co-location but it fully endorsed tri-location, which is entirely consistent with Ireland's first and only national maternity strategy. This is very important.

Another very important issue to take into account is that we are not just talking about moving to any hospital. We are talking about moving to the St. James's Hospital campus. It is important to remember that St. James's Hospital is the largest and leading adult acute service in the entire country. It has the greatest number of national specialties and the greatest number of acute specialties. This is not just moving to any adult service, it is moving to the leading service for clinical specialties and research and innovation on the St. James's Hospital campus.

When we look at tri-location, and it has been raised previously, we speak about the transition for mothers and their babies to paediatric services, but we must also think about the transition for mothers and women to adult services. It is not just about children moving from paediatrics to adult care, it is about mothers moving across in a seamless transition to adult services. We are not just talking about buildings, and this is very important. Ms Hardiman mentioned this in her statement. Much work has already taken place, so we are in a position where we can state we are virtually tri-

locating. There is a huge difference between tri-locating and "virtually" tri-locating. Until it becomes a reality the danger to the lives of sick newborns will continue.

This is not just waiting for a new shiny building and expecting our services to transition patients seamlessly across them. This is all about the collaboration that happens long before any planning permission applications are sought or a sod is turned in the ground. This is going on.

If I can speak about what is going on in the Coombe hospital at present with regard to maternal medicine, we operate one of the largest maternal medicine and comprehensive services for women with complicated medical histories during their pregnancies. Consultation is provided across our experts in the Coombe hospital and experts in St. James's Hospital and Tallaght hospital. This is already happening. We offer mothers who come in with complex maternal medicine cases the absolute optimum of care.

With regard to location with the children's hospital, extensive collaboration is going on regarding our services and paediatric services. An example of this is the all-Ireland fetal cardiac clinic. This is being led by Dr. Orla Franklin, who is a consultant cardiologist in Our Lady's children's hospital in Crumlin and Dr. Caoimhe Lynch, consultant obstetrician and gynaecologist and fetal medicine specialist in the Coombe hospital. This clinic looks after women from all 32 counties in Ireland. No other fetal service in the country is doing this. Mothers diagnosed with congenital cardiac anomalies in their babies in the womb are transferred and referred the Coombe hospital. They meet experts in our hospital and in Crumlin hospital, where their care is mapped out as is a plan for their labour and delivery and for what happens to the baby once it is born. This is happening right now.

This is the type of collaboration we need to have well-established before we think a shiny building will better enable it. We already know the service we offer for those mothers whose babies have been diagnosed with this condition in utero means the outcomes for those babies has improved. We are able to say this right now. Tri-locating only enhances this in terms of the physical space. Tri-location does much more than this.

A physically connected maternity hospital reduces both death and disability as evidenced in the letter which the Oireachtas Committee received from the 15 most expert Paediatric Specialists in the country.

So much work is already going on. Understanding the importance of tri-location across maternity services for women, paediatrics and adult services is very important. It is essential we do not lose sight of why we are moving onto the St. James's Hospital campus. It is because of the benefits the hospital will be able to deliver for us and the benefits the new children's hospital will bring. The benefits of tri-location are really simple. It will improve outcomes for our women and their families and it will improve efficiencies across our services. Dr. Sheehan does not deal with the critical

question of the transfer of sick newborns.

We agree with her belief in the benefit of tri location. However, we remain firmly convinced that a full service maternity hospital cannot be accommodated at the St James's site.

Senator Colm Burke: I apologise for not being here for the start of the presentation. Unfortunately I had business in the Seanad I had to attend to.....

ONE of Senator Burke's questions was **not answered**

Mr. John Pollock: Deputy Louise Reilly's question was linked with this issue. In terms of timelines, we are further on than the Rotunda Hospital in moving to Connolly Hospital because we have done two things. First, we have a master plan in place. There is no Master Plan.

The Master of the Rotunda, Professor Fergal Malone, has stated that he will be cutting the ribbon at the new Rotunda hospital Connolly in five to six years. This will improve clinical outcomes and save the lives of children. If the political will is there to do it, we believe that the two hospitals could be built simultaneously as requested by the Board of Directors of Crumlin in 2006.

We have physically identified the location of the site. Second, we have future-proofed our services within the children's hospital. For instance, in the case of the energy centre, clinical sterilisation service and facilities management, FM, logistics, we have built in spare capacity for when the maternity unit will come on line. That will help to bring down costs. The Rotunda Hospital is not as far advanced. A master plan for the site has not been completed.

I am not aware of when the Government will commit funding, but I estimate that it will take approximately two years from when the funding is committed to develop the brief, lodge the planning application with An Bord Pleanála and receive planning permission for the St. James's hospital site. Thereafter, it will probably take two years to build the hospital. If the Government was to commit funding, that would be the timeframe involved, but it is a matter for the Government to decide.

Ms Eilísh Hardiman: I hope it is okay to group some of the questions on services. Specifically, questions were asked about the figures that had been made public for health care planning. To be clear, the figures quoted for the children who attended the three children's hospitals are factual. We collate the data for the counties from which children come to avail of inpatient and day case services. Not only that, we have carried out a geo-analysis of where children attend emergency departments. We did this with the health intelligence unit and found that 95% of the children had attended their local emergency department. Using CSO figures, with the health intelligence unit, it has been mapped that the children were from within a 10 km radius of St. James's Hospital. The mapping exercise was engaged in using postcodes. It has demonstrated to us that 48% of the children living in Dublin are within 10 km of St.

James's Hospital. This was a key element in identifying where a hospital should be sited.

It is misleading and unjustifiable to use population statistics for Dublin only when the Tertiary catchment area is the entire country and the secondary catchment area is the Greater Dublin Area (Dublin, Kildare, Meath and Wicklow).

Most of the rest, from a health care planning perspective, was focused on where we saw the population growing in the future - to the north west and south west of the city and in the greater Dublin area. Hence, both the analysis and the social deprivation index, an indicator of where families use health care facilities, were used in identifying where paediatric outpatient and urgent care satellite centres should be based - in Tallaght and Connolly hospitals.

It is clear from all published reports that the future growth of paediatric populations will predominantly occur outside the M50. This data was applied to the location of the Satellite Urgent Care centres but was not applied to the location of the NPH.

One of the primary objectives, as a service provider, is to locate a hospital where most of the population live - the inner city This statement is **false**

and then provide what is predominantly used on a daily basis, that is, outpatient and urgent care centres, at locations convenient to these families, that is, off the M50 to provide access to outpatient and emergency services. That would meet most of their needs. This statement contradicts itself.

The first statement, that most of the population live in the Inner City, is factually incorrect and grossly misleading and we reject it completely. Firstly, it is based on the Dublin population, secondly 48% is not "most", and thirdly a 10km radius around St. James's does not constitute the "inner city". The second statement that a location convenient to the families is a location off the M50,contradites the first statement and should promote the requirement for the Children's Hospital to be located off the M50, not in the Inner City.

A first draft of the model of care to be used was developed in the planning of the hospital at the location of the Mater hospital. This was endorsed by the three children's hospitals. The HSE has since established the clinical care programmes, as part of which a clinical care programme for paediatrics and neonatology was established. There was extensive engagement that was much wider than that engaged in previously in all of the paediatric, neonatal and maternal units. A consensus based model of care has been developed, the engagement on which not only included the doctors, nurses and health and social care professionals in the three Dublin children's hospitals, as well as the maternity hospitals in Dublin, but in all 20 paediatric units throughout Ireland, as well as in the three regional units at Galway, Limerick and Cork. A family advisory group that represented many of the advocacy groups on children's diseases and health care issues also took part in the

process.

The fundamental principles underpinning a single hospital have never been refuted. Everyone understands we would all be better under one roof. However, that it be at the centre of a network for paediatrics is a strong requirement. We do not want it to be all about a building. We believe the services for children in Cork, Limerick and Galway and regional areas need to benefit from us working in a networked way. Therefore, while we are coming together as specialists under one roof, the plan is to afford specialties opportunities to support our colleagues in the regions. For example, five doctors are working across the three locations in endocrinology and diabetics. Many of them could subspecialise if they were all working together and help our colleagues in the regional units.

Expansion was one of the issues raised. Again, this is a health care planning objective of ours. We have planned to 2046, which was as far as we could go using CSO projections. When we looked at the issue of expansion, we took into account all activity in the children's hospitals, all unmet clinical needs because of capacity issues, future population growth and trends in epidemiology. As hospitals expand, it occurs predominantly in two areas - intensive care and high dependency units and outpatient units. Taking these into account, we have demonstrated that the hospital will meet population requirements until 2046. We are doubling capacity in the facility in the area of critical care. We will not open all of the beds when it opens in 2021.

This indicates that the commitment to open in 2020 has now been **delayed.**

Experience shows that hospitals can expand as much as 100% within 10 years. The claim that 20% expansion space would be adequate over a 25 year period up until 2046 is disingenuous.

We have designed the hospital in such a way that the corporate offices will be located beside critical care services in order that they will be able to expand by one third within the existing building by moving the corporate offices to another part of the campus. We have also identified grey space in services that cannot be moved within the hospital such as the emergency department, the imaging department, ICU and the theatres. We are building rooms that are probably bigger than the ones we are in in the middle of the imaging department. In ten or 20 years new technology could be developed and we will have the capacity in the imaging department to take it on board.

Size and scale of future technology cannot be predicted.

When looking at the provision of an outpatients department, it is important to note that everything does not necessarily need to happen at the hospital, as we have demonstrated in locating paediatric outpatient and urgent care centres at Tallaght and Connolly hospitals.

The idea that an outpatients department could be located off site is a very clear

indication that they are fully aware that the site is too small.

The intention is to have the people whom we serve in the greater Dublin area use them and not the hospital when it opens. If we need to expand further after 2046, we will look at having further outpatient and urgent care centres, as opposed to everything having to be provided in a hospital that provides for the tertiary-quaternary needs of children.

This hospital is to serve all the inpatient needs of children in the Greater Dublin Area and was not just for the tertiary-quaternary needs of the country.

The hospital, we have been told, was to last the children of Ireland for 100 years. We are now looking at a situation where there is acknowledgement that after 25 years there are going to be serious space and capacity difficulties.

Ms Eilísh Hardiman: Particular futuristic treatments were mentioned. To be clear, the national cancer programme has led the way in planning proton therapy which only three to five children need. It is more for adults. We access such facilities in London. Something of that nature, a highly specialised treatment, would have to be developed with paediatric and adult services in mind. St. James's Hospital is the largest provider of cancer services in the State. It is also the provider of radiation oncology services. There will be future expansion of radiation oncology services for both paediatric and adult services. I heard mention of a PET-CT scanner. No, we do not have a PET-CT scanner and will not in the children's hospital because such small numbers use it. We will access the one that is already in St. James's Hospital. Yes, we have developed a workforce plan. We engaged with the directors of nursing, the clinical directors, the health and social care professionals and the management of the three children's hospitals. The plan outlines our staffing requirements for the next five years to open up both the paediatric and outpatient urgent care centres at Connolly hospital and Tallaght hospital and the new children's hospital. We have also identified that the majority of the staffing increase is in the nursing area. In planning for that we have a workforce planner specifically for nursing looking at the supply of children's health nursing over the next five years in a planned way, as opposed to getting to the point where we realise we need to train more such nurses. We have a systematic process identified of what our requirements are and a plan put in place over the next five years to look at how we can supply. There is a global shortage of some specialties but we are also looking at whether there are new and different roles that can be introduced to alleviate some of the pressures that have been well established in other jurisdictions in particular areas.

It is interesting that their workforce planning is looking at the supply of children's health nursing in light of the fact that the National Children's Hospital will not be open until five years time. It is also surprising that it is reported to us that staff in the existing three children's hospitals have not been consulted regarding work force planning.

I am pleased that people picked up on the fact that it is really important that while the building is a catalyst, there is strong consensus across the staff of the three children's hospitals. We have had more than 1,000 hours of engagement. Currently, we have 200 of our staff working in planning the rooms. We have 6,000 rooms that are being designed. They are attending meetings on planning. I reassure the committee that the staff within the three children's hospitals are actively engaged in designing the hospital and, more important, they are actively engaged in how we are going to work together as a single legal entity by 2018, before we move into the new hospital. Before I came here my previous role was CEO of Tallaght hospital, which was a merger of three hospitals. It is really important that the building works because we are the hospital that will be providing services to the children of the greater Dublin area and all of the national services but it is really when people come to get treated by doctors, nurses and health care professionals that we will get the integration right. We have some great fundamentals driving that, because no other hospitals in the adult system or even in the maternity system, work in an integrated way as do the three children's hospitals. Every day we have staff going between the three children's hospitals. Every day we have patients and families going between the three hospitals so we work already in that manner.

Despite the claim of over 6000 rooms, there is marked concern among the staff particularly at the introduction of hot-desking for the social workers and psychologists which lacks a respect for privacy. Lack of a dedicated office for these professionals is inappropriate for children who need the familiarity and security created by a familiar space.

I heard reference to a staff survey. I wish to clarify that is not an official survey. It was not endorsed by the management and leadership of Crumlin hospital. It was a SurveyMonkey survey that one puts up on a web page. I completed it myself ten times so I question the validity of the outcomes of the survey.

It was never claimed that it was an official survey. We suggest and would welcome that staff should be officially surveyed by a questionnaire agreed by both parties. This should have been undertaken many years ago but was, most surprisingly, never done.

In the absence of any consultation by management with the staff of Crumlin hospital in relation to the choice of the location we conducted the survey. It was conducted in an understanding of a culture of trust by staff. The action of the CEO of the National Children's Hospital Development Board, interfering in such a manner, suggests malfeasance on her part and is shocking.

I was asked whether I personally believe that St. James's Hospital is the right site. Absolutely, yes. I come very much from a personal position..... I am very much personally driven by that most harrowing experience of my career.

In terms of weaknesses in Connolly hospital, we work with the management and staff

in that hospital because we are planning an urgent paediatric care and outpatient centre. We have very good relationships with the hospital in regard to that. People in the area are very pleased to have paediatrics on the site of that hospital. Families are already attending the emergency department there because of their adult requirements and they look forward to the day when they will be able to attend for all of their requirements, not just adult but paediatrics. We have had engagement with the GPs locally who see this as a good development, as opposed to going into the inner city to get those treatments. Having said that, if I was to outline some of the examples of where the benefits are between Connolly hospital and St. James's Hospital, it has to lie-----

Senator Rónán Mullen: Will Ms Hardiman please put it in terms of the relative weaknesses of Connolly hospital?

Ms Eilísh Hardiman: Yes, I am going to do that. For example, we have 300 children with cancer and a lot of them have leukaemia.

This figure is meaningless given that it has no context. There are approx.180 newly diagnosed children with cancer each year in Ireland.

We are rated fourth in the world for outcomes for paediatric leukaemia. Some children require bone marrow transplant. At the moment if a relative such as the mother or father is the donor, he or she has to have bone marrow extracted in St. James's Hospital, while at the same time the child is in a theatre in Crumlin hospital. The bone marrow is brought over and has to be donated there. That service is not moving from St. James's, which has been well established as a leading national service for adults. We want a situation whereby the mother and child are on the same campus at this very traumatic time when the bone marrow is donated and is also transplanted.

Not only is the answer not relevant to Senator Mullins question but it is misleading and factually incorrect. Only a tiny proportion of children require stem cell transplantation. It is exceedingly rare for a parent to be a suitable donor. It is also becoming extremely rare for bone marrow to be used. The vast majority of stem cells for these children are delivered from International Donor Panels to the child's bedside - not to an operating theatre. If a suitable donor is found in Ireland, peripheral blood stem cells are collected in Crumlin. A visit to an operating theatre is unnecessary.

Radiation oncology is already on the site. St. Luke's has moved its services to St. James's Hospital. We have children with cancer who require full body radiation and at the moment they travel to St. Luke's. Our intention is to move that to St. James's so that there is a corridor length involved when they attend for radiation oncology as opposed to having to travel from another campus for the service. This is **misleading**.

St Luke's has not moved its services to St James's. In fact its move has been delayed by at least five years as it has been deferred due to the construction of the

Children's Hospital. Preparation of children to receive a stem cell transplant rarely requires total body radiation.

A total of 25% of consultants within the three children's hospitals have adult-based specialties with a special interest in paediatrics. All of our cardiac surgeons are also adult cardiac surgeons. All of our neurosurgeons are also adult neurosurgeons and that will not change. None of those are at Connolly hospital. **Neither are they at St James's.**

At the moment, within the three children's hospitals we have to engage with our colleagues in the adult hospitals to support us in some very specific areas. For example, we do not have vascular surgeons in paediatrics.

We have a very early stage development of interventional radiology where imaging radiologists go through veins instead of using open surgery to get to the organs they need to get to. That is much more established in the adult services. Those types of consultants are very competent in dealing with highly complex situations around bleeding. Sometimes when we have children that need very complex surgery we invite those surgeons to attend and be in the theatre at the same time so that they can help the paediatric surgeons. Those are the types of specialists who are in St. James's Hospital and who are not in other hospitals and who really help us at times of crisis and when we have really sick patients.

This is not site-specific. The vast majority of adult consultants work in more than one hospital. This cannot possibly be seen as a weakness of Connolly.

In regard to rare diseases, we definitely are working-----

Senator Rónán Mullen: Is Ms Hardiman addressing Senator James Reilly's comments?

Ms Eilísh Hardiman: Yes. St. James's Hospital's laboratory services already support the three children's hospitals so they help us in the diagnosis of some illnesses and conditions. The new challenge with the children's hospitals is that we are getting successful at treating some very rare diseases and children are now surviving into adulthood. One example of that is intestinal dysfunction. It is where a small number of young children do not have any small intestine and they end up not being able to absorb some key nutritions and they have to have them delivered intravenously. That is done in the children's hospitals. Those children are now surviving into adolescence and we are now working with St. James's Hospital, which has the greatest gastroenterology unit, in order for those children to move from Crumlin hospital to St. James's Hospital.

Last year, in the case of haematology, which is the blood diseases, we transferred some of the sickle cell anemia cases. Sickle cell anemia is a very rare condition. Due to the inward migration, particularly from sub-Saharan Africa where there is a high prevalence of the disease, it was evident in the children in Crumlin. We have

successfully treated those children to adolescent stage and they are now transferring to the haematology services at St. James's Hospital. For the first time on this campus-----

This response fails to address the cohort of children to which Senator Reilly referred when speaking about children with very rare diseases who cannot be treated in Ireland. Ms Hardiman seems to have missed the point of the questions, as she is talking about children with rare conditions who are already being treated in Ireland. Furthermore she refers to sickle cell anaemia, which is not a rare disease, and none of these children travel abroad for treatment for this condition.

Ms Hardiman has diverted the question to speak about children who are transitioning into adult services - the question was about children with rare diseases.

Senator Rónán Mullen: Excuse me, the former Minister, now Senator Reilly, said it was the primary clinical driver for the decision. Could that have been true?

Ms Eilísh Hardiman: The primary reason is that some of the high level specialties we are doing in paediatrics are best supported by the specialties at St. James's Hospital.

This is not true.

Senator Rónán Mullen: This is for the rare diseases.

Ms Eilísh Hardiman: I have just given the committee two examples. Sickle cell anemia is a rare-----

Senator Rónán Mullen: Was he correct in saying that the primary clinical driver for the decision was that children with very rare diseases could be treated by St. James's Hospital's adult hospital consultants? The group we met this morning said that was false. I seek an answer to that.

Ms Eilísh Hardiman: I am saying that one works together with one's colleagues in the adult service. Perhaps I could give a fourth example.

Senator Rónán Mullen: No, please do not. Just tell me if, in Ms Hardiman's view, he was correct that it was the primary clinical driver for the decision.

Ms Eilísh Hardiman: I cannot attest for what he said. I have not heard the interview. However, I know that we are working with St. James's Hospital and some of the rare specialties for rare diseases.

Senator Rónán Mullen: I know the great work the witnesses are doing, but does Ms Hardiman think that could have been true?

Ms Eilísh Hardiman: Yes. The co-location with St. James's Hospital is about supporting the 22% of the really complex work we do.

It is obvious from Ms Hardiman's answers that there are no rare diseases that can be treated at the adult hospital at St James's for which children would otherwise have to seek treatment abroad. The nonsensical claim from Senator Reilly cannot be substantiated and the supposed clinical benefits, the claimed primary driver for adult co-location, remains unjustified.

Our other core objective is meeting the local requirements of the local children, given that 48% of them live in the area within the M50. These figures are **incorrect**

One third of the local children live within the M50.

If I may continue with the example, we are very successful in our paediatric cancer services. We are approximately fourth in the world with some of our outcomes. However, we have concerns with regard to adolescent cancer, because it is an area that falls between the adult and the paediatric services. The new cancer strategy has identified that as a key area for significant investment and improvement so we can save lives. Some of the adolescent children require paediatric chemotherapy regimens, which are very well understood by oncologists in the paediatric service, but because some of their cancers are adult type cancers such as sarcomas they need to be based with colleagues who deal with those in the adult service.

Paediatric oncology centres are very familiar with treating sarcomas in childhood. The concern with adolescents seems at odds with the cut off age of the eve of the 16th birthday for children to be admitted to the Children's Hospital at St James's. The WHO says a child is a person 19 years of age or younger.

Figures from the RKW report show that an extra 50 beds would be required were the 16 and 17 year olds to be treated. A paediatric hospital at Connolly has capacity for these beds and to cater for this cohort.

In the future it is about co-working between paediatrics and adult services to get the best people together on these types of rare conditions. Internationally, that has been demonstrated to lead to better outcomes, which means more survivors and less mortality from these rare diseases. St. James's Hospital provides us with the opportunity to do that.

Chairman: I have a few questions. When Dr. Finn Breathnach and several other members of the delegation from Connolly for Kids appeared before the committee they were quite definite that co-locating with an adult teaching hospital brought no additional benefits to children. You have referred to some of the benefits that will arise, so how can experienced paediatricians be so diametrically different on that point?

Ms Eilísh Hardiman: We are going to differ on this because we have very experienced paediatricians currently delivering the most specialist services to our children and they fundamentally believe that co-location will add benefit. If you speak to Professor Smith or Professor Capra about oncology, they believe and strongly

advocate that being on this campus will result in better survivorship for children with complex conditions. Dr. Peter Greally might wish to add to that.

Dr. Peter Greally: I can base it on my own experience. In addition to being a respiratory paediatrician I cover the acute and general on-call roster, so it is unselected patients coming in with any number of disorders. I am based in Tallaght Hospital where we are co-located with adult services. Over the last year I have had three cases of adolescent patients who have presented with conditions that are relatively rare in children, and there was not necessarily the expertise within paediatrics to deal with them, where we called in the relevant specialists in the adult services to help us. That was just my experience and other colleagues in Tallaght would have had the same experience. Sometimes it can work the other way. Again, these are rare situations but it is one piece of a jigsaw. It is not just one thing that dictates whether co-location or tri-location is important, it is the totality. Sometimes adult physicians encounter rare disorders which are more commonly seen in children, so it works the other way. We are occasionally consulted to give our opinion on those disorders. It is part of the overall picture. It is not necessarily the key driver, but it is an important contributor.

The paediatric unit in Tallaght is a small unit in a predominantly adult hospital. Dr Greally's experience would not apply in a large National Paediatric Hospital. Again the question asked has not been answered.

Chairman: Is there evidence, which Dr. Breathnach denied, of better outcomes from co-locating with an adult hospital?

Dr. Peter Greally: As I said earlier, I do not think anybody has ever done a clinical trial or reviewed the outcomes in care by comparing one system to another. Ethically, I do not believe it would be possible to do it.

One does not require a clinical trial to establish whether or not there is a benefit to adult co-location. All one need do is look at outcomes, as has been done to clearly establish the benefits of maternity co-location with a children's hospital.

However, I point to the fact that newly built children's hospitals are rarely stand-alone now. The tri-location model is the norm. Stand-alone new builds for children's hospitals are the exception. **Chairman:** Dr. Breathnach spoke about Melbourne and Liverpool having stand-alone paediatric hospitals.

Dr. Peter Greally: Alder Hey Children's Hospital is the hospital he mentioned. As I understand it, Alder Hey as an institution wanted to tri-locate but because of spatial issues in Liverpool and the scale of the Alder Hey clinical operation there was not the capacity to accommodate it. With regard to Melbourne, which historically has been a stand-alone children's hospital, it is adjacent to Flemington Road and, if memory serves, there is an adult hospital and maternity services 2 km to 3 km up Flemington Road. Although it is stand-alone, those services are adjacent.

Ms Eilísh Hardiman: If I may add to that, it is important to point out that the chief executive of Alder Hey was on the Dolphin group and fully supports tri-location. That was what Alder Hey was trying to do, but it was not viable. Previous reports of CEOs of major children's hospitals, which are often referred to, all support tri-location, including the CEO of Great Ormond Street Hospital.

Dr. Sharon Sheehan: I remind everybody that the Connolly for Kids group also proposes a tri-located model. It is not proposing that we build a stand-alone hospital. We are saying the same thing as the group that appeared before the committee before us. Tri-location has been shown to be a better model, and we are all saying that. We are showing with our proposal that tri-locating on the St. James's Hospital site is the best option. However, there is no dispute among ourselves or any other group that tri-location is the preferential model.

Chairman: Access is a very emotive issue for mothers, who believe they will be travelling long distances and will encounter huge traffic problems. I experienced that when I went to visit the site. How can you allay the fears of people who think they will not get to the hospital in a timely manner? **Not Answered despite two opportunities given.**

Mr. John Pollock: Before I reply, that question is relevant to Caitríona Sharkey as a parent who has experience with paediatric services. She is under time pressure to leave and she has first hand experience of this.

Ms Caitríona Sharkey: To give the committee a little background, I am here as a parent representative..... Sick children do not need a space the size of Croke Park but a place where they can spend some time with siblings and other family members and get some fresh air. From what I have seen in the plans for the new children's hospital, they will deliver this.

Chairman: Does Mr. Pollock wish to add to Ms Sharkey's comments?

Mr. John Pollock: Yes. We have always been conscious that parents coming to the hospital with a sick child will drive and we have never suggested they take a bus or Luas. That was never our plan. From the outset, we have prioritised the car parking spaces for families and parents coming to the hospital. A total of 675 car parking spaces have been ring-fenced for parents. An Bord Pleanála has confirmed this and made the number of spaces a planning condition. This means we could not change it, even we wanted to do so.

As Ms Sharkey indicated, one of the anxieties parents have when coming to the hospital is whether they will find a car parking space. Parents will be able to pre-book parking using a facility similar to what available to visitors to Dublin Airport where people can pre-book a space and when they arrive at the car park their car registration is recognised. The barrier is then lifted and the driver parks in an assigned parking space. The new pre-booking facility at the hospital will remove an

anxiety faced by parents.

We also recognised that some parents will arrive at the hospital in highly distressed circumstances and will obviously not have the luxury of pre-booking a parking space. The accident and emergency department will have 27 car parking spaces. A parent who arrives at the accident and emergency department with a child in an emergency will find a concierge service. The parent will hand the car keys to the concierge and enter the hospital and the car will be parked for him or her. The St. James's hospital campus caters for everybody, those who need to drive to the hospital and those who prefer to use public transport. As Ms Sharkey stated, grandparents who do not drive may wish to visit their grandchildren at the weekend. They will be able to take a train to Connolly Station or Heuston Station or a bus to Busáras and travel straight to the hospital. The green and red Luas lines will connect next year, making the site even more accessible.

This raises questions of the 675 parking spaces being diluted by those reserved for valet and pre-booked parking. Further, it is our contention that the 675 spaces cannot be provided as the width of the spaces between the columns does not comply with required standards.

We also recognise the need to look after staff and a further 325 car parking spaces have been provided for staff. These spaces will be prioritised, for example, members of staff living 1 mile from the hospital do not need to drive to the hospital. This is the way cities have evolved.

I am sorry Senator Rónán Mullen has left the meeting. He asked what is the significant weakness of the Connolly Memorial Hospital site. We know a great deal about Connolly hospital. In lodging an application for planning permission for a 5,000 sq. m. site, we had to comply with local, regional and national transportation policies. The An Bord Pleanála inspector, in his report ruling on granting us planning permission, The inspector's report does not 'rule', it recommends states:

There is a flaw, in my opinion, in the argument put forward by some of those who advocate a greenfield site adjacent the M50. They appear to assume that unfettered access off the national and primary route and unfettered access to on-site car parking can be accommodated. The same national, regional and local transportation policies are equally applicable at that location as they are at the application site and do not support such a strategy.

The applicable policies referred to by the Inspector have been interpreted by Dublin City Council to permit 2 parking spaces per bed-space on the St. James's site. However, contrary to the assertion by the Inspector, they have been interpreted very differently by other Local Authorities. These same policies have allowed South Dublin County Council to allocate 5 parking spaces per bed-space at the Hermitage Clinic and Fingal County Council to permit 7,000 parking spaces in Blanchardstown

Shopping Centre. It appears clear that the Inspector's observation doesn't hold up.

What the inspector was very much calling out in these remarks is that if one chooses a greenfield site without access to public transport, only one mode of transport, namely, the private car, is available to access the site and this means providing car parking. This does not align with transportation policies. The idea that thousands of car parking spaces would be provided at the Connolly hospital site is, therefore, a myth.

We do not concur with this interpretation of the Inspector's intention since a greenfield site without access to public transport has not been suggested by anyone. The Martin and Clear Report were very favourable in their assessment of public transport to Connolly, noting also that Regional busses serve the Blanchardstown Shopping Centre

The inspector went further in his report when he stated:

In that regard, it is interesting to note that in its written submission to the Board, Transport Infrastructure Ireland (TII) placed strong emphasis on the applicant delivering upon its MMP to reduce the generation of car commuter traffic, especially in relation to the satellite centre sites at Tallaght and Connolly hospitals to protect the national road network in the vicinity of those sites... If the TII was concerned about the relatively small satellite centre of *c*. 5,000 sq.m. proposed under the current application at Connolly hospital, it may not be unreasonable here to suggest that they might have greater concerns if the NCH/CRIC/FAU of *c.*125,000 sq.m. was proposed there instead.

He is pointing out that if the TII had concerns about a 5,000 sq. m., what would be its concerns in respect of a site of 125,000 sq. m. The inspector's report continues:

Furthermore, there is no guarantee that locating the NCH on a greenfield site adjacent the M50 will avoid the congestion some fear will be encountered accessing the St. James's site. The upgraded M50, as referred to by some at the Hearing, is experiencing congestion too.

There will be an estimated c.4,000 additional vehicular movements per day associated with the Children's Hospital. The majority of these vehicles will travel for at least some distance on the M50. It is obvious that the capacity of the M50 to absorb this additional traffic is far greater than the capacity of the very narrow roads in mediaeval Dublin around St. James's.

On this day last week there was major congestion on the M50 where even the hard shoulder was closed. That is a recurring theme. It is a myth to think that the M50 does not have problems because it does have problems.

No one has ever suggested that the M50 does not have problems. However, even if it is blocked, the road is wide enough for vehicles to make space for an ambulance,

which is not the case for the roads surrounding St. James's Hospital. It is crucial to remember that the new Children's Hospital will be the ONLY hospital in the Greater Dublin Area to which ambulances will deliver patients. We know their movement will be impeded on a daily basis at St. James's.

An Bord Pleanála, in its wisdom, looked at all of these issues and called out very strongly that it has concerns. I think that is a fundamental weakness.

Is Mr. Pollock seriously suggesting that it is easier for the 9 out of 10 children who live outside the M50 to negotiate the M50 and then drive into the narrow choked streets of the Inner City, than to get off the M50 at the N3 interchange? We vehemently dispute his assessment that traffic consideration on the M50 would be a weakness while clearly much worse traffic difficulties pertain at the St. James's site.

The inspector also referenced the other major weakness in his report. He said there are many people who are not in favour of the St. James's Hospital site and on that point they are in agreement. After that they are not in agreement

It is grasping at straws to suggest that simply because Connolly is not everyone's favourite site this is a 'major weakness'.

because some favour Tallaght, the Coombe, Connolly hospital or a greenfield site in the middle of the country. The Inspector did not make any reference to a 'site in the middle of the country'.

There will never be a site that everybody rallies around because there is no perfect site. We say Connolly is the perfect site. The two 'weaknesses' claimed by Mr. Pollock are totally contrived.

There is the best site and that is what we have got. The only justification provided to date for this statement is incorrect.

Chairman: I wish to ask a final question before I bring in Senator Burke. Is there a security issue at the St. James's site?

Mr. John Pollock: Does the Chairman mean security on the campus?

Chairman: Yes.

Mr. John Pollock: There is no security issue that I am aware of.

Other people working on the site are very aware of security issues. We know that nurses have to wait to be accompanied by security staff to go to their cars. This would not be required if the area did not have a security problem.

I have heard some people opposed to the site run down the Dublin 8 area, which I think is inappropriate. I would describe it as a diverse community. We discovered that as part of a study on the impact of the hospital. The people living in the community

range from people with low levels of educational attainment to people with the highest levels and PhDs. One of the ambitions we have set ourselves and with which we have engaged with Dublin City Council is the opportunity for a project like this to support the regeneration of an area. This opportunity cannot be missed and the docklands is an example. Regeneration can take place with proper planning. The big vision piece that I spoke about for the campus will attract other industries that want to locate in close proximity to us. The opportunity for regeneration of the area is huge.

The wish to regenerate an area of the Inner City **cannot** be allowed to take precedence over the imperative to provide the optimum health care for the children of Ireland.

Within our construction contracts we have embedded community clauses. It means the contractor has a contractual obligation to employ staff from the area. We have gone into schools and sold the ambition of having a career in hospitals. Some people have said people should just think about careers in catering and cleaning. We wanted to set a bigger ambition and for children to say, "Why can't I be a nurse or doctor and this is the campus I want to work in."

Our offices are on the site, as the Chairman is aware. We have experienced no issues with security. We have a drop-in centre at the Rialto bridge where residents have been invited to visit the site. Residents support the project on a 10:1 ratio. Our offices on the site have models and images of what the hospital will look like. We have encountered no issues at the location, so we are welcome in the area.

Senator Colm Burke: I want to deal with an issue that was raised in the presentation made by the previous group of witnesses. They expressed the view that the Minister should intervene and locate the hospital the Connolly Hospital site. The last paragraph reads: "If the Minister fails to do so he should know with certainty that he will be responsible for the deaths of many children and the avoidable anguish of countless parents." It has been implied in the submission that the location at St. James's Hospital will cause deaths. It is a serious suggestion that needs a response.

Ms Eilísh Hardiman: I shall reply. I thank the Senator and agree because our primary focus is to improve services and patient safety is always of paramount importance. The reference to loss of life is usually made to the transportation of neonates just born. We are all on the same side in terms of supporting the tri-location argument.

The leading clinical expert in the transportation of neonates, who are small babies, is the neonatology transportation programme. Dr. Jan Franta, who leads that programme, presented at the oral hearing on the 4,000 transfers that happen between the maternity hospitals located all around Ireland and the children's hospitals and maternity units in Dublin. All of those transfers were analysed for an instance or learning that can take place and nothing untoward has occurred in the

transportation approach.

Dr Breatnach has explained how the neonate is resuscitated throughout the ambulance journey. It is only after they reach the hospital that ventilation would be discontinued and therefore the death is recorded as having taken place in the hospital.

The Department of Health states in a press release dated 1 July 2012, that "These infants are often delicate and corridor transfer minimises the risk of destabilisation during external transfer. Co-location facilitates co-ordinated planning and allows for the presence of the appropriate specialists at the birth with immediate take-over of care."

We have a challenge because the vast majority of the population that we want to serve, the people who live in the greater Dublin area, need a new hospital.

This is extremely misleading. As we have set out previously, 9 out of 10 children live outside the M50.

That is one of the hospital's functions. In addition, we can only have one hospital on the island that deals with highly specialist cases and, therefore, it must be based in the greater Dublin area. How do we work as a system to ensure that, where we have rural-based sick children, they safely transfer? That is how other jurisdictions like Wales and Scotland look at the issue and the same happens in Australia, which has a large landmass to cover.

We have clearly identified, in the national model of care for paediatrics and neonatology, that while one centralises highly specialist services one must put in what we call a retrieval service where we retrieve really sick babies and children. At the moment the retrieval service is 24-hour and seven days a week for neonates, who are the small babies born in any of the maternity units. I shall let Dr. Sharon Sheehan talk about this matter too. I note the vast majority of babies who are born with serious medical issues tend to be diagnosed beforehand and tend to experience a planned delivery, predominantly in the Coombe but also in the other maternity hospitals in Dublin. Even with that one will have babies who are born with a condition that went undetected. We have put in place a process where a highly specialist neonatologist who works in intensive care and a nurse or midwife will travel to the maternity unit where the child is stabilised. They will stabilise the child there and bring him or her back to Dublin. That system has been demonstrated internationally as a much safer way than trying to do this work in another way.

We have reports of patients who could not be moved due to delay of the transfer as the team was being used for a transfer somewhere else in the country.

The retrieval service is fine for children up to the age of six weeks. In paediatrics we are looking to roll-out a similar retrieval service for children aged six weeks up to 16 years. We have managed to do so on a Monday-to-Friday basis. We continue to

recruit paediatric intensivists and will expand the programme to provide a 24-hour and seven-days-a-week service. The plan is if there is a really sick child anywhere outside of Dublin, or even within Dublin, one needs to use the ambulance service, which is very good at dealing with these cases. I have heard some of the parents talk about travelling in ambulances with really sick children but travelling is the right thing to do. The children can be stabilised and we send our specialists to places like the Cork, Limerick or Galway units, where the child should go to be stabilised, and then we bring them back to the children's hospital. We would use the helipad and helicopters or roads, whichever is the best method of transportation. That model is part of the national model of care for paediatrics. We will roll it out over the next five years. I wish to assure the public and parents that really sick children should use the ambulance or go to their regional hospital where we will go to retrieve the really sick children and bring them to Dublin. This type of model has saved lives in other systems.

Deputy Bernard J. Durkan: I apologise for arriving late but I had to attend a funeral in Tipperary and hence my absence.

I want to be assured that the easiest and fastest access to a children's hospital is the optimum, particularly at rush hour or peak traffic times. At other times it does not make a difference as it is easy to reach the required destination. As has been mentioned, the M50 is always extremely overcrowded at peak times and sometimes it is virtually impassable. Some people even refer to it as a carpark in the morning and evening peak times. If anything goes wrong, the M50 gets blocked for quite a while.

We must aim to provide the highest quality and most extensive services at the one location, in so far as is possible, in order to ensure there is a service available to patients and their families.

We reiterate that the M50 has a hard shoulder. We would further remind the Committee that the New Children's Hospital will be the only hospital in the whole of the Greater Dublin Area that will receive children in ambulances.

There are six adult emergency departments in Dublin and ambulances serving the St James's hospital have a much smaller local catchment area that the planned Children's Hospital. The Head of the National Ambulance Service stated that : "*An important factor for the national ambulance service in relation to location [of the NPH] is good access to a major thoroughfare such as the M50."*

As 9 out of 10 children live outside the M50 they will have to cross or travel along part of the M50 to get to St James's Hospital.

Deputy Kelleher .....

Ms Eilísh Hardiman: We assure the committee that we have involved parents to a great extent in designing the hospital. We had a family forum which was made up of family representatives. Many of those who have presented to the committee as

members of the Connolly for Kids Hospital Group actually sat with us in designing the hospital.

We were amazed as this statement. None of us was involved in the designing of the hospital. One of our group did attend the Family Forum but found there was absolutely no culture of participation in decision making.

As such, we have engaged in meeting the requirements of families. From a family perspective, there are single rooms which will contain a bed for a parent to sleep comfortably with a child. In addition, there will be a family lounge within what we call "dressing gown distance" of the critical care units, including ICU and the neo-natal intensive care unit, which, because they tend to work on a 24/7 basis, can be noisy, particularly because there are ventilated patients. The family lounge will include 28 bedrooms, as well as a seating area, a kitchen area and showers in order that predominantly mothers but parents can stay within dressing gown distance of critically ill children. The planning application also included a 53-bed family accommodation unit adjacent to the front door of the children's hospital. That is where the Ronald McDonald House will be located. Ronald McDonald House has long experience in Dublin at Crumlin hospital, as well as internationally, in accommodating families who stay overnight or must travel long distances. Currently, there are 16 such beds available; therefore, 53 beds represents a significant increase.

We wish to highlight that, in addition to the 16 beds at the Ronald McDonald House at Crumlin, two houses are also available for families on Crumlin Road. Fifty three beds falls short of what was requested and there is no room for expansion. In comparison, The Alder Hey, a hospital with approx. 200 fewer beds provides 69 family bedrooms and 15 family apartments. Our new Children's Hospital will provide only one third of the family accommodation offered at the Alder Hey - the new Children's Hospital in Liverpool.

We receive requests for accommodation in Dublin in the children's hospitals and have matched that demand and planned for it. We intend to deliver these services.

One of the things at which we are looking in collaboration with Dublin City Council is what the accommodation around the hospital needs to be like more generally. There should be accommodation for key workers. I have worked in London and the USA where one was able to find an apartment near a hospital. We have not previously looked at this issue in the design of cities to support really big developments such as the planned campus at St. James's Hospital. We are looking at general accommodation needs which require to be met to support a campus of this size.

Mr. John Pollock: Our board is probably unique. As our remit is to design, build and equip the hospital, the skill set on the board reflects this. We have Mr. Tom Costello who was CEO of Sisk, the largest builder in the country; procurement expertise from the Office of Government Procurement; an architect from Northern Ireland, Mr. John

Cole, who was the chief architect for the Northern Ireland health service; and financial services, contracts and legal expertise. It is very much a board that was assembled with a fixed remit to deliver a hospital from start to finish. We were asked if we had looked at equipping the hospital. We absolutely have. We have appointed a dedicated team of four people and have lists of all the equipment that will be provided in the hospital - from desks, beds, imaging and theatre equipment to X-ray machines. It is on our procurement list and we are advancing with these plans. They have been put out to tender.

We were asked to elaborate on the provision of green spaces. We have four acres of green space in total on the campus.

This may give the wrong impression. The four acres are not at ground level and are dispersed in small lots hroughout the site. Nowhere is there an expansive green space.

There are multiple gardens. From the point of view of parents and children, it is within that oval, a garden that is longer than Croke Park,

This is a **false** statement - it is much shorter than Croke Park. Additionally Croke Park is comprised of 3.15 acres while the garden referred to within the oval, totals approximately two thirds of an acre of garden and is divided into two parts.

in the middle of which we have what we call a biome in order that, even on a wet day, one will be able to sit in that space and look out on the garden. It is very sheltered because the in-patient wards will surround it.

The fact that it is in an enclosed well that is 50 feet deep, means that the amount of sunshine reaching the surface is limited.

Staff, families and patients will be able to go there and it is big enough to be segregated. Children who are immuno-suppressed and cannot go out with the other children will be able to use the segregated areas.

It is difficult to see how much space will be available for children to play given the tiny size. Most of these areas are either private or semi-private and are not available to the public.

At ground level, we will have what we call our "meadow garden" which will be open to everybody, including the public and local residents, and which will be over an acre in size. On the southern boundary where the Luas line runs, there will be a linear park which are creating as part of the development. The Luas stop at Rialto is 30 m from the front door of the hospital and there will be another garden located there. The three-storey finger buildings out towards the South Circular Road will feature internal courtyards. We are very conscious of our neighbours across the road, which is why the buildings will not be too high. The courtyards will be accessible to out-patients who want some fresh air and to get out of the hospital environment. On the third

floors of the buildings, there will be break-out spaces for staff. If one needs a break from the hospital, one will have a quiet space where one will be able to take a cup of coffee and sit. In total, four acres of green space will be provided on the campus.

All of the above small sections of artificially created open space in an urban environment described by Ms Hardiman, cannot be compared to the 50 acres of healing parkland available at Connolly.

Chairman: I thank Mr. Pollock, Ms Hardiman, Dr. Greally, Dr. Sheehan and, of course, Ms Sharkey for attending and giving us their views and updating us on how the hospital will develop. I propose that we send a transcript of the hearing to the Minister and the Department for Health and ask for their comments when the Minister and his officials meet us on 10 November. Is that agreed? Agreed.

The joint committee adjourned at 1.40 p.m. until 9 a.m. on Thursday, 10 November 2016.