

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

ABP Ref. PL29N.PA0043

AND IN THE MATTER OF AN ORAL HEARING

Statement of Evidence of Dr Emma Curtis

30 November 2015

1.0 QUALIFICATIONS AND EXPERIENCE

1.1 My name is Dr Emma Curtis. I am a Consultant Paediatrician at the National Children's Hospital, Tallaght. I work as an acute, general paediatrician with a special interest in developmental paediatrics and child protection. I have worked as a paediatrician for 28 years. I graduated from UCD in 1983, obtained Membership of the Royal College of Physicians in Ireland in 1985 and trained in paediatrics in the Children's University Hospital, Temple Street, the Rotunda Hospital and Our Lady's Children's Hospital, Crumlin. From December 1990 to May 1994 I worked as a paediatrician in Esteli, Nicaragua and from August 1994 to March 1999 completed my paediatric training in Newcastle upon Tyne, England where I was appointed to a consultant post in 1999. In 2002, I was appointed to a consultant paediatric post in the National Children's Hospital, Tallaght. I was Chair of the National Children's Hospital Paediatric Medical Advisory Committee from June 2006 to June 2008 and I was appointed by the Tallaght Hospital Board to the NPHDB in 2007 as the Tallaght Hospital clinical representative to the Development Board.

1.2 In September 2008 I was appointed, in open competition, to the post of medical director to the National Paediatric Hospital Development Board. I have worked on the project since that time. The Medical Director post is a half-time post. I continue to work half time as a Consultant Paediatrician at the National Children's Hospital, Tallaght. As Medical Director to the project I have the following responsibilities:

- I ensure there is appropriate clinical input to the project
- I liaise closely with the clinicians in the three Dublin children's hospitals and nationally
- I represent the clinicians' views to the Development Board and to the design team
- I work closely with the Health Service Executive, the Children's Hospital Group, and with the National Paediatric Clinical Programme

- I have worked closely with the Operations Managers, the Directors of Nursing, the health planners and the clinicians in the development of the activity and capacity modelling on which this design has been based

1.3 I have supported, and along with the majority of practising paediatricians in the country, been involved in the development of the National Model of Care 2015. I support the ongoing work on the hospital model of care for the New Children's Hospital, the specialty models of care and the model of care for the New Children's Hospital's satellite centres.

1.4 In order to learn from similar children's hospitals projects and new hospital projects elsewhere, I have visited a large number of hospitals in England, Scotland, the Netherlands, the United States, Canada and Australia.

2.0 INTRODUCTION

2.1 Before addressing certain submissions and observations made to An Bord Pleanála [the Board] on the application for permission, I would like to make the following point: everyone involved in the development of the New Children's Hospital is totally committed to building a hospital in which the highest quality of clinical care can be delivered to the children and young people of Ireland and their families. The National Paediatric Hospital Development Board (NPHDB) is committed to creating an environment in which children and their families feel valued and where the children will receive modern, safe, effective, timely, patient-centred, efficient, equitable and holistic team-based care. The NPHDB is committed to creating a New Children's Hospital, with its two satellite centres, in which staff will feel safe, supported and part of a team all working to a single aim. That aim is to deliver the best clinical care and achieve the best outcomes for children and their families.

2.2 The NPHDB is joined in this endeavour to deliver the best clinical outcomes for children by the Children's Hospital Group (CHG) and supported by the children's hospitals' Boards and their staff, the Faculty of Paediatrics, the National Paediatric Clinical Programme Leads, the paediatric Clinical Directors and the Directors of Nursing in the three children's hospitals.

2.3 In relation to the application for permission before the Board, a number of submissions and observations have been made in relation to clinical matters and which have raised issues within the following categories: clinical need, model of care, co-location, tri-location and expansion. I shall address each of the issues raised in this statement of evidence. Where an issue does not fall neatly within the categories identified above, I shall address miscellaneous issues at the end.

2.4 On the issue of the model of clinical care, co-location, tri-location and expansion I shall address the observations made by the following third party observers: National Children's Hospital Alliance; Mr. James Sheehan; Tanya Kenny and Daniel Watkins; Margaret Healy; Aaron Daly; Michael Hennigan; Fionnbarr Walsh; Noel Dever & Others; Michael Muldoon; Valerin O'Shea; Jack and Jill Foundation; St James Concerned Residents; Departments of Paediatric Intensive Care; Pamela O'Connor; SCR/Kilmainham Residents' Associations; Mark Dunne; Desmond J Riordan; Elida Maquis; Christine and David Harmes; St. Martin's Resident's Association; Dunboyne Mums' Tallaght Hospital Action Group; Caitlin Woods; Michael Hennigan; Desmond Cox; McDowell Avenue Residents; Gloria Rooney; Desmond J Riordan; An Taisce; Philip Ward; Parish of St. James; Heather Iland; St. James Concerned Residents; Lorraine Murray; Nigel Buchalter; John Early and John Lane; Tanya Kenny & Daniel Watkins; John and Josephine McMorrin; Neil Donnellan & Others Deirdre Carrol, and, Elena and John Cassidy.

3.0 CLINICAL NEED

3.1 I understand that the overarching requirement for An Bord Pleanála is to consider the proper planning and sustainable development of the area or areas in which a development is proposed to be located. Accordingly, the issues of sustainability and the need for the development are important considerations for the Board. In this context, the question might be asked, ‘why do we need a new children’s hospital and why do we need it now’? After all, it is true to say that there are well three established children’s hospitals in Dublin in which the staff work incredibly hard to deliver safe, high quality clinical care to children and young people.

3.2 There are two main reasons why a new children’s hospital is needed, and needed now. The first is that the New Children’s Hospital has the potential to ensure that clinical care, and the patient and family experience, is so much better. The children and young people of Ireland deserve that now. The second reason is that, as recommended in the McKinsey Report (“Children’s Health First”, 2006), the optimal paediatric service for a population of up to 5 million is a single centre providing tertiary, or specialist, care for that population which would also provide secondary care for its local catchment population which, in this instance, is the Greater Dublin Area. (By ‘tertiary care’ I mean specialist care of children with complex conditions such as cancer, heart disease, brain surgery etc. By ‘secondary care’ I mean the care of children requiring paediatric care with conditions such as chest infections, kidney infections, broken bones needing surgery, meningitis, asthma, headaches etc.) By creating a single national children’s hospital out of the three existing Dublin children’s hospitals, there is a real opportunity to improve clinical outcomes by bringing all specialist paediatric care to one location.

3.3 International evidence demonstrates that clinical outcomes are better in units where a higher volume of difficult and complex care is delivered. This is because there is improved access to, and availability of, the key sub-specialist clinical

teams, as well having all of the medically advanced and expensive diagnostic machines and supplies in one place. McKinsey quantified this improvement in their example of the mortality rate in Swedish heart hospitals which decreased from 9.5% to 1.9% one year after a similar merger, despite taking on more complex cases. This improvement can be attributed to the fact that specialist teams improve in their management of complex cases when they physically manage more of them and when they are surrounded by the sub-specialist team members and resources which they require. This is the kind of improvement that is expected to result from the delivery of the New Children's Hospital.

3.4 The three Dublin children's hospitals have a proud and fascinating history. The National Children's Hospital is the oldest of the three. It has been located in Tallaght since 1998 but was founded in 1821, almost 200 years ago. It was known as the "Pitt Street Institution" and it was the first hospital in Ireland and Britain established specifically for the care and treatment of children. Dr Charles West, who worked in the hospital, went on to found Great Ormond Street Hospital 1852. In 1875 the National Orthopaedic and Children's Hospital was established and it was formally joined with the Pitt Street Institution in 1884 and, in 1887, they both moved to Harcourt Street. The stated objective of the hospital at that time was, "to educate mothers and nurses regarding the proper management of children in both health and disease."

3.5 Temple Street Children's University Hospital was founded as a charitable infirmary in Dublin in 1872. Thomas Moore Madden, one of the hospital's founding doctors, spoke on its behalf at the Spencer Commission presenting the case that Irish children deserved to be treated in a special environment of their own rather than in an adult hospital.

3.6 Our Lady's Children's Hospital Dublin opened in Crumlin in 1956 and was specifically designed to care for and treat children.

3.7 As stated previously, the National Children’s Hospital moved from Harcourt Street to Tallaght in 1998 and, therefore, is a relatively modern build. One of its three wards has 100% single bedrooms with parent accommodation provided in the room. However, the other two wards have a mixture of multi-occupancy rooms and single rooms and the majority of single rooms do not have en-suite facilities provided. The National Children’s Hospital Tallaght has a paediatric Emergency Department which saw 32,387 children in 2014. However, access to the paediatric emergency department is through the adult emergency department and this is not optimal practice. Tallaght has three high dependency beds but there is no intensive care and children who are critically unwell and require intensive care management must be transferred to either Our Lady’s Children’s Hospital, Crumlin or to Temple Street Children’s University Hospital. The National Children’s Hospital in Tallaght provides a secondary general paediatric service to south-west, west and central Dublin, Kildare and Wicklow and also has a number of subspecialties but children with complex, multi-organ problems must attend one of the other two Dublin children’s hospitals for any other specialist care.

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

children's hospital, the access they will have to a wider range of specialist and multi-disciplinary care and a vastly improved physical infrastructure.

3.9 Our Lady's Children's Hospital, Crumlin is the largest children's hospital in Ireland and provides the majority, but not all, of specialist paediatric care in Ireland. The hospital has been committed to developing and improving its infrastructure over the decades. However, it was not designed for the delivery of modern paediatric care or for optimal efficiency. While historically, the infant ward has had single rooms, these are small and allow parents to sleep overnight in only a chair. Some recent ward upgrades have provided single rooms with parent accommodation but this is not yet uniform. There are many multi-occupancy rooms which mix children of different ages and genders and where parents sleep on the floor beside their child's bed overnight. This means that in a ward there might be 4 to 6 mums and dads sleeping on the floor each night. The building standards are compliant with standards of a different era. Clinical adjacencies have developed rather than being planned for optimal clinical care and efficiency. The children attending Our Lady's Children's Hospital, Crumlin will also benefit from the planned clinical adjacencies in the new children's hospital and the availability of the full range of clinical specialists there. In Our Lady's Children's Hospital, Crumlin and Temple Street Children's University Hospital the commitment of the staff to the delivery of excellence in clinical care shines through but many elements of the physical environment pose a challenge.

3.10 It is against this background that the New Children's Hospital must improve the clinical care which children and young people receive. The first means of achieving this improvement in clinical care is to bringing together all the specialists and their teams into one hospital, which will have an enormous impact. Secondly, the New Children's Hospital has been planned and designed in a sustainable manner to deliver modern paediatric care now and into the future. The existing three Dublin children's hospitals have 432 beds. Approximately 53% of the inpatient rooms are single rooms and the remainder are shared. In the New Children's Hospital, there will

be 473 beds, of which 380 will be inpatient beds and 93 day-care beds. Of the inpatient beds, 100% all of the rooms are single rooms and, with the exception of intensive care, all rooms are en-suite and all have parent overnight accommodation provided within the room. Within the hospital there is a parent centre with bedrooms, bathroom facilities, a parent lounge/work area and a gym. There is also an application for a parent accommodation unit right beside the hospital to accommodate children and their families from outside of Dublin. There will be 93 day care beds because of an increase in day-care activity, which is reflective of modern practice. Currently, there are 12 theatres between the three existing hospitals, whereas in the New Children's Hospital there will be 18 theatres as well as cardiac and interventional radiology theatres and two endoscopy theatres. The current overall space occupied by the three children's hospitals is approximately 75,000 Sq. m. which will be replaced by the new children's hospital on the campus at St James's Hospital with c. 118,000 Sq. m. . There will be out-patient care and urgent care delivered both in the hospital on the campus at St James's Hospital and in the New Children's Hospital's two satellite centres on the campuses of Tallaght and Connolly Hospitals. There will be 123 outpatient examination rooms between the New Children's Hospital located on the campus at St James's Hospital and the satellite centres. Emergency care will be delivered in the New Children's Hospital Emergency Department and urgent care in the hospital and in the two satellite centres.

3.11 The New Children's Hospital has been planned as a large, integrated children's hospital. It has been designed to facilitate optimal clinical care, efficiency and the patient and family experience. The Emergency Department, Paediatric Intensive Care Department, Operating Theatres and the Helipad are all placed one above the other, vertically adjacent thereby facilitating rapid, safe transfer of the sickest children. The orthopaedic outpatient service, a high user of X Ray facilities, is located beside the Radiology Department. The outpatient departments have been designed with the clinical consulting examination rooms and the multi-disciplinary support facilities in the same area to reduce patient travel and inconvenience and to

deliver a cohesive multi-disciplinary service in one place. Complex national services such as oncology, cardiology and nephrology, which care for vulnerable patients with complex needs have been designed to have all elements of their service, inpatient, outpatient and day-care beside each other. The New Children's Hospital has, accordingly, been specifically designed to deliver high quality, efficient, effective, family-centred and safe clinical care. The proposed facility promises a new era in the delivery of excellent healthcare to the children and young people of Ireland.

3.12 The fact that there are three children's hospitals in Dublin results in splitting of specialist care across the city as well as duplication and triplication of some clinical services within a 14Km distance. This means that a child with a single condition which affects different body organs has to attend different specialists in more than one hospital. This system cannot deliver optimal 'joined-up', holistic care and adds to the family's burden of care. Having all of the specialists working together under one roof means that the child's care can be co-ordinated and integrated resulting in higher quality clinical care and this will reduce the stress and inconvenience for the child's family. The planned development of a secondary general paediatric department and bringing all the specialists together will provide an opportunity for sub-specialisation within the specialty. This is what happens in all of the major children's hospitals internationally where subspecialisation allows for expertise to develop even in rare conditions. This could reduce the need for Irish children to travel to seek such expertise in other countries. This travel incurs cost to, and inconvenience for, the child and family and cost to the state. This level of subspecialisation is not possible with specialists split across the city.

3.13 It is also important to realise that in circumstances where Temple Street Children's University Hospital was built in 1872 and Our Lady's Children's Hospital Crumlin was built in 1956, they both have an infrastructure which is no longer fit for purpose. The National Children's Hospital in Tallaght (formerly located in Harcourt Street) opened in 1998 but it is small, particularly in terms of specialist services and intensive care, and has the potential to become isolated.

3.14 The New Children's Hospital will provide national paediatric specialist (tertiary) care for the island of Ireland and secondary general paediatric care for children of the Greater Dublin Area. The greater Dublin area includes Dublin city and counties Dublin, Kildare, Wicklow and part of Meath (it should be noted that those children in parts of County Meath who live close to Our Lady of Lourdes Hospital in Drogheda are likely to attend Drogheda as their nearest secondary paediatric hospital).

3.15 While the New Children's Hospital is undoubtedly a national hospital in terms of the tertiary paediatric services which it will provide, in strictly numerical terms and in terms of service volume, secondary general paediatric care makes up the greater part of the clinical service which will be provided. To put this duality of function in perspective, it is important to note that, currently, at the three existing Dublin children's hospitals, 94% of emergency department attendances, 78% of inpatients, 75% of outpatients and 63% of day-care patients come from the Greater Dublin area (DeLoitte 2014 Clinical Activity Data from the Three Dublin Children's Hospitals). These are not surprising statistics in circumstances where, in Ireland, most children who need hospital care receive it in the 16 no. local and regional hospitals nearest to where they live and sick children from outside the Greater Dublin Area only travel to one of the three Dublin children's hospitals when a tertiary, or specialist, healthcare service is required. The low number of children attending the three Dublin children's hospitals from the regional centres supports this conclusion and is demonstrated graphically on this slide.

4.0 NATIONAL MODEL OF CARE

4.1 I would like to briefly discuss the National Model of Care for Paediatric Healthcare Services in Ireland and the contribution that the new children's hospital will make to the successful delivery of the national model of care. Indeed, a number of submissions and observations made to the Board have addressed the model of

care. I should begin by explaining that a model of care is a clinical and organisational framework for evaluating how and where healthcare services are delivered, managed and organised. The term “model of care” covers both methods of care at the individual patient level and the clinical and organisational framework at a unit, hospital and state-wide level. A model of care is based on current best clinical practice and evidence but, as these are organic and respond to the emergence of new evidence and standards, a model of care will continue to change and develop in the future.

4.2 The National Model of Care for Paediatric Healthcare Services in Ireland has been developed over the past 4 years. The process has been led by Professor Alf Nicholson and Dr John Murphy, the lead clinicians for the National Paediatric Clinical Programme, and has involved visits to every paediatric unit in the country and to every subspecialty. The programme team consulted with all the paediatricians, paediatric trainees, nurses, health and social care professionals, parents and, significantly, with children themselves. All the practising paediatricians in the country have been closely involved in the development of the document and the specialty models of care have been written by the clinical staff themselves. The model of care document is unique in that it represents unprecedented, unanimous agreement among child healthcare workers about the future shape and direction of paediatric healthcare delivery in Ireland. I understand that the final draft of the National Model of Care document is currently with the HSE Leadership Group and will be publicly issued shortly. This slide quotes from the first paragraph of the model of care and emphasises the central role of the New Children’s Hospital in the national model of care.

4.3 The national model of care strongly advocates a “*hub and spoke*” model. This is a model where a larger unit, which can provide more complex care, supports a number of smaller units within a geographical area. The new children’s hospital would be the national hub providing support to the 16 regional and local units nationally. The regional units would, utilising the same model, support their local

units. Within the Greater Dublin Area, the New Children's Hospital will act as the hub for the two satellite centres which will deliver secondary paediatric care locally to south-west and north-west populations of the Greater Dublin Area.

4.4 The national model of care states that there is agreement that there should be a 'cut-off age' for admission to paediatric services and that this age should be 16 years. The new children's hospital conforms to this, accepting new admissions of children and young people up to the age of 16 years. Readmissions will include for young people up to their 18th birthday, at which time those with chronic conditions will complete their transition to adult services. However, the New Children's Hospital admissions policy also permits the new admission of a young person between the ages of 16 and 18 years where it is in the interest of the young person and is considered clinically appropriate.

4.5 The national model of care envisages that, where clinically appropriate, ambulatory care should be provided in preference to inpatient care. (By ambulatory care I mean non inpatient care.) This relative importance of this care is demonstrated by the hospital's clinical data. In 2021, 237,540 patients will attend outpatient clinics in either the New Children's Hospital on the campus of St James' Hospital and in the hospitals' satellite centres at Tallaght and Connolly Hospitals. 127,095 patients will attend the emergency and urgent care departments. 34,480 patients will attend the hospital for day-care procedures and 29,324 patients will require inpatient admission. The New Children's Hospital design with 93 day-care beds, "day of surgery" admission unit and extensive outpatient facilities respond to this requirement. This shift towards the majority receiving ambulatory care results in an inpatient population which has more complex illnesses. This is reflected in an increased percentage of intensive care beds, from the current total of 39 across the three hospitals to 60 in the New Children's Hospital. In addition, the New Children's Hospital will also have 48 beds in an acute assessment unit, which will be a high turnover, secondary paediatric care unit dedicated to returning children to their homes as quickly as possible.

4.6 The national model of care is based on the philosophy that care should be provided as close to the child's home as possible. The New Children's Hospital responds to this requirement in two ways. The first is the development of a "hub and spoke" model in Dublin between the New Children's Hospital and its satellite centres at Tallaght and Connolly Hospitals, thereby providing paediatric services to the child population of the north, north-west, south and southwest areas of Dublin, counties Kildare, West Wicklow and parts of Meath. Secondly, and importantly, there is a clear commitment to further expand specialist outreach clinics in regional centres. Modern healthcare is not solely about the quantum of beds but how the skills and resources of the multiple clinical teams are best leveraged. An example of this is when St James's Hospital leveraged its scale and clinical operational model to create an Acute Medical Admission Unit in 2003, hospital mortality decreased from 12.6% (2002) to 7.0% (2006), saving an estimated 300 lives per year. (Impact of an acute admission unit on hospital mortality: a 5 year prospective study. Silke et al. (2008) QJM, 101 (6): 457-65)

4.7 The New Children's Hospital is critical to the delivery of the proposed National Model of Care for Paediatric Healthcare Services in Ireland. The New Children's Hospital will become the hub for paediatric care nationally and will play a key role in facilitating the delivery of the national model of care and its national network of integrated paediatric care.

5.0 The New Children's Hospital's Satellite Centres

5.1 The two hospital satellite centres at Tallaght and Connolly Hospitals respond to the third of the national model of care's principles of an integrated national network by providing care as close to home as possible. The satellite centres will deliver urgent care and secondary care to children in the greater Dublin area as close as possible to their homes. Some submissions have queried the difference between "urgent care" and "emergency care". Simply stated, "urgent care" is for the diagnosis

and treatment of injuries or illnesses which require medical review in a dedicated facility but are not serious enough to require emergency department attendance or inpatient admission. Examples of this include fever, rash, vomiting and diarrhoea, sprains, simple fractures and urinary tract infections. Local children with these types of conditions should attend the new children's hospital satellite centres at Tallaght and Connolly Hospitals. It is estimated that 26,054 children will attend the urgent care centre in each of the satellite centres annually. Whereas, "emergency care" involves life-saving and limb-saving treatment, the provision of timely pain relief and the psychological care of patients and their families. Emergency care is available all of the time and is delivered by an emergency medicine team of clinical and support staff. Examples of where emergency care is required include a collapsed child, a child with meningitis or pneumonia, a child with a serious complicated fracture or multiple injuries. Children with these types of conditions should attend the New Children's Hospital emergency department at the St. James's Hospital campus. It is estimated that 74,986 children will attend the New Children's Hospital emergency department annually. (Source of definitions: Model of Care for Paediatric Urgent and Ambulatory Care Centre produced by the HSE National Clinical Programme for Paediatrics and Neonatology and the National Clinical Programme for Emergency Medicine. 2015).

5.2 The satellite centres will also play a role in preventing an unsustainable and unmanageable concentration of all emergency care admissions for the Greater Dublin Area in one hospital. In 2014, more than 120,000 children attended the three Dublin children's hospitals' emergency departments. It is projected that future attendance (in 2021) will be 127,095, approximately 350 infants, children and young people attending the emergency department each day. There is no children's hospital in the developed world which has an annual emergency department attendance of this magnitude. Organisationally, it would present a very significant challenge to the any children's hospital to safely provide clinical care to this number of children in a single emergency department.

5.3 I have investigated annual emergency department attendance at major international paediatric centres*. The busiest centre is at Cincinnati Children's Hospital and has 92,000 attendances annually.

- Cincinnati Children's Hospital Medical Centre
 - Main Burnett Campus 92,000 (100 less/day)
 - Liberty Campus 34,000
 - 3 urgent care centres 25,000
- CHOP [Pittsburgh] 77,800
- Dell Children's Hospital, Austin 75,000
- Los Angeles Children's Hospital 66,000
- Alder Hey Children's Hospital, Liverpool 60,000
- Boston Children's Hospital 60,000
- Morgan Stanley Hospital New York 50,000
- Yorkhill Children's Hospital Glasgow 43,000 (<14 years)
- Starship Children's Hospital, Auckland 32,000

[source: referenced hospitals' own websites]

5.4 The vast majority of children who attend the three Dublin children's hospitals emergency departments are assessed, treated and discharged home the same day. The average admission rate is approximately 14%. The majority of these children do not require the resources of a specialist tertiary paediatric hospital. Accordingly, the level of care which these children require is at a secondary level. Therefore, the satellite centres meet the requirement of delivering appropriate clinical care to the child as close to home as possible.

5.5 Care at the satellite centres will be delivered by consultants during all their opening hours. There will be no inpatient beds in the satellite centres. The satellite centres will have observation beds which will allow for assessment, treatment, observation and discharge of the majority of children who present to the satellite centres. While there will be ambulance bypass of the satellite centres in certain cases, if a seriously ill or injured child arrives at the satellite centre, the clinical staff

there will have the expertise to stabilise the child for transfer to the New Children's Hospital. The emergency ambulance service will be responsible for the transfer of seriously ill or injured children from the satellite centres. For children who require inpatient admission at the New Children's Hospital, there will be a designated transport service. There will be a comprehensive public education campaign to ensure healthcare professionals and parents know which facility to use. There are examples of this type of information set out in the EIS.

5.6 In accordance with the "hub and spoke" model, secondary outpatient clinics will be delivered at the satellite centres. Approximately 16,500 children will attend outpatient clinics in each of the satellite centres annually. Included will be general paediatric clinics, rapid access clinics, developmental clinics, fracture clinics, to support the urgent care centre, and care of some children with chronic conditions. The clinics will be responsive to primary care and community child health services in the catchment area. There will be phlebotomy, plain X ray and ultrasound available in the satellite centres. The centres will be under the governance of the New Children's Hospital children's hospital and the staff who work at the satellite centres will be New Children's Hospital staff who will rotate between the New Children's Hospital and the satellite centres. The satellite centres will open in advance of the New Children's Hospital on the St James' Hospital campus which will allow the satellite service to become established, and understood by the local population, well before the opening of the New Children's Hospital*. This model promotes safe, convenient and patient – centred care and is well established internationally including, by way of example only, Cincinnati Children's Hospital and the PANDA unit in Salford, Greater Manchester in the UK.

6.0 CO-LOCATION

6.1 A primary objective of the New Children's Hospital is to ensure that the children of Ireland are provided with a level of healthcare that meets international

best practice. Above all, the New Children's Hospital must offer highly developed tertiary services across a broad range of sub-specialities, so that children and young people with life-threatening and complex chronic medical and surgical conditions can have the best possible therapeutic interventions which will deliver the best clinical outcomes. Such excellence in modern paediatric clinical practice can only be provided with the centralisation of paediatric specialities in one location which, significantly, is supported by a large academic adult hospital with a broad range of sub-specialities that supports the delivery of acute paediatric healthcare and provides support for basic science research-led discovery and its translation into clinical practice.

6.2 Accordingly, in the event that An Bord Pleanála decides to grant permission for the proposed development, the New Children's Hospital will be built on the campus at St James's Hospital. On foot of a series of reports and consultations, the Government determined that St James's Hospital was the most suitable adult partner hospital for the New Children's Hospital. As set out in more detail in later statements, this Government decision followed, in particular, the deliberations of the Dolphin Group which identified St James's Hospital as the most appropriate adult partner for the New Children's Hospital with which to co-locate because St. James's Hospital had the broadest range of national adult specialities and an excellent and well established research and education culture and infrastructure. St James's Hospital and the New Children's Hospital are appropriately matched as they are both Model 4 hospitals. A Model 4 Hospital provides acute surgical care, acute medical care, critical care, tertiary care (specialist care) and in certain locations (such as St James' Hospital) supra-regional or national care, whereas a Model 3 Hospital provides 24/7 acute surgical care, acute medical care and critical care (Source: HSE).

6.3 St James's Hospital has the widest range of sub-specialities and the highest level of clinical complexity of all the adult hospitals in Ireland and provides a number of national services. The New Children's Hospital will have a similar clinical profile. The skill and expertise of the clinical staff in the co-located New Children's Hospital

and St James's Hospital match appropriately and these shared skills and expertise are precisely what is required for the care of the most complex and life-threatening conditions with which children from all over Ireland will present to the New Children's Hospital. There are many specialists who work between both hospitals already. Having these specialists on the one campus will enhance joint working. It is also likely that the number of joint appointments will increase once the New Children's Hospital opens.

6.4 As mentioned previously, there are many shared appointments between the three existing children's hospitals and adult hospitals. These are mainly specialist surgeons and some physicians e.g. dermatologists. There are also shared appointments between the children's hospitals and the three Dublin maternity hospitals, these are mainly neonatologists and specialist physicians e.g. endocrinology, haematology, radiology, microbiology and pathology. It has been suggested in certain submissions made to the Board that 'only paediatricians look after children', and that for this reason, there is no need for paediatric-adult co-location. However, staffing data does not support this contention. A recent analysis of the paediatric hospitals' workforce identified the following facts: 9341 consultant hours worked by the consultants attached to the three Dublin children's hospitals which includes their hours worked in adult and maternity hospitals. Of those hours:

- 75% of those hours (7489) in the children's hospitals,
- 20% of the hours (1458) in adult
- 5% of the hours (394) in maternity hospitals

It is likely to be some time [decades] before the new children's hospital has a fully individual consultant staff and this may never be practical or appropriate for some specialties such as plastic surgery, cardio-thoracic surgery and neurosurgery.

6.5 It has been also been suggested in submissions to the Board that there is no scientific evidence to support the co-location of a paediatric hospital with a major adult teaching hospital while suggesting, somewhat paradoxically, that there is

ample scientific evidence supporting co-location with a maternity hospital. This first statement suggests that the issue as to whether co-location with an adult hospital improves outcomes is amenable to the type of scientific research/evidence applied to the comparison of one drug with another or one surgical procedure with another. However, the McKinsey Report in 2006 identified how centres of excellence strive for, and often achieve, excellence across five components:

- (i) breadth and depth of service;
- (ii) access;
- (iii) efficient use of resources;
- (iv) recruiting and retention; and
- (v) teaching and research.

6.6 The McKinsey report concludes that to achieve subspecialist critical mass, tertiary centres virtually always (i) serve a large enough population to support a full complement of paediatric subspecialists, and (ii) co-locate with an adult teaching hospital to access specialities that generally split between adult and paediatric patients to facilitate clinical and academic ‘cross-fertilization’ and to attract top staff. McKinsey also provides examples of specialties in which children make the transition to adult care, however, they are just some among a number of specialties where adult co-location is of benefit to children. McKinsey also references economies of scale in relation to diagnostic and therapeutic equipment which are best achieved in co-location with an adult hospital. An example of this is that the new children’s hospital could not justify (in terms of its ability to get full use from the machine) the purchase of a PET scanner, or in the future, proton beam therapy as referred to by Mr James Sheehan, whereas co-location with the largest adult teaching hospital in the country provides children with access to this resource. St James’ Hospital is the only adult hospital in Dublin to have a public PET scanner and the New Children’s Hospital will have access to this facility. This will continue to be the case in the future as new, expensive equipment becomes available.

6.7 The Mellis Review (March 2006) recommended the construction of a single integrated children's hospital in Brisbane adjacent to an adult teaching hospital and in close proximity to an obstetrics unit to act as the hub of a state-wide network of paediatric tertiary service in Queensland. The resulting Lady Cilento Children's Hospital, fulfilling these requirements, opened in November 2014. The Bristol Inquiry Report 2001 (established to investigate the deaths of 29 babies undergoing heart surgery at Bristol Royal Infirmary between the late 1980s and 1990s) supported adult co-location. As a result of the Scottish Review of Paediatric Services 2004, paediatric services have moved from Yorkhill, a respected, stand-alone children's hospital, to the Southern General site where it is tri-located with adult and maternity services. McKinsey distinguished between co-location and integration. It is intended that the New Children's Hospital will be co-located with St James' Hospital but separately governed. McKinsey mentions that it is important to weigh a decision to co-locate against pragmatic considerations which are enumerated in that report. However, notwithstanding such considerations, McKinsey state that most recent build decisions are opting for co-location.

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

dermatology, radiation oncology and maxilo-facial surgery. These are all tertiary level complex specialties.

6.9 A clear example arises from the intention that the New Children's Hospital at St. James's Hospital will be the national paediatric oncology (cancer) centre. St James's Hospital is the largest provider of adult cancer services nationally. There is a radiotherapy centre on the site of St James's Hospital that will be accessed directly by children and young people with cancer, as opposed to having to travel to St Luke's Hospital from the three children's hospitals for this treatment as currently happens. Cancer treatment services in Our Lady's Children's Hospital, Crumlin are recognised as being of a high standard and comparable with international centres. However, there are two areas in which Our Lady's Children's Hospital identifies need for improvement. The first is the care of adolescents/young adults with cancer and the second is the establishment of a Survivorship Programme. Co-location with the adult medical oncology service on the campus of St James' Hospital will provide a unique opportunity to ensure that an adolescent or young adult with a particular cancer will receive the appropriate treatment for that cancer, irrespective of their age. It is expected that cancer services will monitor the growing number of children and young people who survive cancer. This monitoring is essential to understanding the therapies used for treating cancers. Co-location with a leading adult medical oncology programme, allied with a survivorship programme is an enormous benefit of this co-location.

6.10 Young people with complex chronic haematological disorders, such as sickle cell disease, haemophilia and related inherited bleeding disorders will be able to transition to the National Centres for these conditions at St James's Hospital.

6.11 Another advantage of co-location is the development of a model for transition to adult services for children with chronic conditions. The manner in which this transition is effected can influence the manner in which the young adult handles their condition for the remainder of their lives. There are excellent models of

transition care but also much room for improvement. All children with complex conditions from all over Ireland will attend the New Children's Hospital. Some of these conditions will be life-long and those young people will make the transition to adult services, usually between their 16th and 18th birthdays. Children with very rare conditions for which there is an existing national adult service in Dublin, many of them in St James' Hospital, will transition into that national service. However, many regional hospitals offer specialist care to adults, more than in paediatrics, and those children will be able to transition to adult services in their regional hospital. Co-location with St James' Hospital, to which children with complex conditions and the many children within the catchment of the St James' adult Hospital will transition, will allow the development of the optimal model for transition to adult care. St James' Hospital, co-located with the New Children's Hospital and its satellite centres located at Tallaght and Connolly Hospitals, will all work together to achieve the best transition model. The National Children's Hospital in Tallaght is currently co-located with the adult hospital and there already exists an excellent model of transitional care in Tallaght Hospital for young people with diabetes and chronic endocrine conditions. The adult department in Tallaght Hospital works closely with its sister department in St James' Hospital and they have already approached the Children's Hospital Group in relation to lending their experience and expertise to developing transition care models for the new children's hospital. Examples of other conditions which transition into adulthood include respiratory conditions including cystic fibrosis, kidney failure and other chronic renal conditions, rheumatological disorders such as arthritis, epilepsy and neurological disorders other than epilepsy, gynaecological disorders, chronic skin disorders and immuno-deficiencies. Many of these conditions are life-long and a formal, well-structured transition will allow the young person to take over responsibility of their condition from their parents and enhance their disease management during the transition period and in the long term. This will be a significant benefit of co-location with St James' Hospital.

6.12 It has been suggested in other submissions and observations made to An Bord Pleanála that adult co-location will benefit the doctor who currently works

between the two hospitals and not the child. For all the reasons set out already, it is clear that the advantages of paediatric hospital co-location with an adult teaching hospital are to the benefit of the children whose treatment and care will be directly improved. Moreover, the full-time presence of the clinician on one campus will mean that s/he is available at all times for the child. This will certainly benefit the child.

7.0 TRI-LOCATION

7.1 As has been frequently stated, the Children's Hospital Group and the three Dublin Children's Hospitals believe that the optimal future model is that of tri-location of a major adult teaching hospital, the New Children's Hospital (which will be a major paediatric teaching hospital) and a maternity hospital and all welcomed the Department of Health announcement in June 2015 that the Coombe Women's and Infants Hospital will be re-developed on the site of St James' Hospital. Welcoming that announcement, Dr Sharon Sheehan, Master of the Coombe said *"The tri-location model of maternity, paediatric and adult services will, I believe, enhance the quality of care provided to women and children across the country and as such, we fully endorse the development of the new children's hospital at St James's and we welcome the opportunity to be the maternity hospital within this tri-located model."*

7.2 There are a number of submissions to the Board which also highlight the importance of paediatric hospital co-location with a maternity hospital and some parties seek to suggest that this view is not shared by the NPHDB and Children's Hospital Group. However, on behalf of the NPHDB, I can categorically state that any such suggestions are incorrect and reiterate that there is no dispute between the NPHDB, Children's Hospital Group or the Coombe Women's and Infants Hospital in this regard. Both the NPHDB and the CHG recognise the importance for maternity hospitals of also co-locating with an adult teaching hospital. With this in mind, and

considering the benefits for the children's hospital to be co-located with an adult teaching hospital, the NPHDB, CHG and the Coombe are pursuing an outcome which can ultimately deliver tri-location.

7.3 Concern has been expressed in submissions to the Board about the transport of neonates (i.e., infants aged less than one month) in advance of the presence of a maternity hospital on the same site as the new children's hospital. Neonates who require transfer to a specialist children's hospital are, by definition, delicate and ill infants. It would be preferable if transport of such infants could be avoided. Best options include corridor transfer from a maternity to a paediatric hospital, where the adverse incidents quoted for road transport, as tube dislodgement, can also occur or, as happens in some countries, the paediatric specialist team comes to the maternity hospital. Currently, in Ireland, there is no maternity – specialist paediatric hospital co-location and we do not have a situation where the specialist paediatric team can operate in the maternity hospital. Therefore, neonates requiring specialist paediatric services must be transported from maternity hospitals from all around the country to the children's hospitals in Dublin. For this reason, the neonatal transport service was set up 14 years ago to ensure that the necessary transport of neonates requiring specialist paediatric care is as safe as possible. Where it is possible, and when it is known before the baby's birth that she or he is likely to need specialist paediatric care, arrangements are made for the mother to give birth in one of the Dublin maternity hospitals. Currently, the majority of neonatal transfers are from outside Dublin indicating that these children's difficulties have not been identified in the womb or there has not been the time or opportunity to transfer the mother before delivery. Therefore, there will be an ongoing need for a safe neonatal transport system even when tri-location exists. The neonatal transport programme transfers 550-600 neonates each year. It has transported 4,425 neonates since it began and there has not been 1 fatality during transport in the 14 years of the programme.

7.4 There is a need for the New Children's Hospital. Indeed, the New Children's Hospital is needed now. There is a Government commitment to the re-development of the Coombe Hospital on the campus of St James' Hospital. In the meantime, where a condition is identified which will require admission after birth to one of the Dublin children's hospitals, the mother should be transferred to one of the three Dublin maternity hospitals where the neonate can be delivered and stabilised after birth in a Level 3 NICU and transferred by the neonatal transport programme within Dublin to the specialist children's hospital. One of the submissions suggested that the dangers were equal in a short and a long journey transfer (100m and 100Km). This is incorrect. There are greater risks involved with transferring a neonate a longer distance compared to the risk of transferring a neonate a shorter distance. The least risk in neonatal transfer in Ireland is associated with transfer within Dublin.

7.5 Tri-location, which involves having an adult, children's and maternity hospital together on the same site, is the optimal situation. Sick new-born babies can then be transferred easily to the children's hospital. These vulnerable neonates need the new children's hospital as they need the specialist services in the current children's hospitals. Now and in the interim, the neonatal transport programme will continue to transport these neonates to the highest possible standard.

7.6 It must be remembered that co-location between a maternity hospital and an adult hospital allows for improved clinical care of ill-mothers. Often, unlike in conditions affecting the new born infant, those serious conditions affecting the mother develop with little warning and can place a previously healthy, often young, woman and new mother in a critical condition. The conclusion of the KPMG Report on Maternity Services (2008) was that the three stand-alone maternity hospitals in Dublin should be co-located with a major adult hospital. The reason for this is to enhance the medical and surgical care of very ill women.

7.7 There will be further synergy between maternity and adult services through the shared care of gynaecological cancers. St James's Hospital is one of the eight

national cancer centres providing oncology, radiotherapy and specialist surgical services on site. There are already many joint consultant appointments and shared services between St James's Hospital and the Coombe Women and Infants University Hospital across surgical and medical specialities.

8.0 Children's Research and Innovation Centre (CRIC)

8.1 *"Paediatric research enhances our most important national resource - healthy children"* (E. Richard Stiehm. Pediatric Research. National Institutes of Health support in the 'steady-state' decade, 1983-1993. Arch Pediatr Adolesc Med. 1996;150(9):971.)

8.2 Professor Jonathan Hourihane chaired the National Paediatric Hospital Development Board Research Sub-Committee in March 2009 and generated a report which argued that research facilities and activities are critical to the success of New Children's Hospital in providing the best outcomes for its patients. The report states that *'today's child health research is tomorrow's standard of care for children'*, that medical advances do not usually happen by chance, rather by systematic observation and experimentation. This is what research is. The report notes that children are physiologically different from adults and many diseases of childhood are unique to children, without "adult" counterparts. For these and other reasons paediatricians consider it unethical *not* to carry out research with children. Ireland leads the field in some disciplines of paediatric research and Irish researchers have contributed to better outcomes for children internationally in diverse areas such as leukaemia, sepsis, dermatology, allergy and diabetes. The New Children's Hospital represents a unique opportunity to fill the gaps in Irish paediatric medical, nursing and health and social care professional practice relating to specific national knowledge about the diseases that Irish children suffer and to make a better contribution to the knowledge economy, not only in Ireland, but also internationally. The report stresses that to have optimum impact on patient care and to facilitate

major clinical and translational research studies of international impact, the Research Institute must be located on the main New Children's Hospital site. The report continues to state that sufficient clinical and laboratory space should be provided for both clinical and translational research so that clinical care, research, education and training will be fully integrated. The report urges that research should be a core function of New Children's Hospital, supporting clinical care of patients and education of health professionals. Research activity in the New Children's Hospital should have a high profile, both geographically within the hospital and politically within the management structures of New Children's Hospital and experience supports the view that families will support research as part of their children's medical care in the knowledge that research-led medical care leads to better outcomes. The New Children's Hospital will ensure the delivery of the infrastructure, governance and support personnel for research in the new campus so that funders will know their resources will be used well for research that is fully integrated into clinical care.

8.3 The report emphasises that the research facilities must be located in New Children's Hospital, and not off site, not only to foster the interactivity required between academic and clinical staff but also to make participation in research as easy and meaningful as possible for families and their children. The research facilities in the New Children's Hospital must include the capacity for encounters with patients during and around their clinical care. It is very important to provide sufficient multipurpose rooms and laboratory space to permit the performance of research by other health professionals and to allow translational research and clinical trials to proceed on site. The proposed research and innovation centre is designed to strengthen and build on current on-site research facilities in Our Lady's Children's Hospital, Crumlin.

8.4 From a clinical and academic perspective the Dolphin Group identified St James's Hospital as the most appropriate adult co-location partner for the New Children's Hospital because it has the broadest range of national specialities.

Perhaps equally importantly, St. James's Hospital has a very strong, internationally recognised, clinical, research and education culture and infrastructure. The adjacency of the proposed children research and innovation centre to the Institute of Molecular Medicine on the St James' Hospital campus is an outstanding example of such strength. This will be of huge benefit to the new children's hospital and the re-developed Coombe Women and Infants University Hospital and, from the perspective of the new children's hospital, will make it a place where the best child and adolescent healthcare professionals will want to train and work.

9.0 EXPANSION

9.1 The design of the hospital is based on validated current clinical activity, having regard to projected population growth as well as an allowance for extra capacity for new treatment developments and current unmet need. The population aged 16 years and under is set to experience a short-term peak in the year 2021, followed by a period of minor retrenchment in the years to 2030 or so, followed by a renewed period of growth out to the end of the appraisal horizon. Capacity planning for the new children's hospital has incorporated likely increases peaking in 2021. In addition to this, and in recognition of current, very significant unmet need, additional uplift has been added to the capacity in the anticipation that the new facility and its workforce will be better equipped to address demand. In some areas, this uplift is very significant and incorporates into the proposed design very significant capacity for expansion on current activity. The following are examples of the uplifts which have been applied in recognition of unmet need:

- Inpatient care 8%
- Day-care 14.6%
- Outpatient care:
 - Cardiology 53%
 - General paediatrics 173%
 - ENT 100%
 - Urology 80%
 - Diabetes 60%

9.2 While the Design Team has identified 20% expansion capacity on the site by way of future development works, there is also expansion designed into the current model in recognition of likely future developments and changes in clinical practice. For example, space has been allocated for 7 MRI scanners, 6 in the radiology department and 1 in the theatre area. Currently, there are 2.5 MRI scanners within the three Dublin children's hospitals. However, there is an increasing reluctance to expose children to the radiation associated with other modalities when there is an alternative option and for that reason there is significant extra MRI capacity already built into the hospital. In place of the traditional nuclear imaging, space has been allocated for a SPECT CT scanner which is not currently a standard requirement but is likely to be in the future. Calculations suggest that 1 CT scanner would be sufficient [particularly given the generous allocation of MRI scanners] but a second has been placed in the emergency department because it is considered that this is current best practice. In theatre, there are two emergency theatres without any activity behind them in order to support optimal flow in theatres and timely allocation of urgent and emergency cases. One of these is allocated to trauma and the other to general cases. Current activity in paediatric interventional radiology is very low in the children's hospitals. As it is recognised that this is a likely area of growth, a full theatre has been allocated to this with a second theatre alongside it, suited to paediatric interventional radiology, which as this activity grows and assumes tasks from other surgical specialties will convert to a second interventional radiology theatre. All of these provisions represent expansion already designed into the hospital along with the additional 20% identified for new build.

9.3 The new children's hospital satellite centres will open in 2017. Their ambulatory function has been described above. There is spare capacity for increased clinical activity in both satellite centres. Additionally, RKW and the Dolphin Committee suggested that in an area such as the greater Dublin area, there could be demand for up to 4 satellite centres providing urgent care and secondary general paediatric care close to local communities.

9.4 In recognition of the complexity of the conditions of the children attending the new children's hospital, clinic space allocation has been generous in relation to patient consult time [average of 30 minutes] and multi-disciplinary team input. Capacity has been calculated on only two 4 hour clinic sessions per day. There would be the potential to run three sessions with an extended day, this is common practice in adult services and the potential to increase service delivery with an extended week, including the potential for Saturday clinics in keeping with the modern demand for a 7 day active hospital.

9.5 A number of observations have expressed concern regarding the expansion capacity for the Children's Hospital on the proposed site. For example, in his submission, Dr Sheehan claimed that the projected expansion capacity was inadequate based on his experience of building both the Blackrock and Galway Clinics and the experience in OLCH. In relation to the Blackrock and Galway clinics, these are private clinics which, while providing excellent health care, were built to meet a market demand and not in response to population health needs. They are influenced by the ability of the public health service to meet demand and the level of health insurance within the population. Therefore, to compare their growth in recent years (when public funding was cut back) is to not to compare like with like. OLCH was built in the 1950s when healthcare was very different, inpatient stays were longer, disease modifying drugs were not available, day-care for medical and surgical procedures was in its infancy and specialist care was very centralised. It is very difficult to predict how future healthcare delivery will evolve but in recent years care has moved towards the community, day-care has increased hugely, disease modifying drugs have altered the course of many conditions, IV home services have facilitated early discharge, average length of stay has reduced and hub and spoke models for specialist care have developed. These factors would suggest that OLCH's experience in the past 60 years will not be replicated in the next 60.

9.6 Many submissions make reference to hospitals doubling in size in 10 years. As described, capacity in the new children's hospital has been calculated to include

many factors which will allow greatly increased clinical activity within current build without developing the 20% expansion capacity on site. Moreover, internationally there is a move to increase efficiency and optimal use of current resources rather than continually building. In Cincinnati Children's Hospital Medical Centre, they initiated a redesign of perioperative flow management in 2006. As a result of this and without any increase in space, between 2006 and June 2008, revenue (total dollars) has increased by 34%; overtime dollars as a percentage of total dollars have decreased by 26% (by 6% in 2007-2008 and by 20% in 2008-2009) and overtime hours as a percentage of total hours have decreased by 31% (10.2% in 2007-2008 and 20.6% in 2008-2009). Improvements in efficiency have boosted the hospital's capacity by the equivalent of a \$100 million, 100 bed expansion and increased income from patients by even more. This was a radical approach in a hospital internationally recognised for its institutional commitment to the principles of safe, reliable, high quality, effective, efficient, patient-centred and equitable clinical care. One must question if the quoted physical expansion in other hospital expansions would have been necessary had such an approach been universally applied? (Reference: *Cincinnati Children's Hospital Medical Centre: Redesigning Perioperative Flow Using Operations Management Tools to Improve Access and Safety*, Frederick C. Ryckman et al. Chapter 6, pages 97-111).

10.0 CLINICAL & COMMUNITY SUPPORT FOR THIS PROJECT

10.1 A number of submissions make reference to 'experts' who do not support this application. Within the submissions is the statement that *'those that represent the core substantive interests of sick children in Ireland recommend the rejection of this application'*. This is not true. This application is supported by all of the leading paediatric bodies in the State. These are bodies whose sole purpose for existence is to promote high quality, safe clinical care and the best outcomes for children. These include the National Paediatric Programme Lead Professor Alf Nicholson, the National Neonatal Programme Lead Dr John Murphy, The Board of Our Lady's

Children’s Hospital, Crumlin, The Board of The Children’s University Hospital, Temple St, The Board of the National Children’s Hospital, Tallaght, the chairs of the three Medical Boards, The Neonatal Clinical Advisory Group, The Clinical Director of the Children’s Hospital Group, The Project Lead for Paediatric outpatients and urgent care services, The children’s hospitals’ Directors of Nursing, The Paediatric Medical Advisory Board, National Children’s Hospital, Tallaght and the Faculty of Paediatrics. Associated charities such as Sunshine Home/Laura Lynn, the Ronald McDonald Charity, Children in Hospital Ireland and CARI have also written of their support for the new children’s hospital.

11.0 THE HOLISTIC NATURE OF THE DEVELOPMENT

11.1 It has been suggested that this new children’s hospital, because of its location, will not deliver holistic care. This contention is unfounded. The hospital planning and design has been developed to support the best clinical care and to provide the best experience for children and their families during what is a very stressful time. For children and young people, there are age specific play and recreation areas both on and off the wards. Every room will have a console with internet access which will allow young people to remain in contact with school and their family and friends during hospitalisation. There will be a school in the hospital to ensure that children and young people can keep up academically with their peers during a hospital stay. This can be delivered in the custom built classrooms and/or in individual patient rooms using the technology which will be available. There will be art and music therapy and an art and craft room available. There are multiple areas of green space and gardens planned throughout the hospital. The hospital is bright and airy. There is an enormous garden at the ward level both within and outside the ward floors where those who are able may spend time in the fresh air and play. There are dining rooms and play areas on the wards. While every inpatient room (with the exception of intensive care) will have pull-out parent accommodation, there is also an area within the hospital for parents with 30 en-suite bedrooms, a

lounge, a family resource room/library, a fitness suite, a pantry and dining area and a laundry in order to support parents and families during their child's inpatient stay. This hospital is planned and designed with all the needs of children, young people and their parents in mind. Additionally, an application for a family accommodation unit has also been submitted which, if granted will provide further accommodation, for children and their families.

12.0 CONCLUSION

12.1 The primary driver for the development of the New Children's Hospital is to improve clinical outcomes for the children of Ireland. We believe the proposed application meets that objective.

12.2 The decision to build the New Children's Hospital and its satellite centre to provide secondary general paediatric care to the Greater Dublin area and specialist paediatric care to the whole country is a unique opportunity to radically improve the delivery of paediatric care, the experience of children and their families and the working life and experience of paediatric staff.

12.3 Co-location with St James' Hospital provides access to the greatest breadth and depth of subspecialties to optimally support the New Children's Hospital. There is an internationally recognised research intensive culture and infrastructure at St James' Hospital that best matches and supports the research and innovation ambitions of the New Children's Hospital. This is a critical element of the future vision for paediatrics in Ireland. The proposed campus capability for education of clinical undergraduates and postgraduates will be unmatched in the Irish healthcare system and provides an unrivalled opportunity for leading clinical research.

12.4 Ultimately, tri-location of the New Children's Hospital with St James's Hospital and the proposed re-development of the Coombe Women and Infant's

Hospital will provide the best possible modern environment for the delivery of excellent clinical care for sickest children and high-risk mothers. Whilst the functioning of the New Children's Hospital is not dependent upon the development of a maternity hospital on the St. James' Hospital site, the NCH has been designed in a sustainable manner so as to interface with a possible future maternity hospital on the campus and is capable, therefore, of delivering the tri-location model identified in the National Model of Care.

12.5 This is one of the most positive developments in child health in the history of the State and NPHDB and its partners are driven by a shared passion and commitment to bring this development to fruition in order to provide the best possible care for the children of Ireland now and into the future.

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