



PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

Wellington Centre

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TABLE OF CONTENTS

1.	INTRODUCTION	2
2.	BACKGROUND.....	2
3.	PROJECT FUNDING & COSTS	3
4.	EVIDENCE.....	4
5.	DOCUMENTS TAKEN INTO EVIDENCE	11
6.	CONCLUSION	11

1. INTRODUCTION

The Committee has the honour to report to the House of Assembly in accordance with the provisions of the *Public Works Committee Act 1914* on the -

Wellington Centre at 42 Argyle Street Hobart: Fit Out and Air Bridge for Ambulatory Clinics

and now has the honour to present the Report to Your Excellency in accordance with the *Public Works Committee Act 1914*.

2. BACKGROUND

The Wellington Centre is a building currently under construction and owned by Sultan Holdings. Once completed, the Centre will include: a Woolworths supermarket; 15 speciality retail shops; 6 levels of car parking connected to the existing Hobart City Council Argyle Street Carpark; and approximately 6000m² of leased office and consulting space. The Department of Health and Human Services (DHHS) will be leasing 5000 m² with one floor available for another tenant.

Approval of the Parliamentary Standing Committee on Public Works was sought for works to fit out leased spaces in the Wellington Centre building in Argyle St, Hobart, and to construct an air bridge across Argyle Street linking the Wellington Centre with the Royal Hobart Hospital (RHH).

The leasing of approximately 5000 m² will establish a much needed ambulatory care centre, which was previously to have been an element of the “New Royal”. It will overcome existing lack of capacity and will support the on-site redevelopment by relieving congestion.

The clinics proposed to be relocated are:

- Pharmacy;
- Centrepath;
- Specialist Clinics - Medical;
- Specialist Clinics - Surgical;
- Hand Physiotherapy;
- Cardio Respiratory;
- Audiology;
- Ear, Nose, Throat (ENT);
- Eye Clinic;
- Special Dental;
- Oral Maxillo-Facial Unit;
- Orthopaedics;

- Plaster; and
- Medical Imaging (X-Ray only).

It was submitted that the works are designed to provide vastly improved spaces for provision of the above clinical services and will afford the opportunity to gain additional revenue from additional services.

The relocation of the abovementioned clinical services off the RHH site for the medium term will free up existing spaces to be redeveloped and allow other projects to proceed. The proximity to the RHH will enable excellent access for clinicians working across sites and for patients referred to and from other services on the RHH campus. The car parking amenity for patients and their carers will also be significantly improved.

The full submission of the Department of Health and Human Services in support of the reference is published on the website of the Committee at:

<http://www.parliament.tas.gov.au/ctee/Joint/works.htm>

3. PROJECT FUNDING & COSTS

The capital budget for the Wellington Centre Ambulatory Clinics project is \$12.2 Million, as below.

Design & Construction

Includes design consultants, CPI, escalation and contingencies

Fit Out	\$7,200,000
Air Bridge	\$1,500,000

Subtotal	\$8,700,000
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Medical Equipment	\$1,500,000
IT including VOIP & Patient Appointment Management systems	\$470,000
Furniture, fittings & general equipment	\$400,000
Artworks	\$80,000
Set up & relocation costs	\$50,000

Subtotal	\$2,500,000
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Initial rental contribution*	\$1,000,000
	\$12,200,000

The initial project budget was developed knowing that DHHS requirements for clinic space would be higher than a landlord would usually provide, in terms of building services such as air handling and acoustic protection. This is in part due to the medical needs of the space and in part due to the number of enclosed rooms on each floor compared to open plan office space.

Sultan Holdings, as the building owner, is installing those building services which would conventionally form part of Lessor's Works to DHHS standards and design. Sultan Holdings will continue to own and maintain these services over the life of the DHHS lease. In order to minimise RHH ongoing recurrent costs, RHH has elected to make an initial rental contribution.

* The final amount to be confirmed once actual construction tenders are received.

4. EVIDENCE

The Committee commenced its inquiry on Monday, 5 September last with an inspection of the site of the proposed works. The Committee then reconvened in Committee Room 2, Parliament House where the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Peter Alexander, Director RHH Redevelopment
- Wendy Rowell, Group Manager Clinical Support
- Kim Ford, Nurse Unit Manager Specialist Clinics
- Tim Penny, Architect

Overview

The Director RHH Redevelopment, Peter Alexander provided a narrative to a 'Power Point' presentation which provided detail of the concept design and detail of the staging of the works. Mr Alexander made the following observations during his presentation:-

... The proximity to the hospital is very important and a key in that and the Wellington Centre is the biggest one of those. The others are all pretty much in place. We have leased some space that has clinics in it elsewhere - other clinics, pain management, diabetes management, things that are more stand-alone - and we are finishing a reconstruction of a kitchen at the airport...

... We have a whole lot of constraints about being able to rebuild the existing hospital ... 'an optimal design is one which inhibits change of use least rather than one which meets a specific use best' is referenced back to the World Health Organisation and it is really my mantra. The external of the buildings will last 100 years. The way health is changing, the way we do our business will change. It changes every year but the use of technology like imaging equipment in theatres and all those sorts of things mean we are changing internally. Floor-to-ceiling heights means that we cannot run adequate services. The column grids and low-bearing structures means we cannot move walls around. Fire compliance, spatial efficiencies we really cannot get.

... The importance of this to what you are talking about - 'A promise' is my final slide - that is in a sense a master plan for the hospital in three stages so the big blue building that we want to build out of the funding we now have; the footprint of that building, the floor area, is enough for a 32-bed ward and a 32-bed ward is nationally recognised as the most efficient to staff. They do it in pods of eight and you get the best ratio of staffing to patients. A lot of wards in the existing hospital are 18 and 19 beds which means that they are effectively overstaffed for the number of patients and they are that size because - and this is very relevant to what we are doing - we have had to crib into the space to put in the

clinics, we have had to crib into the space to put offices and other things which means that we are sort of shooting ourselves in the foot every time we do that sort of thing but we have had no option.

Eventually we will get 64 beds on the ward with two buildings and where they join together in the lower floors the central block that they join into is D Block so we will get contiguous operating theatres. The operating theatres are in D Block and that is the really efficient part. Most modern hospitals have what they call 'hot floors', so all the operating theatres, recovery spaces and medical imaging are all in very close proximity.

... We need to get to that stage to have an efficient modern hospital and at that time the white stuff on the left, currently Hobart Private, and the clinical school, we are getting back from the university. What we have done is prove that by investing on that site we can make a hospital that will last us for generations but it is going to take us that long to get there. So this is a very necessary stage to create the ambulatory clinics that we need which help keep people out of hospital beds, but the intended long term is to bring them back on site. Currently H Block is a very narrow building. It was designed to have a couple of extra floors put on top, which is why the plant room is in the lift - to go up higher, but it is not of itself big enough or efficient enough for what we want to use it for.

Lease arrangements

The Committee questioned the witnesses about the likelihood of taking up the four year extension option at the end of the ten year lease. Mr Alexander responded that it was entirely dependant upon government's capacity to fund redevelopment on site but that if the redevelopment eventuated in accordance with the planning then the off-site Wellington would not be required then.

The Committee questioned the witnesses as to what benefits, if any, were achieved by the election of DHHS to prepay some rental. Mr Alexander responded:-

We have asked Sultan Holdings to put in a much higher level of mechanical and electrical services than would have been ... provided if they had built as an office building. They have taken a commercial risk on some of those issues like over-sizing lifts and things. We have asked for higher standards of airflows and fire detection and things like that. To do that we are intending to provide an up-front rental payment. That is still subject to negotiation because it depends on our tender price as well and if we cannot afford to do it, and it is our option to do it, then we need to complete the tender obviously. It does not come with the discount as such, it is pretty much par for the course. Over 10 years, depending on what discount rate you use for the net present value calculations, it is within \$50 000 one way or the other.

... but if we do not (make a prepayment rental), the annual rental will go up and by paying up-front if we can and reducing the rental, it helps us with our recurrent target over the next decade.

The Committee questioned the witnesses as to whether the \$1 million factored into the project cost would be diverted to building costs in the event it was not used to pay rental in advance. Mr Alexander responded:-

It would go into the fit-out costs. We cannot compromise the fit-out costs. They have been gone into and my colleagues will go into those in some detail and there are really no

luxuries in there so if we get a high tender - we are hoping we will not because it has been costed well, and when I say 'hoping', it has been costed as well as we can - then we would have to wear a higher rental cost. One of the practical issues behind that is we did look at having the owner build mechanical services to the standard he was going to and then us building additional mechanical services as part of the fit-out but, needless to say, there was a lot of duplication and things that would not fit and things that would have to be redone in the construction but as well as that, throughout the occupation of it when the present corporate knowledge goes, I think there would be continual arguments about whether it is his fault or our fault or whether we get a rental abatement or who is paying so it makes much more sense to ask him to provide the mechanical services; he carries all the risk and the maintenance liability for them. We get a reduced rental of that and it is a much more practical option.

Potential for expansion

The Committee questioned the witnesses as to whether there was potential for expansion given the likely increase in demand due to changes in population demographics. Mr Alexander responded:-

There is. Currently cancer is only on the bottom two floors of A Block - and some of it goes into B Block, I think. Cancer will end up with all nine floors of A Block, and that includes the day chemotherapy. There will be a big expansion of people who are not inpatients anymore and people who are in recovery phases, and the cancer centre will eventually have a whole floor of what is called a wellness centre, which is where people can de-stress and receive education, and those sorts of things.

There is a model in Britain called the Maggie centres, and they tend to be close to but not in the hospital. So it is one of a number of things where we are building in some expansion capacity. So we will build it into the hospital and if in 20 years we need another floor of chemotherapy chairs, that can be pulled out and put somewhere close. In Launceston it has been built across the street. There are some advantages - people say, 'I'm not in the hospital, I don't want to hear another machine that goes "ping", I can just make a cup of tea and relax a little bit but still be very close'. We are building in a lot of what they call self-space like that, really useful space, but if we had to take it out to expand something that is more necessary, we have that choice.

Programming

The Committee questioned the witnesses as to whether the completion of the works can be achieved in the time frame programmed. Mr Alexander responded:-

It is being done as quickly as possible. To have got from a mind state across government that we were going to go with the new Royal to a master plan that we had confidence in, which is really through the process of the HHF funding submission last year, was an extraordinary process, it really was. Having done that - and we had a little bit of a hiatus because we had no confirmation of that funding until the Federal Budget in May this year and we did not get written confirmation of it until June this year - it has been a very quick curve. There is a lot of things happening in the background. This week we have the third of four master planning workshops on the overall project, which have a lot of the clinical input. All the senior clinicians are coming to those. They are all on board, all in the room together and there are no major conflicts of people saying that this does not suit them or meet their needs or anything else.

With the form of contract that I intend to use - and I need a final sign-off for that - we have to stage it. We cannot wait until we have designed it down to the last door handle for a project of that size before we start building it, so we will start and have a contractor engaged and be underway with construction by mid-next year. The State funding finishes in the 2014-15 financial year - so 30 June 2015 - and the Federal funding finishes 30 June 2016. We are planning to have the building up and finished by Christmas 2015, the whole of stage 1, and that is obviously not the Wellington centre; it is a lot faster than that. We have had significant discussions with industry, consultants and others and that is all doable

The Committee questioned the witnesses as to what consultative processes had been utilised with employees of the hospital. Mr Alexander responded:-

... In the general project, even at the master planning level, as I say, this week we are having the third of four master planning workshops. That includes all the senior clinical people, a cross-section of people through the clinical areas, engineering people, the hotel services people who manage the cleaners, the orderlies and everybody else. It talks of car parking and administrative offices. There are big debates, for instance, around whether certain groups of clinical people should have their office space with their clinical space or whether you bring all the different clinical disciplines together for their offices because there are interactions between a lot of those things.

... debates are everywhere and they are very active debates. We are encouraging people into those. Below those master planning workshops we have a series of project control groups and a series of user groups which brings those in and then they come up to a steering committee which is chaired by the CEO. There is another coordination committee so it does bring all those things together.

Ms Rowell added:-

As well as the master planning workshops we also have 'models of care workshops' at the moment around clinical need. We are conducting those with food services and cleaning and all of those people involved in what their requirements are in the clinical space and where they actually provide those support services in their department. The plan is to get everyone involved in it and the CEO has forums around telling people what they are up to in the redevelopment and what we are planning on doing.

Mr Penny concluded:-

Specifically with the Wellington Centre there are individual user groups across all the different floors and they have been consulted extensively at every step through the process. It has been led primarily through Kim at a clinical point, which has translated into the architectural brief. So overall concern about functionality, operation, design and all those sorts of things have been extensively consulted.

Optimum design

The Committee questioned the witnesses as to whether or not the proposed design met all requirements. Ms Ford responded:-

... we have spent a lot of time looking at workflows, doing the patient journey, as we did this morning, looking at how things will move through the system. Along the way we have moved some of the utility rooms and treatment rooms to make it more efficient and better suiting that patient journey.

Mr Alexander added:-

I think you will always find discussions between people wanting private offices against open-plan spaces and this model brings some of that together. There are other people who have overviews, such as the infection control people, whom we bring into that, too, because sometimes they have a slightly different view from an individual clinician. We have brought all those people together to the greatest extent possible and I do not think there is any great dissent. Occasionally there are people who would rather have their own office than share an office.

Mr Penny concluded:-

I think it is worth elaborating on that. It must be said that we are fitting into an envelope that has been determined by the developer. That is designing from the outside in, so you have to get the functional relationships right. There are some clinical relationships between, say, optical and audiology, so there is a need for co-location. We have the limitation that each floor has a certain area. The other limitation is on levels 1 and 2, where they are reasonably narrow spaces on the buildings that are immediately fronting Argyle Street. In a perfect world, if you were designing those as a new building you would have them as a square space so that it is more effective. That was simply a limitation of the existing space.

Design life

The Committee questioned the witnesses as to what the design life and energy rating of the proposed works would be. Mr Penny responded:-

The department has guidelines such that any external envelope was up to 100 years. Services are up to 20 years and generally all internal partitioning has a design life of 15 to 20 years.

... we have had the opportunity of being able to talk to the developer as we are going through this design process, which has offered some efficiencies. The hot water, for instance, which was initially electric and distributed throughout the building, has now been redesigned as a single plant on level 13, which has reticulated gas. It is not only more cost-effective but also smarter energywise.

The external envelope is being determined by Sultan Holdings and we are fitting within it. When you are doing energy modelling, a lot of the significant inputs are in the design of the external façade. To answer your question specifically, it is not designed to a green star rating but it is equivalent to a five-and-a-half star rating. We have had some inputs to Sultan Holdings to upgrade to double-glazing with quite a lot of thermal efficiency for external glazing. There has been redesign of the mechanical services, so it is a very effective model. In terms of fit-out, obviously the two key components are what goes on the floors and ceilings. We have re-specified a ceiling tile that has a rating in. They are manufactured from recycled materials but can also be recycled, and the same with the floor finishes.

(the lighting) is fully programmable so for the life of this building those spaces by simply reprogramming them changes your functionality of the lighting rather than having to go back and pull out wires and switches and redo all that. It is a Dali system.

Mr Alexander added:-

There are some Federal Government standards on green leasing and it is a conversation with industry which is really government using its buying power to say, 'If you want to lease to government, we want you to build your buildings', because we have limited say over them, 'to a standard which allows us to do that'. Because we have been working with the developer on this, as Tim said, we have been able to have significant influence, including double glazing which the owner did not want to do. In terms of benchmarking, I work with my colleagues nationally and it is extraordinarily difficult but we are working towards trying to get benchmarks for energy usage either per square metre or per patient day or those sorts of things but because there is such a variety of climatic conditions and building ages that also makes it difficult to benchmark internationally. The Americans do a lot more airconditioning than the Europeans, for instance, and all of those have impacts. In some ways it is as useful to benchmark and try to improve your own performance as it is to try to balance against someone else but we are developing efficient benchmarks for water usage, maintenance costs, energy usage, et cetera.

Renewable energy

The Committee questioned the witnesses as to whether solar hot water systems were proposed to be installed. Mr Penny responded:-

The modelling was that gas gave us the better solution and bearing in mind that the department is not the only decision-maker in that process as the developer has a role in saying what his model is as well.

Mr Alexander added:-

... we have specialist ESD consultants working with us on the new site across a whole range of areas, which includes consideration of embodied energy and things like that. This one is a leased property so the capital cost, the rental cost, et cetera, are important to us and one of the major costs that we have avoided in this is whenever you lease a property there is what they call a 'make good' clause. Even if you improve it, at the end of the lease the owner can require you to take out all your improvements at your cost and in a lot of the commercial world they will say, 'Write me a cheque and I won't make you do that'. He then on-leases it to someone else and does not do anything but he has made a cheque. There are no 'make good' clauses in this so we have had to work with them, so we do not have to pay for the cost of our fit-out at the end of the day of removing things that we have specified to the builder.

Mr Penny elaborated upon the use of double glazing and air conditioning:-

When we did the initial modelling it showed that the west and the northern two parts of the facade were at high risk of solar loading and so we started dialogue with Sultan Holdings very early on in the piece. They had single glaze with a reasonably low shading coefficient but they took it upon themselves to upgrade both to a higher shading coefficient as well as to go to double glazing. They initially only had double glazing on the southern side.

... the Wellington Centre, it is fully air-conditioned. If you look on page 17, it talks about variable refrigerant flow, and that really is talking about rather than having a single plant, like on the current hospital with chillers and those sorts of things, it effectively uses heat pump technology which gives you a high level of being able to zone, but with it goes energy efficiency because of the capacity for the zoning.

Use of capital equipment

The Committee questioned the witnesses as to whether there was an intention in to expand the operating hours and therefore be more efficient with the use of the capital equipment moving to this new facility. The following exchange ensued:-

Ms FORD - There are a couple of issues there. One is getting the clinicians to agree to do earlier or later extra shifts; the other is a resourcing issue around nursing staff and scheduling staff. If you bring on an evening clinic or a later clinic or a weekend clinic then that is going to increase your human resource cost, so you would have to look at how that could be funded.

Ms ROWELL - There are some private clinicians, allied health as well as medical staff, who we believe are interested in using those facilities and conducting their own clinics. We actually see that as revenue raising.

Ms FORD - Especially a GP clinic and that would help decrease the burden on the ED department. Category 4s and 5s, the lower end of the acute presentations, could be sent over to a GP clinic that could run there after hours. That is one of the models that we have been exploring with GP South - the local GP division.

Mr ALEXANDER - As I said, the buildings are there to support the service. We could not extend what we do in this hospital for a number of security reasons, for instance, with the low staffing levels at night, having people wandering independently through the hospital where there are big empty spaces. We cannot supervise them and other things make that impossible. In this facility, the facility can cope with that because it is a dedicated facility. It has its own lifts that go nowhere else. It is designed so that there are areas that the public can get to, like the waiting rooms. They can be invited into the clinics, and areas that they cannot go into would be closed off. So the question becomes a government resourcing decision around staffing numbers and recurrent funding, but the building will have the capacity to cope with exactly what you are saying, whereas with the current building you could not do it even if you were given the money.

Ms FORD - We did talk this morning about the reasons we put the various services or specialities on floors together - so that we could have an efficiency around co-located services. There was a lot of thought given to how we would fit them in and who would go where.

Ms ROWELL - We put an expression of interest out when we knew about the availability of the Wellington Centre for clinicians, asking them if they saw some benefits of going over there. They talked to their colleagues about where their best fit would be and with whom and then put together submissions.

Ms FORD - So anyone from the hospital who had an interest in going to the Wellington Centre put in an expression of interest. That included some other areas like podiatry, speech, lymphedema and some other outpatient areas, and a group of clinicians made a collective decision about who should go over there. So it was part of the process we went through to make sure that everyone was in agreement about what should be there.

Ms ROWELL - And to make the most efficient use of the space and location.

... There are a lot of design principles in there, too, that we have developed over many of the projects we have done. We talked about having graded areas without hard security or impediments that annoy people, places where people can wander at will or by invitation. A

lot of those consulting rooms have separate egress, which is a requirement if there is a duress situation where a clinician can back out a separate way; they do not have to go past an aggressive person to get out. There are places where we can improve professional interactions. There is a professor in America called Frank Becker who makes his living out of telling us about corridor conversations and the professional interaction that happens in the tearoom. So we are trying to gain the benefits out of corridor spaces where there are write-up areas and areas for professionals to have conversations where they are not in a public corridor and can be overheard. There are a lot of those issues incorporated in that design.

Ms ROWELL - So what you saw today in the orthopaedic clinic, where we were standing and there was a gentleman being seen in the consulting room, will not happen in the Wellington Centre because the doctors and nurses will be able to go elsewhere, away from where the patients are.

Mr PENNY - My closest analogy would be that the planning there is like a spinning wheel in that the centralised activities with clinicians and delivering the service is in those rooms, and on the public site people can come and go quite effectively and efficiently in a pleasant environment, whereas what you saw today is like a cone, where all the circulation is along a big spine; everything happens in that area and it is highly inefficient.

5. DOCUMENTS TAKEN INTO EVIDENCE

The following documents were taken into evidence and considered by the Committee:-

- Submission to the Parliamentary Standing Committee on Public Works – Wellington Centre at 42 Argyle Street Hobart: Fit Out and Air Bridge for Ambulatory Clinics, August 2011

6. CONCLUSION

The need for the proposed works was clearly established. The project will provide vastly improved spaces for provision of the targeted clinical services, including the opportunity to gain additional revenue from additional services and enable the targeted clinical services to move off the RHH site for the medium term, to free up existing spaces to be redeveloped and allow other projects to proceed.

The unique proximity of the Wellington Centre to the RHH will enable excellent access for clinicians working across sites and for patients referred to and from other services on the RHH campus. The adjacent car parking for patients and their carers will also be vastly improved.

The Committee recommends the project in accordance with the plans and specifications submitted, at an estimated cost of \$12.2 million.

**Parliament House
Hobart
28 September 2011**

**Hon. A. P. Harriss M.L.C.
Chairman**