PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN THE LATROBE COUNCIL CHAMBERS ON TUESDAY 5 OCTOBER 2021

MERSEY COMMUNITY HOSPITAL - THEATRES AND OUTPATIENT CLINICS REDEVELOPMENT PROJECT

Mr RICHARD RAINBIRD, PROJECT MANAGER, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; **Ms VICTORIA BROWN**, PROJECT NURSE CAPITAL WORKS, MERSEY COMMUNITY HOSPITAL, DEPARTMENT OF HEALTH; **Mr ALISDAIR McPHEE**, SENIOR ASSOCIATE, ARCHITECT, ARTAS ARCHITECTS WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr VALENTINE) - Thank you for appearing today to hear the submission that we have with regard to the Mersey Community Hospital. For the sake of *Hansard*, we will introduce those present around the table: Mr Scott Hennessy, Secretary of the committee; Mr John Tucker, myself Mr Robert Valentine as Chair, Ms Tania Rattray Deputy Chair, Mr Felix Ellis, and Mr James Reynolds for *Hansard*. Ms Jennifer Butler MP is an apology. Before we commence we have a message from Her Excellency the Governor in Council. Mr Secretary, would you please read the message?

The Secretary read the Governor's Message.

CHAIR - Thank you, Mr Secretary. We are in receipt of one submission, Mersey Community Hospital out-patient clinics and operating theatres re-development. I ask for a member to move a motion that the submission be received and taken into evidence and published? Thank you, gentlemen. Seconded. Thank you very much Tania. I put that motion - all those in favour?

The item is carried. Mr Secretary, could you please swear in the witnesses?

CHAIR - Thank you; and thank you for providing us with a site tour prior to this hearing. It was very valuable. We always appreciate the opportunity.

Before we commence the hearing, I want to make sure that you are aware that there are some important aspects of committee proceedings.

Today our committee hearing is a proceeding in parliament and that means that it receives the protection of parliamentary privilege. This is an important legal protection that allows individuals giving evidence to a parliamentary committee to speak with complete freedom without the fear of being sued or questioned in any court or place out of parliament, and it applies to ensure that parliament receives the very best information when conducting its enquiries.

It is also important to be aware that this protection is not accorded to you if statements that may be defamatory are repeated or referred to by you outside the confines of the parliamentary proceedings.

It is a public hearing and members of the public and journalists may be present, and this means your evidence may be reported. Do you understand? I need a 'Yes', from each of you.

Messrs RAINBIRD and McPHEE and Ms BROWN - Yes.

CHAIR - Thank you. Would you like to make an opening statement with respect to the submission that's been provided?

Ms BROWN - Let's launch in.

CHAIR - We usually go through the submission page by page so that we don't miss anything, and to give members the opportunity to ask questions, and I move to page 4 in the submission. Could you outline the objectives of this particular set of works for us and for *Hansard*?

Mr RAINBIRD - Currently with the redevelopment we are looking at expanding the capacity of our outpatients and our operating theatres at Mersey Community Hospital. This is inclusive of an additional endoscope and a recovery theatre space. This will be a two-storey facility which we class at the moment as a wedge which will be placed between C and D Block. We will look at upgrading staff facilities which would account for the additional capacity that we will be maintaining or running at Mersey Community Hospital and the infrastructure upgrades which will support this new facility.

Current objectives are basically to redevelop the Mersey Community Hospital to fulfil that capacity of having an outpatients and operating theatre.

CHAIR - And where it fits in the wider scheme of things in terms of the Tasmanian health system.

Mr RAINBIRD - Yes, ideally this program is about ensuring that we look at our wait list and have the service delivery or the model that's been presented to support the community on the north-west under, I am assuming, the statewide White Paper clinical redesign.

CHAIR - Thank you.

Mr TUCKER - How is it consistent with the Department of Health's Strategic Asset Management Plan?

Mr RAINBIRD - The current asset management plan is focussed around the maintenance of our facilities moving forward with this facility. This is for future-proofing of this site. There has been a significant amount of work into the infrastructure upgrade to account for this, and we are currently developing an asset management schedule which will account for the ongoing maintenance of this site continuously.

Ms RATTRAY - I also appreciated the opportunity to visit the site. I had not been to the Mersey Community Hospital before, being based in the north-east.

I am interested in the consult rooms. We were given some advice around the fact that the number would be increased. Can we have the increased numbers? And Victoria shared

some information about the efficiency of the consulting rooms and the redevelopment around that. That would be useful to have on the public record. Thank you.

Mr RAINBIRD - I will touch on the number of rooms. This is from an outpatient's perspective. Originally, I did state 25; I was incorrect. This has 19 consult rooms currently which will be included in the outpatients clinic. We originally had proposed 21, but because additional services were being brought in to support the existing onsite we reduced those numbers to account for those services. As an example, the physiotherapy department had to come down so we lost that.

I will hand over to Victoria to talk about the capacity.

Ms BROWN - At the moment the hospital has consulting clinics in various locations around the building where spare rooms have been converted to consulting rooms. This redevelopment allows us to consolidate and have all of the rooms together in one space so that we can have a pool of staff.

It also allows for multi-disciplinary consultation such as a consultant, a registrar, a physio, a paediatrician; different teams having rooms together where the patient can come and see multiple people at the same time. At the moment, we're spread throughout the building so it's very difficult to do that sort of thing.

Ms RATTRAY - We also heard about the efficiency that would lead to, by having them all together and being able to see more patients.

Ms BROWN - Absolutely. At the moment, with any system where you don't have a consolidation of resources you have inefficiencies. Where you have staff spread across the hospital, you actually need more staff to service those rooms and to support those rooms. It all makes sense that consolidation allows for better efficiencies, less bottlenecking and fewer staff to produce the same amount of consultations.

Ms RATTRAY - We had a conversation as we walked around the building about the number of staff you might need into the future to provide the services in an expanded space. Would you share that with the committee, thank you, Victoria?

Ms BROWN - Both with the operating rooms, day surgery unit and outpatients, we will not have enough staff initially to support the full bill. When we first move in, we will run to whatever maximum service delivery we can whilst we recruit. It is going to be a great recruitment tool to have a purpose-built state of the art facility. That is a great way to get staff from other areas, other states, other parts of the state to come and work here.

There will be quite a lot of recruitment and training that will need to happen in order to maximise the service delivery into the future.

Ms RATTRAY - Do you see an opportunity to undertake that process prior to the completion of works? Is that something that would be considered?

Ms BROWN - It is going to be very difficult with the staging and decanting because we are going to be working out of a very small footprint at some stages of the redevelopment. I think it is not conducive to educating and orientating new staff. What we will do, is we will

have those plans in place that as soon as we take over the new building we can recruit and start employing straight away.

It will be very difficult to have additional staff coming into an already crowded workspace and work environment. It would be better for everybody to wait until we are ready to open those facilities.

CHAIR - Further to that, in the grander scheme of things, with the elective surgery load building is the expectation you would be recruiting staff in the immediate location, rather than other staff coming in temporarily from other locations? Is that the way it goes?

Mr RAINBIRD - The way we put our advertising out is certainly open to the states, but we have not an open tender ad yet. Locally first is normally what we do within the department if they have that skill and then from there it will broaden the scope and very dependent on the resources and their capability to undertake the role.

Mr ELLIS - Firstly, thank you for your time today, it is an incredibly important project for this region and I really appreciate all of your expertise and work you are doing. To give the community a sense of perspective on some of the works that are going to be happening at the Mersey, this particular project we are looking at today is $37 million. People may be aware there is more money in the budget for capital works for the expanded redevelopment of the rural clinical school. Can you give a sense of what this project is and what is outside of the scope?

Mr RAINBIRD - At the moment with this redevelopment, the funding available is allowing us to proceed with this development once approval is pushing us forward. We are looking at a clinical strategic plan for the north-west which will obviously drive the services and the changes we may need to see up from the North West Regional and Mersey Community Hospital at the moment. That is ongoing. By next year, we will have a better idea of what those services are or what the delivery of service will be outside of our hospitals.

Following the Mersey Community Hospital development, we will be looking at our strategic plan. That plan originally looked at our medical ward, the relocation of our kitchen to support the hospital. We do have a strategic direction following the theatres and outpatients' redevelopment.

CHAIR - With respect to the consultation associated with this particular development, how much consultation happens between the North West Regional Hospital and the Mersey Hospital in terms of how you are going to cope with the decanting and services that might be offered elsewhere?

Mr RAINBIRD - Victoria's been leading the charge on that one from a THS perspective and I will pass that one on.

Ms BROWN - The way the THS north-west works - which has suited the project purposes quite nicely - is that some of the positions are regional. For example, our nursing director of perioperative services sits in a regional position and coordinates bookings for the North West Regional, the private brokerage and the Mersey. She has been part of the design team and has consulted right the way through. We also consulted with the Director of Surgery for the North West. We did allow for that consultation and bigger picture as far as bookings,

staging, how we were going to manage, reduce through-put and more long-term planning into the future.

CHAIR - It is not a case of services being duplicated.

Ms BROWN - No, the North West Regional does, as you know, different surgery than the Mersey. They have an ICU for support, they provide an emergency theatre and an on-call service, which the Mersey does not. The Mersey has a niche for elective day surgery and endoscopy. The endoscopy area is growing all the time and we would like to grow it more. This facility allows us to do that. The facilities at North West Regional only allow for very limited endoscopy services. The services we provide in each place aare quite different. Having said that, Burnie are able to pick up some of our day surgery while our through-put is down.

CHAIR - Okay. It is complementary.

Ms BROWN - It is complementary, yes and it works very well supporting each other.

Ms RATTRAY - While the development is proceeding - should it receive this committee's approval - the North West Regional and the LGH will pick up some of the procedures that would require an overnight stay, is that correct?

Ms BROWN - Yes, the plan will be they will pick up some, but not necessarily only overnight. It may also be day surgery they pick up. We can utilise the government policy on brokerage to the private facility that already exists more.

Ms RATTRAY - We also heard this morning bed space will be increased. I believe it was three times the current size. Did I write that down correctly?

Ms BROWN - Yes, you are talking about individual bed space.

Ms RATTRAY - Yes.

Ms BROWN - The actual number of overnight beds for the hospital is not going to be increased because day surgery does not utilise overnight beds. It is a different measurement. We are looking at bed space for service delivery for the individual patient in-line with standards for Australian health-care facilities.

CHAIR - The standards have changed over time and you are constructing to those new standards.

Ms BROWN - Yes, that is correct.

Ms RATTRAY - I believe the hospital was built in the early 1960s.

CHAIR - We will go back to the submission, if there are any other questions?

Mr ELLIS - While we were touring we saw the existing central sterile supply department facility is quite small. Could you give us a sense of what the expansion is going to be like for that facility and what that will mean in terms of the ability to operate?

Mr RAINBIRD - Not necessarily focusing on CSSD, but the increased capacity of floor space we are looking at is going to be a number of around 2850 square metres on top of what we have at the moment. An increase in terms of the CSSD, it is probably going to be three to four times larger than it currently is and is going to support those four suites we are including at this stage. It is significant development, from that capacity. Overall, we are looking at around 5450 metres of redevelopment being undertaken within the Mersey Community Hospital, which is a significant-sized project.

Mr ELLIS - Using the CSSD as an example, what do the current limitations stop you doing and what will the expanded space allow you to do you that have not been able to do in efficiencies and that sort of thing?

Ms BROWN - The limitations with the current design we have is, for example, our CSSD is fragmented at the moment. The decontamination zone is right down the bottom, between the two theatres and the reprocessing, sterilisation zone is the door I showed you at the beginning of D-block. It is broken apart using this central corridor. Best practice guidelines and Australian Standard 4187 prescribe a circular flow of dirty to clean to sterile equipment, which is standard for the reprocessing of RMDs, which is reusable medical devices. The new design allows us to comply with those standards, produce that circular flow, reducing any risk of incidents with RMDs and patient safety ultimately but it also allows for the staff to work within one department and have decontamination, packing, sterilising, cooling and then back into the area all in one department.

It also allows us to put some extra equipment in so we'll be purchasing an additional washer/disinfector which will support not only the operating room but the hospital and even some services in the community that we provide with sterilising and decontamination services.

Mr ELLIS - Thank you. Chair, if I may just one more: I note substantial consultation with the project working group. How important is it to have clinical input in the way that we design our hospitals and refurbishments and all that sort of thing?

Mr RAINBIRD - It's very important from a patient flow and a clinical infection point of view in where we're leading.

Victoria has spent many a month talking to the specialists across the north-west and updating staff at Mersey Community Hospital. Having the right people and the key stakeholders at the table has been important. It's been challenging to get them because of their workload and capacity but the way we've done over, I think, is over and above on our consultation process for this project. Victoria needs to be recognised for that because it's not an easy job doing that.

Ms RATTRAY - What about the community consultation as well? We know that's often where the highest level of criticism comes from, the community, once something is being developed. I'm interested in that process as well.

Ms BROWN - Initially I presented this project to the community engagement group that the hospital uses, and from that initial presentation there were two representatives who expressed a desire to be involved in the process. They were consulted several times on different stages of the design via email and sharing of design plans, mostly looking at things like waiting rooms, public facilities, access, the admissions area, those sorts of things we felt that their input

would be really valuable. We did meet again just before sign-off of all the plans for me to present the final submission before it went away for approval. A couple of them right through were involved but the whole group had an initial briefing and presentation on what we were doing and we asked for any feedback at the time.

CHAIR - Can you perhaps give us an idea of the makeup of that group? How did you choose your members and bring them together?

Ms BROWN - They are volunteers. They are people who expressed an interest in being involved. They were recruited through our Quality and Safety Unit. The idea is that they're not staff, they don't have a background in health and they represent different facets of the organisation - business people, tradesmen. There was a mother with young children who was also on the committee when I was talking to them so it was quite a varied group.

CHAIR - Which is good.

Ms RATTRAY - A follow up, in one of the areas and I think it was outside the consult rooms, the waiting area was actually a chair against the wall. Will that approach change?

Ms BROWN - Absolutely. It wasn't in the original design of that wing to have people waiting in the corridor. There are separate waiting areas within the consult areas but we've outgrown it and because of social distancing requirements as well we've had to move chairs into the corridor just to allow people to have somewhere to sit while they are waiting, otherwise they're standing. So it's just making the best of a bad situation but we have allowed for quite generous waiting rooms both preoperatively in the perioperative area and also in the outpatients area. We've also included a separate waiting room in the paediatric wing of our outpatients department so that the children can have a closed-door environment. This is a little bit less stressful for parents trying to juggle a few children and that sort of thing and keeping the children separate from the main waiting room.

Ms RATTRAY - And a door to keep them in that room. Very useful.

Ms BROWN - Quite handy.

Ms RATTRAY - I've had four young children. Doors are good.

CHAIR - A follow-up on that too. When we were walking around, COVID-19 was mentioned. Is there any specific design that's taken place here that had to be altered because of COVID-19? Can you talk us through that?

Mr RAINBIRD - Under the changes that have come through, it is certainly about capacity within the room. How many people we have, the spacing within the wait area has certainly changed. We couldn't increase the size of the footprints to account for that, but the layout of the rooms with furniture fittings and equipment has helped us on that component.

CHAIR - You were saying that people presenting at the emergency department with COVID-19 would not be entering the hospital anyway. Could you explain that?

Mr RAINBIRD - I will leave that to Victoria.

Ms BROWN - Coming in through the emergency department, the patients would be in a completely separate part of the building. If they were coming into the new outpatients department, one of the security things we have put in place, from a COVID-19 perspective, is the ability to separate off one component - the paediatric clinics - from the rest of the hospital. If we wanted to run a respiratory clinic or anything to do with any infectious diseases, we could have them accessing this area, completely separate, that is exhausted with its own air-conditioning system separate from the rest of the outpatients department.

CHAIR - Okay. If there was someone in that circumstance they would be sent to the North West Regional to be dealt with?

Ms BROWN - Yes. I think I mentioned to you before, anybody with COVID-19, for example, wouldn't be coming in for a procedure because they are screened out. Anyone through outpatients that was known to have COVID-19 wouldn't be asked to come in for a consultation and, hopefully, they would be picked up at the screening doors or through the emergency department anyway.

CHAIR - Thank you for that. I wanted to have that on the record. Looking at page 5, ground floor Block E, outpatients department, 13 consulting rooms including one with cardio rehab capacity, now that we are becoming an older community and those sorts of facilities being important. Is that the only cardio room that is being constructed and there are other rooms available, or is this the only cardio room in the hospital?

Ms BROWN - Really, the cardiac rehab room is just a room with specific equipment in it. That equipment can be moved anywhere to any room it is needed. We run a cardiac rehabilitation service at the Mersey at the moment which is staffed by a registered nurse. It is a one full-time equivalent. That is why we have only built one room. She needs to be close to the physio gym because that's where they run their rehabilitation classes but physio is being relocated to this area anyway. There is capacity, easily, for the room next door, for example, to be converted to an additional room just by buying some extra equipment.

CHAIR - Okay, thanks, I wanted to clarify that.

Ms RATTRAY - Have you seen an increase in the demand for the cardio rehab service?

Ms BROWN - Yes, there in an increase in demand.

Ms RATTRAY - That's what happens after strokes and heart attacks -

Ms BROWN - Stents, that sort of thing.

Ms RATTRAY - I think this one is for Alisdair, as the architect in charge. You have consulted with Victoria, her team, and Richard. Can you give us an understanding of your design approach?

Mr McPHEE - On engagement, a master plan was completed by Silver Thomas Hanley, who are medical architects based on the mainland. When we commenced this project, we used that as the basis of the master plan. We also used the Australasian Health Facility Guidelines document that produces guidelines and standards for all of the different rooms in a medical facility. We also engaged a health architect based in a separate architecture firm, who is also

a registered nurse who effectively provided peer review on our design as we were going through. There was also significant consultation with the project working group and both Victoria and Richard over an almost 12-month period. That was basically doing the weeding of the project, and then that was presented. We also had two separate internal design presentations to the staff and to stakeholders, where we provided a 3D walk-through of the facility. That is how we have got to where we are.

Mr ELLIS - Can I ask about the importance of level four classifications and what that means, and how does that compare to, say, some of our other facilities around the state and the significance of it?

Mr McPHEE - The importance of level four under the National Construction Code is relevant to seismic events and how a building needs to maintain or retain operations, or how it operates after a natural disaster, being an earthquake. The importance of level four is that it is effectively the highest classification, meaning that any new design that we construct needs to stay in operation or have the capacity to remain operable. That's what we've designed to, in conjunction with all of our consulting engines.

CHAIR - In terms of the infrastructure, itself - fire arrangements and those sorts of things - can you tell us how you've revamped that in relation to what's currently there? Are you pulling out old systems? Putting in new ones? Are you refurbishing the systems that are already there? Those sorts of utility issues.

Mr RAINBIRD - With the critical infrastructure upgrade, that's one of the components we look at, at increasing capacity to meet the new build. When we looked at this design, we looked at our Australian standards for fire which are 317 and 4183. It allowed us to look at our floor space and how we would do that change.

Emergency management plans internally for the building will be constructed once this is done. That highlights the fire compartments, and looks at our evacuation processes and procedures. It does have the full capacity of the standards at the moment, which means sprinkler systems, fire hydrants, internal hose reels and all lighting that is required for any type of evacuation within this facility. That is an increased scope from our point of view and is going to be a high-quality standard in this building, ensuring that we have the safety of our patients and staff in hand.

CHAIR - In terms of air-conditioning - it is probably something that the member to my left will want to ask further questions on - I noticed that when we were doing the walk-through, you had a screen that kept lifting and lowering for various reasons. Perhaps you could place on the record what is happening with regard to that.

Mr RAINBIRD - Victoria, did you want to talk about that?

Ms BROWN - With the perioperative environment, at the moment we only have the section behind that door that you're talking about. That is currently airconditioned and the rest of the facility, including the stage one, two and three recovery, are not.

In the new build, the whole department has some form of climate control. It's maximised in the operating rooms, endoscopy rooms, sterile stock rooms and those sorts of things. In the theatres, we have hepafiltration units, we have laminar flow facilities and state of the art

facilities. In some of the other areas, it's more climate control. It's suited to what's required and what the standards say for each specific use of each specific area.

CHAIR - Any other questions on this part? Page seven?

Ms RATTRAY - I have a question on the service. I notice the documentation says -

This development will be a 23-hour surgical service.

Which hour don't we cover?

Ms BROWN - It's the way it is. The White Paper stipulates that the Mersey will be used for twenty-three hour surgery. At the moment, we use overnight beds either in the close observation unit or on the medical ward for patients that require a bed. They are usually discharged before they hit the twenty-four hour mark. It is to do with the type of surgery that you do. The new area has mostly been built for high flow, high turnover day surgery patients. There will be part of 1 B that will not be re -developed that will still have some single rooms that can be used for these twenty-three hour stay patients, as well as beds on the close observation unit and medical ward.

Ms RATTRAY - Is the twenty-three hour surgical service arrangement part of the dollar deal that was done all those years ago?

Ms BROWN - That is part of our clinical service delivery. That is what we are being asked to do. As you know, there is a current review going on about what services the Mersey will be providing into the future. We are hoping to have that report next year and that will inform any future re -developments of different areas of the hospital.

Ms RATTRAY - But that will not impede on what is proposed here at all regardless -

Ms BROWN - It will not impact on what is proposed here. No.

Ms RATTRAY - of what comes out of that review?

Ms BROWN - No.

Mr RAINBIRD - That is more around the level of service being provided.

Ms BROWN - This is what we are working towards, it is the old White Paper. So the new one is what will prescribe into the future.

Ms RATTRAY - So we might get a twenty-four hour service?

Ms BROWN - You never know.

Mr RAINBIRD - You never know.

Ms BROWN - But our operating theatres will still be able to service that if that happens.

Mr RAINBIRD - Correct.

Ms BROWN - They are spec'd so that they would be perfectly able to cope with anything that even the North West Regional Hospital delivers.

Mr ELLIS - Can you give us a sense of how bottlenecking is currently occurring in the Mersey and how these works would help alleviate that, and what that would mean for patient care and patient outcomes?

Ms BROWN - Bottlenecking happens in a few different places within the perioperative flow. The first place we usually get bottlenecking is the first stage recovery. At the moment, we have three first-stage recovery beds around in the theatre complex. We have two operating rooms. If they have a high flow short procedure time, quite often the recovery room will be full and we have to stop the lists while we wait for those patients to move on. Obviously, we have to have somewhere for them to go. That is the first place bottlenecking happens. The second place is in the stage two day surgery unit, where they still have previous patients in the beds and we have new admissions coming in for the afternoon, and again we have nowhere to put them because we do not have enough beds. These can all cause delays with the operating lists and potentially lead to cancellations at the end of the day, because we do not run evening shifts at the hospital. It is a day surgery unit. The new facility allows for more stage one and stage two beds. It also allows for more efficient processing of patients as far as their admission and discharge - paperwork, the use of consult rooms for admissions, the use of a discharge lounge for people just waiting for a ride or a prescription. We don't have those facilities at the moment.

Mr ELLIS - And so by this infrastructure change and removing some of those bottlenecks, we are likely to see the capacity to do more elective surgeries more efficiently?

Ms BROWN - Absolutely. I would like to see one to two more people on every list because I think we will have the capacity to increase the throughput by that much, just with removing some of these design issues.

Mr TUCKER - On the list, you are talking per day, is that correct?

Ms BROWN - Yes.

Mr TUCKER - We will let that be on the record.

Ms BROWN - Okay.

CHAIR - For the record, can you describe low case weight procedures as it mentions on this page? What is a low case weight procedure? It says:

> Mersey Community Hospital specialise in high volume low case weight procedures.

Ms BROWN - Casemix is a term that they use. It used to be used to do with funding for hospitals, based on the weighting of a type of surgery that you do. This is the context of that conversation. A lot of the stuff that Mersey does is low case weighted. They are not expensive cases. We don't get funded a lot of money, but we do a lot of them - as opposed to something

like brain surgery or a hip replacement where there is more funding associated with it and then they have a high case weight. That's the difference.

CHAIR - I wanted to make sure that was described on the record. Thank you. Anything further on that page? No. Moving across to page nine. Top of the page there:

> Develop adaptable buildings in key locations and create a management and service structure that responds to local needs while maximising professional interaction and economies of scale.

Some might say, for the economies of scale, it might be better to expand what is happening in the North West Regional Hospital rather than doing it here. Is it a matter of population dispersal and proximity to where people live?

Mr RAINBIRD - In this instance this was simply related to the White Paper that was put forward and what level of service was to be managed out of Mersey. That is why we are moving towards this development there rather than the North West Regional.

CHAIR - As it talks about maximising professional interaction I was interested to hear that. The next dot point, what is that trying to get across to us? It says:

> … provide standards of accommodation that promote the recruitment and retention of staff and recognises the physical environment plays a disproportionately large part in the public perception of the quality of service provided.

It is an interesting statement.

Mr RAINBIRD - Victoria touched on that earlier. We are finding in order to attract people to our region, you need to have the appropriate services or, at least, 'look' of that service to draw them in. The Mersey is, as you saw today, a 1962 build with facilities that have not exactly been upgraded. When you are trying to attract professionals and staff to the region, not only are they looking at their location of work, they are looking at the region as a whole.

From our point of view, to have a state-of-the-art facility is certainly going to allow us to make it easier for our recruitment and retention of those staff within the region. That is what this design is proposing, we are going for a complete state-of-the-art facility that will, hopefully, attract specialists from around Australia - nationally or locally - to want to stay, and stay long, within the North West Regional Hospital.

Ms RATTRAY - You are talking about accommodation for their services, not living accommodation.

Mr RAINBIRD - Yes. That accommodation standard was in our strategic plan on what we were looking at with accommodation within the North West to support them.

Mr TUCKER - Following on, we discussed one to two patients improving the list today. With the retention and recruitment of staff, do you believe we will be able to get those staff levels up to be able to do those extra operations?

Ms BROWN - Yes. When the redevelopment's finished we will have an additional procedure room/operating room. At the moment, we have two theatres and one endoscopy and we will have a total of four rooms at the end of the project. Potentially, that is a 25 per cent increase in the number of cases we do. I do not think we will have problems recruiting to fill those rooms and provide those numbers in the future.

We certainly have capacity and educational support to run new graduate and advancing practice programs that will train up perioperative nurses to the level we require. We do not necessarily even need to recruit experienced staff as we have the facilities and we will have the space to be able to train our own, if necessary, local staff to provide that level of service in future.

Mr TUCKER - You have the training staff here at the moment or will you have to recruit them to do that?

Ms BROWN - We would potentially need some additional support but we already provide a team of clinical nurse educators and facilitators within the hospital.

Mr ELLIS - What is the problem we are currently trying to address with the wayfinding and the new reception?

Mr RAINBIRD - I suppose at the moment, Victoria touched on the fact we have multiple services dotted around the hospital itself just for outpatients. When people present to a main reception it is giving them the direction at that time. Having these services consolidated is an easier flow for us to determine or point them in the right direction to do so. That is really what we are generally looking at - having a central hub location that once they present, they know exactly where they need to go and the direction for the consult they need.

Mr ELLIS - COVID-19 has changed things over the last 18 months, but the existing building with multiple entrances can be confusing to try to navigate your way around if you are not familiar.

Mr RAINBIRD - Absolutely.

Ms RATTRAY - No more confusing than the Royal.

Mr RAINBIRD - There are multiple options in terms of wayfinding. As you would have noted when we walked through, there are a lot of hanging signs that give those directions. We have looked at multiple kiosks that provide this service. Certainly, as part of this project scope the colour coding and the central hub should give us that ease of access and make it easier for the community to get to the point they need to.

CHAIR - With respect to the Child Health and Parenting Service, one of the dot points: 'large consultation room allowing for flexible use, including visiting specialist Child Health and Parenting Service'. How are they currently accommodated? Are they working onsite at the moment?

Mr RAINBIRD - No, they are still offsite, from my understanding, out of Devonport.

Ms BROWN - There is a room at outpatients they book periodically but, as we were saying, it has limited availability.

CHAIR - You are wanting to give them a permanent location?

Ms BROWN - It will still be a room that could be used by other people and it will be set up with little baby scales and things they specifically need built into the room.

Mr RAINBIRD - It is important to note as part of the consultation process it was asked: how many days? They have provided input back to us saying: 'Rather than one day a week we want three days a week or two days a week', which allows us to book and program our services out of that area.

Ms RATTRAY - What about the telehealth consultations?

Mr RAINBIRD - The department's working towards that quite commonly now and that is being specifically set up allowing consults to occur that way.

Ms RATTRAY - Nothing more special than having a tv and a monitor?

Mr RAINBIRD - No, just you sitting on the end of a table as a specialist, I suppose, and giving advice that way or supporting it through those services.

CHAIR - No special equipment.

Ms BROWN - Just a telehealth unit.

Mr RAINBIRD - Just a telehealth unit. We use those regionally quite a bit for our communities: King Island, west coast, that sort of thing but it is just a tv with a video camera on it, a camera.

Mr TUCKER - Chair, can we go back to the consultation period?

CHAIR - Yes.

Mr TUCKER - I want to follow up on if there was consultation regarding training and that sort of thing within the hospital rebuild, or not?

Ms BROWN - The perioperative nurse educator was involved with the consultation process. One of the rooms in that V-section of that floor has been designated as an education multi-purpose area. That limited facility has been provided, but we did not have enough floor space to provide a sim lab or a training room as such. We have allowed for some training facilities, but it is reasonably limited considering what is available in other parts of the hospital.

Mr TUCKER - Just so we have it on the record. Thanks for that.

CHAIR - Anything else on page 9? Page 10?

Ms RATTRAY - Page 10, yes. External works, ground floor, talks about: External works primarily directly related to the new buildings and footpaths, vehicle-free movement and landscaping. What is planned for that, if you have got this far?

Mr RAINBIRD - We actually do not have a schematic plan other than what we have put forward on the landscaping component. Obviously, due to the size of this building with the access path of staff coming in and out we have included as part of the project scope that allows us to make those changes to soften it. Currently, as you would have seen, we have got a terrapin, a boiler house and only grass. There is not much we can physically do from a point of view of making it easy on the eye. We have a lot of staff that work there and certainly, from our point of view we will be looking at putting in some sort of landscaping component be that bushes, trees, even seating, depending on where we head with this design into the future. Keeping in mind the access road out the back is more for emergency services because we have our transformer, generator and hydrants located there, but it also can be utilised as a vehicle access to drop off storage or things through that access area door.

CHAIR - On the top of the page you talk about: 'Updated rack room to accommodate increased IT communications requirements'. Can you describe how those sorts of facilities are being upgraded and what that means to the hospital and its operation?

Ms RATTRAY - The Chair has an IT background so he is going to know what you are saying, whether it is right or not.

CHAIR - Do not give the game away.

Mr RAINBIRD - We have certainly found this very challenging in terms of where our locations of our server rooms and rack rooms are currently being accounted for in this build. As the Chair would know, IT want to be the first ones to get a room with them the centre of everything. In this instance, we have tried our best to accommodate in line with what is classed as patient care or consult responsibility. This is a significant build in terms of that. We're increasing the capacity significantly. Our current rack rooms won't meet that. We're looking at consolidation of rooms within the zone, upgrading our coaxial cables to meet the six-day requirement or the standards at the moment. We are looking at additional rack rooms to support level one theatres and outpatients.

We've gone through a significant change in discussion with ITS Hobart and our local ICT manager, ensuring that we are going to meet the roles and responsibility and futureproof this build as is for any additional services or requirements of IT that may come in. As you know, technology changes, and with technology it's normally either on a WIFI basis or some sort of electronic -

CHAIR - So all the cabling is being replaced with category six cabling?

Mr RAINBIRD - Only in this build sense. We are doing the current project under this infrastructure that will look at the redundancies and remove what is not needed or in use. Under this build where we are in this scope, we will be replacing everything with a six to meet the requirements.

CHAIR - So you're not likely to have any dead spots, so to speak?

Mr RAINBIRD - I'm hoping not. We are undertaking a Telstra review to address and identify any dead spots from a mobile point of view because of the type of facility it is and the age and the thickness of walls. That has been emailed to me yesterday and I will review that and ascertain, but I believe it's overkill from the point of where we've gone for IT. Telstra advise significantly on that component. I think we've done everything that we need to make sure that we can develop and futureproof this hospital from that point of view.

CHAIR - You have here:

> … central waiting area for 58 people designed to distribute visitors according to booking schedules and assist to alleviate anxieties associated with clinical environments.

What sort of design features are we building in to enable that to happen, out of interest?

Ms RATTRAY - What's the colour that calms them down?

Mr McPHEE - Due to the wedge shape - the triangular shape of the wedge - and the layout of the current consult rooms, we took the opportunity to utilise the length along C block which allowed patients to be allocated within closer proximity of the consult rooms that they may be going to. With social distancing, COVID-19 and other things, we are able to disperse people throughout the waiting area much more efficiently rather than bundling everybody all in one room, like we are here now looking face-to-face at each other.

We also provided aspects externally, so views outside, and also a little courtyard there in the centre to provide views externally and lots of use of natural colours to help alleviate some anxieties that people may have.

CHAIR - With respect to outpatients dealing with people with mental health issues and the like, it would happen over time. Do you have special facilities for people or children who are autistic and can't hack that closed-in environment? How are you dealing with those sorts of people?

Ms BROWN - That's one of the reasons that we've created this separate paediatric waiting room because we do have quite a few children coming through with special needs sometimes. That does allow them to have at least a segregated space. It is complex to deal with mental health issues in a public area like that. One of the features we put in is the use of consult rooms with two doors.

If you have a patient escalating in behaviours, there's an opportunity for staff to step out and call for some assistance. There are duress alarms being installed in discrete places right through the whole consult rooms.

CHAIR - In this build?

Ms BROWN - In this build. People can call quickly if they need some help because the sooner help arrives, the sooner the de-escalation can happen. We have additional waiting areas rather than, for example, a corridor situation that we have at the moment. This means we can find quiet corners for people if we feel that we need to find areas less out of the thoroughfare for someone who may be stimulated by a lot of noise and activity.

It's not perfect. It's not a mental health facility but it's certainly a big improvement on what we currently offer to the community.

Mr ELLIS - Chair, I might just add on the waiting rooms from our tour today, it became quite apparent there are a lot of informal waiting spaces in corridors next to informal storage spaces.

Would it be fair to say that the Mersey, essentially, is operating at quite a high level of capacity for what the existing building was, which maybe demonstrates the need to expand the hospital and provide more services and more space?

Ms BROWN - I guess that's exactly what we're doing. We're expanding both the outpatients and the perioperative service, so, yes. I don't have any figures but I'm sure that if you looked into it you'd see quite an exponential growth over the last 20 years or so, remembering that the hospital is 60 years old. Looking at the numbers that would have presented 60 years ago, it's no wonder we've outgrown it, really.

CHAIR - Okay. Any further questions on page 10, page 11? We've covered most of this. We could talk about changing facilities. The first floor, block C, 12-seat stage through recovery area that includes a dedicated changing facility block for patient belongings, et cetera. What about the clinical staff? Do they have special allocations as well?

Mr RAINBIRD - That is their location. That is dedicated to staff.

Ms BROWN - I think the one Mr Valentine is talking about was the changing area for the patients in day surgery. The staff, as you know, all have to wear scrubs, so there is quite a large area, they all have their own lockers, surgical scrubs are available, so that everybody will go through that changeroom before they get to the theatre environment.

CHAIR - With respect to the kitchenette for staff to distribute recovery meals and snacks. What is the circumstance there? Do you have meals brought in or do you have kitchen facilities that you provide meals from?

Mr RAINBIRD - We currently have a kitchen located on the third floor of Mersey Community Hospital, above the admin corridor where we were seated in the meeting room. They would be able to provide sandwiches or snacks. Alternatively, if the patients don't require that, we have a canteen facility available or a kiosk downstairs.

CHAIR - How many overnight beds do you have in the hospital, none at all?

Mr RAINBIRD - In the medical ward, we do.

Ms BROWN - We have overnight beds in the close observation unit, the rehab ward, all the medical beds on the third floor.

CHAIR - How many beds are we talking about?

Mr RAINBIRD - We have 12 downstairs in rehab, we have six in COU and 32 upstairs, so, yes, potentially, just under 50.

CHAIR - They're not being impacted by this development?

Ms BROWN - No, they're completely separate to the surgical services. As I said, we will occasionally use a bed for an overnight surgical patient but, pretty much, it's separate.

CHAIR - Thank you. Questions on page 12?

Ms RATTRAY - We looked out the window when we were upstairs having our briefing and saw where there was some decommissioning of a boiler plant and the records store. You might walk the committee through those early works. I want to confirm that the cost of that is not included in this $36 million or $37 million.

Mr RAINBIRD - The early works is a critical infrastructure upgrade to Mersey Community Hospital. That upgrade is going to allow us to support this build. Rather than making it a singular package as such, we have broken it down to make it easier for us to transition from stages technically. The early works include all services like hydraulic, electrical and mechanical. Those are currently being relocated or replaced to meet the current standards because the Mersey's scheduled maintenance program, as John touched on earlier, has been trying to keep up with the current service delivery under those.

We have undertaken that role now to make it a lot easier for us, that when we are building this we are not having to replace pipework five, six or seven metres down the line inside or outside of the scope - it is simply a connecting function to allow us to continue. The funding is currently outside of this funding that's been proposed for the theatres and outpatients build.

Ms RATTRAY - It says here that the aim is to reduce the overall construction time frame. With this work completed, the proposed new works will be able to go ahead and not be interrupted.

Mr RAINBIRD - That was our proposal and, yes, that is how it should proceed.

CHAIR - And the pump rooms that we were looking at from that observation point -

Ms RATTRAY - And the ventilator.

CHAIR - And the ventilation, can you just describe how that is going to be dealt with in relation - because obviously that will impact on the operation of the whole hospital, won't it?

Mr RAINBIRD - Correct.

CHAIR - So how are you managing that?

Mr RAINBIRD - Currently under this project we - or this hospital - is actually supported by heating. It is supported by hot water. That hot water is generated through that boiler -room which is located in that void currently. Part of the early works is to install a HVAC (heating, ventilation and air conditioning) system on the top of the 2D roof. That system is going to support heating throughout the hospital, the existing hospital at the moment. The demolition of that will occur as part of this early works project. So if we do engage a new contractor, or when we engage the new contractor, they can simply come in and start looking at putting in

footings for the development of a level 1 facility as we are proposing. That facility will have a plant on the top roof which will then support those new services within the E and C block.

CHAIR - Okay. Thank you. Further questions?

Ms RATTRAY - We have not talked about the works that have been undertaken now. They are by which contractor?

Mr RAINBIRD - Fairbrother at the moment.

Ms RATTRAY - Fairbrother.

Mr RAINBIRD - Correct.

Ms RATTRAY - So have the tenders been sent out for this?

Mr RAINBIRD - Yes. The theatres and operating tender has actually gone for advertisement and is due to close on 20 October.

Ms RATTRAY - Any idea how many submissions there are to that?

Mr RAINBIRD - Not at the moment, no.

Ms RATTRAY - It is a wonder they have not been engaging with you already.

Mr RAINBIRD - We have had a number of engagements but I will state that is two engagements from two local companies. However, we do find that most tenders, some actually do not ask any questions but do still provide a submission.

Ms RATTRAY - Right, so you -

Mr RAINBIRD - I cannot give the number exactly.

CHAIR - No.

Mr RAINBIRD - But at the moment, we are talking with two local companies.

Ms RATTRAY - Okay. But you are expecting to have more than one?

Mr RAINBIRD - I am expecting to have more than one, correct.

CHAIR - Always good to have competition.

Ms RATTRAY - Well we did not have any in the last reference, if you recall, Chair.

CHAIR - No we didn't. We didn't, that's -

Ms RATTRAY - There was only one.

CHAIR - That is right.

Mr ELLIS - Chair, could I just ask about the record store?

CHAIR - Yes.

Mr ELLIS - Thank you. You mentioned it is vacant. Can you give us a sense of what is happening in the contemporary record management?

Mr RAINBIRD - Yes, when we raised that looking at the demolition of the records and boiler house. Obviously that record store accounted for patient records. I do not know if you are aware that probably about five years ago Mersey Community Hospital actually built a new records store just outside of A block next to the nurses home which accounts for our current - so this records room was technically our archive room. That room was a holding bay for us to allow us to transition the paper records into an electronic form, a digital form, which the department is heading towards. Those records for this project will be retained or taken off site and kept in an archive facility for the term of records management which I am not sure, I think it is seven years within Tasmania at the moment.

CHAIR - So are you doing that scanning on site?

Mr RAINBIRD - Yes, they are doing the scanning on site. Yes.

CHAIR - It has taken some time. I can remember working on that one myself and I have not worked there since 2012. But there you go, it is happening.

Ms RATTRAY - That is right, you have had another job since then.

CHAIR - Yes that is right. Page 13. I think we have dealt with that. Yes?

Mr TUCKER - To Alisdair, obviously the nursing staff have had a fair bit of input on the design of this, that is correct?

Mr McPHEE - Yes.

Mr TUCKER - Yes, I make the comment that what I have seen with hospitals where nursing staff have had a lot of input, the hospitals actually work really, really well. I see a lot of positives in the design that is being put forward here today. I would like to put that on the record and thank the nursing staff especially for what they have done here with this design.

Mr McPHEE - A lot of that coordination has come from Victoria, rounding up the troops. Through our weekly meetings there was really good communication, a really productive couple of hours. We would take that feedback from sketches that we may have produced and then present them again the following week or no later than two weeks for review and comment. That was just a continual process throughout and it ended up working out really well in the end.

Mr TUCKER - Because they are working there every day, they see the issues.

Mr McPHEE - That is right.

Mr TUCKER - They know whether the problems are and what needs to be done to fix those issues to get efficiencies and things in that area, which is a big advantage.

Mr RAINBIRD - We are also very fortunate that Victoria's other hat is that she is a project nurse, a nurse within the theatre, so we have that influence, that input and expertise, we are very lucky there.

Mr TUCKER - It's very good that you've worked so well together.

Ms RATTRAY - I'm sure Victoria's probably going to be pleased to see the end of this project, so you can get back to your work.

Ms BROWN - It's been challenging.

CHAIR - Page 14, any questions?

Mr ELLIS - I might ask about allied health services. The last time I was in there I was engaging some allied health services on our little baby's scan. What is the input they've had in helping to design this project and how important are those services in the Mersey Hospital?

Ms BROWN - I guess the main allied health stakeholder would be the physiotherapy department because we are relocating the physio gym and office space from their current location on the second floor down into outpatients. The reason for that move is that it's much better access for the public, rather than coming up and walking right through an administration building. It also allows them to link in with the consult rooms and what else might be going down there. It's a win-win all around. The physio manager and the people who use the gym were consulted, as were the cardiac rehab nurses because, again, they use the physio gym space. There was quite a bit of consultation through there.

Other than that, the Director of Allied Health wrote, initially, at the briefing stage to provide what sort of use of the facilities they would like, what services they would like to be delivering through the consult rooms, so those needs could be taken into account. Periodically, we have been back in touch, that person has changed roles a couple of times, but they are in the loop as far as the sign-off and the design as it went through the process.

There's not an awful lot of allied health involvement in the perioperative setting in this hospital because of the type of surgery that we do. It's not so much on the level one but definitely on the ground floor.

CHAIR - You talk about the Project User Group and you give quite a good description. What I don't see is any involvement with unions. I am not advocating for them, I am just interested to know why.

Ms BROWN - No, that hasn't been mentioned at all in this document. We have set up a JICC, which is a union consultation meeting, a committee that started meeting about four or five months ago to discuss issues arising from the redevelopment. More likely, we're looking at changes in staffing requirements, recruitment and training as the department expands, but also changes through the build, the staging and the slight reduction in throughput and how that might impact on staffing and possible redeployment. We have engaged with them and, as I

say, I think we've had four meetings so far. That's a monthly meeting that's set up right through, working through the changes brought about through the project.

CHAIR - That's good. You would have staff who may not want to mention various things because they're concerned how it might impact on their work. That's interesting to hear that. Do you have a risk register for this project?

Mr RAINBIRD - I do. At the moment, it's in a draft form at this stage until we've engaged a contractor. We will present that at our first formal meeting, allow them to review what we would class and from there we would look at our extreme and high ratings and see how we can reduce that for the build.

CHAIR - That will be a live document that's updated as you go?

Mr RAINBIRD - That will be a live document. That is mentioned in our fortnightly meetings with our head contractor, any risks associated, same as work health safety. We also discuss that at our steering committee meetings and that is raised with our heads of department if there are any risks that have been associated.

CHAIR - Thank you. Any questions about page 15?

Ms RATTRAY - More of a comment than anything. In the most recent references that we've seen, we've not seen quite so much detail down to the new, on-trend sage green for particular areas. I am interested in the availability of products. You certainly have a colour pallet identified, particularly for the interior. We know with the building industry, the way it is at the present, that sometimes sourcing products has become very difficult. Do you see a flexibility around what's being presented to us?

Mr McPHEE - With materials such as the vinyl, they would say there's not a whole lot of flexibility in swapping that out with something else, purely for the infection control needs of the hospital. With the other materials, we have compact laminate as discussed earlier. That's a reasonably available material.

We're using other materials such as compressed fibre cement, which is readily available also. During the tender submission period, contractors normally address and identify as part of our pre-tender, or QS has identified potential shortages of resources or risk for the type of build that we are proposing.

From there we would look at what our alternatives would be, factoring cost and timeframe associated with that. Once we receive our submissions on the design that we've proposed, if any contractors or head contractor is not providing us enough detail, we will certainly ask the question around that. If they think that they cannot meet a certain product then they are to inform us of an alternative, or simply provide an alternative, and we will assess it at that stage.

CHAIR - Talking about compressed fibre cement reminded me of the issue of asbestos. In terms of dealing with asbestos on site, is there much and can you, for the record, talk about that and how the disposal may be handled?

Mr RAINBIRD - It is being handled. As you know, the department undertook a review and had all our sites investigated for asbestos. Risk registers were proposed. This is something that we're undertaking now, from my understanding, on a regular basis.

The Mersey Community Hospital risk register was updated in November 2020 from memory - maybe not hold me to record on that one ; but certainly, the new register is what we provide with the tender. A head contractor will assess and if there is an unknown substance, for example, if they're not sure, we get them to test it straight away.

Part of WorkSafe standards requirements under health is that it needs to be taken away appropriately and under the stringent guidelines that are provided. We are following through.

It also allows the tenderer to look at latent conditions. As you know, with most facilities of this age we don't access to all areas until we've stripped the building. From that point of view as part of the tender, they are well aware that there is potential for asbestos that has not been registered. Again, if that is an uncertainty then they are to follow the procedures and have it tested and removed first of all.

CHAIR - That could be lagging on pipes?

Mr RAINBIRD - Correct.

CHAIR - It could be floor-tiling too, couldn't it?

Mr RAINBIRD - Correct, absolutely right. Again, most of that has been tested and sampled as you've noted, because we do have access to that. Things like potentially hidden little gems behind walls, even piping that we used to deal with, hydraulic cold-water pipes underground, those are the certain things that we would have tested straight away before we remove anything. When we do, we look at removing all of it within the budget that we have.

Ms RATTRAY - Can we talk about the disruption that will occur? You might walk us through what's planned. We went to the carpark this morning and had a look at where the temporary relocatable building will be. Can you walk us through that as well?

Mr RAINBIRD - One of the other components that we looked at is maintaining the operations of the hospital while these works are undertaken. Victoria, Alisdair and myself, and other services, have worked on a staging and decanting plan. That plan is broken down into a number of stages that allow us to look at decanting staff from a specific area before we go in and demolish that area and redevelop that area.

Stage one accounts for the building of the demountable, which is the temporary outpatients, which will be located in the nurses home carpark where we stood. While that is being built, we will look at the digging or demolition of that E block zone to allow for the footings to be placed in ground for the development of E Block to occur. Once we have the temporary outpatients building we will have the capacity to decant our outpatients into this temporary facility, allowing the contractors then to go in and demolish level 1 and the ground floor simultaneously, reducing the program. Previously, we looked at specific areas but we found that disruption would be too much due to the fact that we have a number of issues of hydraulic runs and cable runs through floors in different sections.

From there, E Block and C Block, we will then move into the theatres, which is D Block. At that stage we should have commissioned C Block, allowing the operating theatre in D Block to relocate to E Block so we can continue demolition work there, while we maintain the service of providing clinical and in this case outpatients and theatre operation.

Ms RATTRAY - Neighbour consultation? Very close ones across the road.

Mr RAINBIRD - We are very fortunate where we are at the moment, due to amount of works that we have had in the past and heading forward. I haven't spoken to them directly recently, but when we have heavy vehicles or heavy noise we normally pop a letter in the post box - we go across the road, drop it off. The letter has my contact details on it and if they have any concerns then they are to notify me.

Ms RATTRAY - What happens to the demountable once you've finished using it? Where does that go?

Mr RAINBIRD - That is the contractors' responsibility, whatever they choose to do with it.

Ms RATTRAY - They provide that?

Mr RAINBIRD - Correct.

Ms RATTRAY - The hospital won't own that?

Mr RAINBIRD - The hospital has the opportunity to own it. It's the question of where we're going to put it.

Mr ELLIS - Can I ask about timber? Obviously, timber products are part of what we do on the north west. I know there are some timber-look products proposed in the build.

Can you give us a sense of why those were substituted for real timber and what some of the limitations may be?

Mr McPHEE - It's best for Victoria to discuss, from an infection control perspective.

Ms BROWN - Timber, as you know, is a porous surface. It's easily scratched as well. When it is sealed with a varnish it is wipeable, but quite often that varnish deteriorates over time or is damaged through nicks or dents from furniture - particularly in a hospital environment with beds and trolleys. Once you get that damage to the varnish, it's no longer an easily cleaned surface. Our infection control department prefers to have non-porous, solid surfaces that are robust and can take those knocks and dents without damage to the integrity of the surface - purely from a cleaning perspective.

Additionally, some of the products that we need to use at times are quite similar to bleach and a lot of surfaces won't withstand repeated cleaning with such a harsh substance. We looked at the best fit that would meet our infection control requirements and durability requirements as well as the cosmetic feel to the room.

Mr ELLIS - On supply issues it was noted that we're looking at lightweight steel framing rather than traditional timber framing, anticipating a continued shortage when this project gets underway. Is that right?

Mr McPHEE - We're seeing at the moment there's a global shortage with timber across all projects, not just due to shipping and the pandemic but also to climate change and the bushfires that we've seen all up the eastern seaboard. It was really a strategic decision that we made early on to design with steel. Also, from a fire-proofing, fire-rating perspective we had to limit the use of timber and those class of materials within the building. The lightweight steel framing is readily available. We haven't seen any shortages, so that for us was the best decision moving forward.

CHAIR - Clearly, steel framing expands and contracts more than wood. Correct me if I'm wrong. When you have that happening there is a fair bit of noise - creaking and all the rest. How do you overcome that? Do you put in interfaces of some kind?

Mr McPHEE - More so when there is direct sun and heat. When it's directly exposed to that, you'll see expansion or contraction. Within the systems that we use, or the steel framing, there is allowance for the expansion and contraction. It really avoids the pressing up against each other, if you like, which is where the noise and the creaking comes from.

We also had an acoustic engineer engaged throughout the process, which has 0assisted us with the detailing of that, and from an acoustics rating perspective between consult rooms and to the exterior of the building as well. Every building, whether it be timber or steel, expands and contracts and it's a matter of the detailing as to how you minimise these things.

CHAIR - Okay. It is certainly taken into account, which is good.

Ms RATTRAY - In regard to the environmentally sustainable design, the second point says that all unglazed walls, ceiling and roof cavity spaces are insulated and sealed. Unglazed is obviously without windows. Can you talk to me about how that might work? I have heard you talk about the glazing of the windows and the space between them, and that was quite useful as well.

Mr McPHEE - The glazing we specified for this project is a double-glazing with a thicker cavity between the glass. That gives a bit more air space and allows vibrations, if you like, to be tempered somewhat.

Ms RATTRAY - It's a busy highway.

Mr McPHEE - The base of those frames has a silicone bead, and that helps to deaden the noise as well. The acoustic engineer we worked with provided us with decibel ratings and CTR. Off the top of my head, I can't remember what CTR means; but he provided us with those ratings. The products we were choosing and the construction systems we were choosing or designing with are rated to those systems as well. We always had a constant reference point or baseline to work to, and we've met those baselines across the whole facility.

Ms RATTRAY - Do you see any impediment in accessing the appropriate glazing?

Mr McPHEE - From an availability perspective?

Ms RATTRAY - Yes. I am hearing it's a 12-month wait for windows at the moment.

Mr McPHEE - Yes, that's constantly evolving. It is getting better now. I can't comment too much on that. Supply chains pick up and slow down, unfortunately; it's the time that we live in. We have to deal with that as best we possibly can. The frames are all standard profiles. There's nothing custom about them as such, so they're readily available and easily manufactured.

Ms RATTRAY - Even though the design of them sort of has a lip, a deeper lip across the top than down the sides and along the bottom. I noticed that on the plan, on the façade. That's not standard.

Mr McPHEE - On the windowsill. That's still, essentially, a standard construction. The strategy behind that, is that we have a fire-rated and acoustically-rated wall that sits internally. What we've done, due to the lack of space that we have to get all of our services running down all of our service rises, we've moved to the external, which is where we get the depth in the façade. That has a double effect, where we've created a deeper reveal and the façade becomes self-shading, in effect, for that westerly sun, particularly. The deep angle on those ledges is also a bird control measure. The hospital currently has -

Ms RATTRAY - I did notice that today, that there was a bit of a bird issue.

Mr Mc PHEE - Birds' nests everywhere, you see the spikes everywhere. Rather than putting spikes on all the window ledges, we put a steep shelf on to discourage birds from nesting.

Ms RATTRAY - It's quite effective, it looks quite good.

Mr TUCKER - Tania, finished?

Ms RATTRAY - I have always finished.

CHAIR - Good to know about that. You go for that.

Mr TUCKER - We have touched on the air-conditioning system a couple of times, but I would like to put it on the record. When this is built, what would happen if someone walks into the emergency department and what are the mechanisms in place and what would happen? So that people -

Ms BROWN - The emergency department is not part of this re-development. It has got nothing to do with it and what is in place today is what will stay in place.

Mr TUCKER - Right.

Ms BROWN -It is all done through triaging and separating potentially at -risk patients from the rest of the patients waiting. Anyone thought to have COVID-19 would immediately be taken into an isolation room and be kept separate from everybody else.

Mr TUCKER - Right.

Ms BROWN - That is what stands at the moment. If someone got off the boat and came in and we thought that happened - so that will continue to happen.

Mr TUCKER - My understanding is before there was no air-conditioning in a lot of the re -development area. Is that correct?

Ms BROWN - But the emergency department does have some air-conditioning, yes.

Mr TUCKER - Emergency does have, and would be out of the same system or is that two different systems?

Ms BROWN - That has its own system. It is a different wing of the hospital. The emergency department is in B block and most of this re -development is in C and D blocks and the new E block. A different part of the hospital.

Mr TUCKER - Right. Can you go through why people will not be able to, if they have COVID-19, get into the C and D block in that area and have that on the record?

Ms BROWN - Okay. People coming in for day surgery or endoscopy go through an initial screening process done days and even potentially a week before they come in, where we look at whether they may be fit for surgery. Because it is elective day surgery, if anybody has any illness or upper respiratory tract infection their surgery or procedure is postponed. That is the first sort of safety mechanism. The second one is the pre -admission clinic where people will go and see an anaesthetist depending on the tick on their request for admission form. Things can be picked up there and they would again be postponed and referred for treatment elsewhere. And they have to get through the screening door on the day. Anybody entering the building has to go through COVID-19 questionnaires and screening. And again, if they do not meet that criteria they are not allowed in the building. All of those mechanisms are in place already and will continue to be in place to protect from people inadvertently coming in carrying the infection.

Mr TUCKER - All right. Yes.

CHAIR - With respect to the electrical, you are talking about the existing TasNetworks power supplied will be maintained to the site. Would the actual load on the system be due to increase and therefore does the current system satisfy the likely demand?

Mr RAINBIRD - It does. We were very fortunate having those two transformers out the back. Even though we looked at this increase in capacity being pulled, it still met the requirements. In saying that, we are undertaking a further assessment because of the age of them and will be looking at some stage to upgrade those transformers. Basically, future proofing for the next fifteen, twenty years.

CHAIR - The question I asked on the trip this morning on backups. Describe for the record the backup system you have in place if you have an electricity outage and also for the computing site?

Mr RAINBIRD - Currently on the existing system we have a generator. This provides power or what we class as essential power to the facility. Throughout the facility, there are

only certain power points which we deem are a requirement to be maintained at all times. If we do have a power outage to the site, the generator will kick in and provide a feed to that. Essential services like IT - certainly UPSs are on hand and those are tested fortnightly now. They provide a programme to see how long the battery life will be maintained or retained on those. But with this new upgrade of this facility, the timeframe associated from the power outage to when the generator is going to become operational -

CHAIR - So the capacity for outage, I suppose comes down to how much diesel you can keep.

Mr RAINBIRD - Correct. It is also dependent on the load.

CHAIR - But with the uninterrupted power supplied for computing it would be hours?

Mr RAINBIRD - Yes, so at the moment within our main server room, we have up to two hours on the UPSs keeping in mind IMTS in Hobart are looking at a secondary core room within Mersey Community Hospital, which will provide backup support again. That will extend it potentially up to four to six hours if need be. Again, the server room is on essential power and if it is lost, the generator will kick in within that three-second period and provide essential power to that room and other clinical rooms within or around the hospital itself, including lighting in some areas.

Ms RATTRAY - What sort of relationship do you have with the likes of TasNetworks andTasWater, because there are some significant works to be undertaken here. Are there any issues with those organisations at this point in time?

Mr RAINBIRD - No, there are no issues as such at this point in time. Through our key stakeholders, they form part of those groups. That is normally left to the engineers to have those formal or upfront discussions on the requirements on the build we are proposing. No, at this stage nothing that is an issue.

Ms RATTRAY - There has already been a conversation about the possible proposed works. I noticed sewerage, stormwater, trade waste - my favourite topic, trade waste.

Mr RAINBIRD - Absolutely. In order for us to proceed under the design for the standards, we need to look at what capacity the road or what the existing services are and what may need to be upgraded, keeping in mind anything from the road inwards is our site, anything outside of that falls to them to maintain. From TasNetworks, TasWater and Telstra we have had consultation with those various groups regarding this design.

Ms RATTRAY - Some of the timeframes on having services addressed can be quite significant.

Mr RAINBIRD - Correct. Again, we were very fortunate with the strategic plan we knew where we were heading. Once we had the go ahead, we were simply on the phone straight away and started having these discussions on what capacity there is. You are right from the resources point of view across all departments, there is a certain timeframe associated with getting that information.

Ms RATTRAY - There has been some significant upgrade requirements for trade waste and you have looked at those because there is a relocation of existing kitchen grease arrester and plaster trap.

Mr RAINBIRD - The plaster trap or the kitchen trap which is the grease trap is located within the zone. Again, as part of the early works package we undertook some works to allow - and with any future works, depending on where we are going - for the relocation of these to be be undertaken.

All consultation with these services, they are well aware of what we are choosing to do.

Ms RATTRAY - Do not forget you have some local members if you need any assistance.

Mr RAINBIRD - Correct, thank you.

CHAIR - A plaster trap, can you explain that?

Mr RAINBIRD - I am not 100 per cent sure to be honest. I do not know if you are aware of the plaster trap?

Ms BROWN - The plaster trap catches bits of plaster as plaster of Paris gets dunked in water to soften it up.

CHAIR - I thought that might be the case.

Ms BROWN - It is simple. It traps the particles so it does not clog up your drain.

CHAIR - And gross pollutants, fair enough.

You have here under power on page 17. You have 'new body protection power'. Are you talking about earth leakage detection?

Mr RAINBIRD - The body protection is part of our standards when we increase more patient safety and staff safety.

CHAIR - Are you providing for charging points for phones, tablets and those sorts of things as a separate thing or not?

Mr RAINBIRD - As in USBs within the power points?

CHAIR - Yes.

Mr RAINBIRD - Yes, we are.

CHAIR - Any further questions on page 17? Network time -

> A fully integrated master clock system to be provided throughout all clinical areas within TP network time protocol and global positioning system synchronisation.

Why would you be needing a GPS there?

Mr RAINBIRD - I found this discussion interesting too.

Ms BROWN - I did not request the GPS facility, but the master clock stuff is important in a perioperative environment. Everything is recorded. The time patients go in, when their anaesthetic starts, all of those sorts of things.

It is also important to have a good clock system as far as cardiac arrest and emergency management goes. GPS? I have no idea.

CHAIR - Is it to do with helicopter services in place maybe?

Ms BROWN - I am not sure on that one.

CHAIR - Do we know?

Mr RAINBIRD - I'd have to consult with the electrical engineer.

CHAIR - It's interesting.

Mr ELLIS - Chair, I think it's just to help Hobart people find where the north-west is.

CHAIR - I see, you don't think they're aware enough?

Ms RATTRAY - You might note that the Chair of the committee is from Hobart. He definitely found his way.

CHAIR - Yes, I found my way here.

Mr TUCKER - It's just the other Hobart member -

CHAIR - Maybe if we could get an answer to that, it would be interesting to know.

Page 18, are there are any questions there?

Mr ELLIS - I want to ask about procurement for fixtures and fittings for water services. The Perth Children's Hospital a couple of years ago had some major issues in using fixtures and fittings with a high amount of lead that contaminated the water. Have any allowances or controls been made to make sure that we don't have something similar happening here?

Mr RAINBIRD - We are in a unique position with that in terms of the supply. The supplier does Q and A and, as you know, they won't be QA-ing every single fitting. When I say 'fitting' we're talking the brass fittings that provide the lead. Certainly before commissioning we'll undertake a Legionnaires and a lead test of this facility. If we have a high lead content we will look at replacing that or fitting that out but at the moment that's all we can do.

We don't have the capacity to test each item before we install it. I believe lead testing takes around 16 days to get a response and if we had to do that for what we have it would be

quite significant. The alternative was to replace it with stainless steel and that is a significant cost associated with works. That's not just the actual TMV or valve set, that's every brass point corner angle, T-section and piping run that you can get, so it would be a significant exercise to do so.

In the past we have gone back to the suppliers to look at their manufacturing process to figure out why this was missed in their Q and A and to look at where that high-lead content has come from, keeping in mind we do flush our systems and that sometimes does reduce it. If it doesn't meet the commissioning then we won't proceed and then we will have to look at alternatives.

CHAIR - As a good practice I always run the tap for a little while before I take a drink of water at home or anywhere. You just never know, do you?

Ms RATTRAY - The water at Avoca is the best water in Australia.

Mr TUCKER - We don't all live in Hobart.

CHAIR - That's right but brass is across the state I remind you.

Gaseous fire suppression. You're talking about having a special gas system for the IT communications and rack rooms and that's really good. In terms of water incursion into those rooms from above, is there any special circumstance there that's being catered for to make sure you don't get water incursion from above from hot water cylinders that burst or those sorts of things?

Mr RAINBIRD - Under the current design, I don't think we have a toilet above the current server room. We won't be breaching through the floor space, it will only be through the external walls to allow for our suppression or damper system or fan operating system to be included, our HVAC. Certainly, anything that is above that will be waterproofed with vinyl more than likely if it is a staff toilet or an access room. From memory, in this design we don't have anything above that would cause a potential risk to that.

CHAIR - Is halon gas being incorporated?

Mr RAINBIRD - Yes, it is a form of halon gas.

CHAIR - Anything further on that page?

Are there any questions on the budget?

Ms RATTRAY - Yes. I am interested in the time frame that's being provided under the project schedule.

Do you see any issues with those, should this pass the committee's scrutiny process?

Mr RAINBIRD - Not at this stage but until we receive the schedules from the head contractor I am not sure. We have proposed the time frame. We are asking them to meet the time frame on their build and if they cannot they will certainly raise that as part of their submission as to why they cannot meet that time frame.

Ms RATTRAY - December 2021 is only about 13 Fridays away now.

Mr RAINBIRD - Correct. When this was submitted it was on that program. Obviously, we have extended the tender period which will then have an impact on that date at the moment, keeping in mind we are doing our utmost to meet the program in the time frame that has been suggested but it's very dependent on approvals.

CHAIR - It adds up. I know that much. I've tested that.

Ms RATTRAY - The Chair always adds up the numbers, and we have found discrepancies.

CHAIR - I am always keen to make sure. Yes, some people don't know how to add up but that's -

Mr TUCKER - Did you pick up on the problem with the construction design contingency, the price there?

CHAIR - The $1.6 million?

Mr TUCKER - Yes, but the comma was put in the wrong place.

CHAIR - It is, too, yes. It's not $1.6 million, it's $160 000.

Mr ELLIS - Can I ask about furniture and equipment? Are we talking medical equipment?

Ms BROWN - There is some office furniture for consult rooms and things like that but, yes, it's mostly a combination I would say.

Mr ELLIS - What sort of equipment would be included in that $3 million?

Mr RAINBIRD - From an office point of view, the stock standard set up of tables, desks, chairs, printers, PCs, that sort of setup. Moving into equipment, as an example, something within the outpatients could be a lifting mechanism they may require. Do we have BP monitors?

Ms BROWN - Not in outpatients but there are examination tables in day surgery, for example, all new patient trolleys for all of the cubicle areas, reclining chairs for the discharge lounge, inter-recovery patient monitoring system for each bed, holding bays, again, mobile monitoring units. In CSD, we are putting in washer disinfectors, new steam sterilisers, new anaesthetic machines, because we are putting pennant-mounted models in the new design and they're due for replacement anyway. There are lots of things.

Mr RAINBIRD - It's a significant list, basically.

Mr ELLIS - In this case, the furniture and equipment component would have a significant positive impact on clinical services and outcomes. Can I ask about consultancy costs? Who are the consultants and what are we consulting on in this case?

Mr RAINBIRD - Consultants are technically the architects, who will become superintendents under the head contractor, so this is their fee for the project and that is from the start, from design brief right the way through to completion of a project.

Mr McPHEE - That includes us engaging mechanical, electrical, structural engineers, hydraulic engineers, acoustic engineers, safety and design specialists, the health planner, an independent building surveyor, all those consultants required to get the building to where it is.

Ms RATTRAY - Were you worried it's just Rob and Alisdair's wages?

Mr ELLIS - It wouldn't surprise me. That's a very nice jacket you've got on.

Mr McPHEE - It's gold-leaf lined.

Mr TUCKER - I think he was more worried it was only six months' work.

Ms RATTRAY - My perennial question is about the Tasmanian Government Art Site Scheme. Richard, we did have a conversation about this, we could be incorporating some aesthetics around the heli-pad. My thoughts are about a functional piece of art. You might like to share your thoughts with the committee.

Mr RAINBIRD - Once we have a contractor engaged, we will then go back to State Growth and start looking, discussing with their arts consultant in the north-west. The first thing she's going to ask us is to form a very small party, which will include Victoria and myself, to discuss what it is we are trying to achieve on the basis of the schematic or the model that has been presented. We will then sit with her and probably other members of the hospital and external community, be that, perhaps, the lady from the Tasmanian Aboriginal community, Candy, I think her name is, other members will sit with us and we will work through what options are available to us.

In this instance we have two options and, again, as I stated, that was an internal viewpoint, be that either in the main reception or in the outpatients as they are our high-traffic areas, that could be a visual component of an artwork or mechanical item. I don't think we want any more ducks in the hospital.

From there, moving toward the option of having something that is external that provides either seating, a safe space or a quiet zone. Our design brief will account for that. If we can do both, we will achieve both within the budget. Again, it is very dependent on the consultation process and who wants what, at the end of the day.

Ms RATTRAY - Will there be some direction to the person that will do the installation of the art component?

Mr RAINBIRD - We won't be able to provide direction. We can certainly ask that they consider opportunities based on what the community and staff would require. No direction can be given in terms of that; just advising on what our design brief entails.

CHAIR - It is just a mix there that can and maybe can be considered. I hear what the member was saying.

Ms RATTRAY - One final question, if I might, Chair?

CHAIR - Yes.

Ms RATTRAY - I should have asked this following on from Mr Ellis' question about furniture and equipment. Is there going to be an opportunity to re -use any of the existing furniture and equipment that is in the building?

Ms BROWN - As you would imagine, it is a constant process of replacing equipment in a hospital. There are things that we purchased over the last few years. The things that have not reached the end of their lifespan will not be replaced. We will carry them over and continue to use them as we are now. There are things in the processing pipeline at the moment, such as new laparoscopic equipment. That will all be pretty new, by the time we move in. There are no plans to waste anything, but some things have come to their end of life. There are some things we have known for a while really need replacing, such as the anaesthetic machines that were due for replacement around about the period of the project starting. They have been picked up in the project, but they were end of life anyway.

Ms RATTRAY - Thank you. We are always looking out in the interest of Tasmanian community money.

CHAIR - That is right. The contingency is roughly five and a half per cent. Quite often, you get contingencies of around ten per cent. I am interested to know why it is lower in this case. Is it the nature of the development? I would have thought being a relatively complex development, being a hospital -

Mr RAINBIRD - I looked at that, and determined that on the basis of the exercises and assessments we have undertaken that five per cent should be sufficient - considering the consultation and the processes that we have been through on this project, should be significant - 1 .6.

CHAIR - Okay.

Mr RAINBIRD - Certainly from that -

CHAIR - Even with COVID-19 and getting materials and the like?

Mr RAINBIRD - We have already seen that, that increase, basically. You are right around COVID-19 and materials, they would simply be classed as latent conditions. We've planned for that at the moment, as best we can. Certainly, any COVID-19 impact would put a halt to the project on site, and I think our tender documentation covers off on that and the associated risks.

CHAIR - Okay. Thank you. Page 20. We have the recommendations. Unless members have any other questions? We have some other witnesses. I will probably be calling you back to the table after we hear from the two witnesses, in case there is anything that needs to be covered off. At that point, I will reiterate the statement of evidence. Thank you again, it has been very informative. Mr Hennessy, if you could please swear in the witnesses

Mr ARNOLD GOLDMAN AND **Mr STEVE MARTIN** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome, who would like to commence - perhaps Mr Goldman?

Mr GOLDMAN - I wasn't quite sure when I was invited here what sort of evidence or what you wanted. I was told it's about you trying to explore the community support for this.

CHAIR - It's not particularly exploring community support. It's an opportunity for members of the community to comment on the development that's before us.

Mr GOLDMAN - As I understand it from listening to what's been going on so far this afternoon, this has been more of a design brief you're discussing, or is it a design specification?

CHAIR - It's the whole thing. It's the whole submission that has been provided to the Parliamentary Public Works Committee by the Government.

Mr GOLDMAN - It all sounds as though we're in an approval stage, that you're keen to go ahead with this project.

CHAIR - That's the decision we have to make after we hear all of the evidence.

Mr GOLDMAN - I'm a resident here. I've been a resident here for 10 years in Latrobe. I live just down the road near the hospital. It's one of the reasons we came to live here in Tasmania and chose this part of Tasmania.

It's my view that we have a hospital in Burnie, we have one here, one in Launceston and a big one where the major population is at present. Future growth is more likely to be up in the north, I think, more than Hobart, because of costs down there. People who move over here aren't necessarily looking for a job. Most of us are pensioner age, and we want somewhere that's flat and easy access to all the services.

I see the amount of money that is being spent on the Mersey Hospital and the Burnie Hospital in the last five or six years whilst I've lived here. I occasionally hear on the radio, or on the television, talk of some politicians, I think, wanting to get rid of the Burnie Hospital and the Mersey Hospital and build a brand new one somewhere like Ulverstone.

That would be very nice if you could do that at minimal cost; but it would be a terrible waste of all the money we've spent. If you think of the growth of population, in another 30-40 years the population here could have gone up by another 100 000 which is more than 10 per cent growth. In that time, you should accept that you require 10 per cent more hospital beds, 10 per cent more nurses, 10 per cent more doctors/surgeons - the whole lot - police, fire stations.

Even though it's hard to justify that you need them all, at the present it's like an insurance policy. I worked for 25 years, or a bit more, in the defence department and during that time no one ever attacked us - so we considered ourselves to have served our purpose where insurance was never needed.

Most people have insurance and hope that they don't ever need it; but they're glad they have it. We seem to be able to spend any amount of money on defence without question, and we're always niggling about getting more ambulance drivers, more nurses, more hospital staff and I think someone needs to get the priorities right.

CHAIR - Mr Goldman, I can assure you that we're not here today deciding whether the Mersey should or shouldn't exist. This is the Public Works Committee which is hearing an application for changes to the Mersey Hospital. We have to decide whether it's value for money and those sorts of things. I appreciate hearing your point of view on that.

Mr ELLIS - Thank you, Mr Goldman, for your perspective. I think you're exactly right in understanding the demographic trends we have here in the north-west and Latrobe. I acknowledge former Devonport mayor, Steve Martin, here as well. It's one of the fastest-growing areas of our state, an area with huge potential and the need to maintain health services and to grow them in line with the population. The need in this part of the state is really important, something I pick up in our local community as well. Thank you for your feedback.

Mr MARTIN - Thank you very much for the opportunity to talk about the Mersey and the project at hand. I note the purpose and objective of what we are here for today. I put a disclaimer at the same time, I had very little notice today that this was on, so I do apologise for lack of preparation. To provide some context for the questions I am going to ask, noting that Ms Brown has said that the new project is catering for an increase in the need and capacity of about 25 per cent.

Ms RATTRAY - Just in one area.

Mr MARTIN- Just in one area, but the philosophy of a hospital is that the knee bone is connected to the thigh bone, connected to the hip bone.

Ms RATTRAY - That's a song, isn't it, Steve?

Mr MARTIN - Maybe, I'm not going to hum it for you though. Touching on the emergency department and I realise that it's not part of this project but it is connected. If we're having an increase of 25 per cent elective surgery, et cetera, there's an increase of 25 per cent in risk, as Mr Goldman has also pointed out. With the emergency department presentations currently running at about 31 500 per annum at the Mersey, compared to North West Regional Hospital's 28 000, it is expected, from what I can find out, that the Mersey will increase by 5 per cent to about 40 000 presentations in the emergency department in the next five years. Due to COVID-19 and living with COVID-19 I would expect that to increase by 10 per cent, which makes it about 45 000 presentations per annum.

Currently, in our hospital system, including the Mersey and the transfer of patients outside the Mersey, North West Regional Hospital and, indeed, the Launceston General Hospital, have all experienced bed blockage and ambulance ramping as well. Even though the elective surgery is supposed to be low-risk, potentially, there is also that risk that something may go wrong and we will need additional beds, probably in the emergency department or close observation unit, et cetera.

Throw in the population growth there as well and the predicted rises in presentations, it also highlights the need for increased acute services at the Mersey, such as HTU, maternity,

et cetera. As we're developing, even with this project, it does link with other services provided at the Mersey and the need for increases in those departments, especially the emergency department.

For clarification, and I know Ms Brown may have touched on this and I do apologise if I am repeating a question or one that has been answered, are the theatre upgrades only for elective surgery or for acute emergency surgeries as well?

CHAIR - I can't give you the answer to that but the department may come back to the table and provide that clarification. Again, the question.

Mr MARTIN - Are the theatre upgrades only for elective surgery or for acute emergency surgery as well? Following on from that, will there be 24/7 surgical staff at the Mersey?

CHAIR - It says 23 in the -

Mr MARTIN - In the old White Paper.

CHAIR - It says 23-hour service.

Mr MARTIN - I understand that. Will additional beds be opened or will they still be reliant on the current bed allocation? I think Ms Brown's touched on that but I couldn't hear all of it.

Ms RATTRAY - There was a response that a review is being undertaken -

Mr MARTIN - For next year?

Ms RATTRAY - And so the outcome of that review, if I understand correctly and I am not necessarily here to answer on behalf of the department, I might add.

CHAIR - No, that is right.

Ms RATTRAY - But the outcome of that review will determine what the parameters and service model will be into the future.

CHAIR - Yes. Anyway, the department can answer that officially when they come to the table.

Ms RATTRAY - But we have already had that answer.

CHAIR - Yes, but they can reiterate it for Mr Martin.

Mr MARTIN - It is for clarification and these questions were - I was trying to filter them in from the lack of preparation time I had and of course the expansion will be the expansion of the emergency department and appropriate staff levels associated with that. Pretty much that is it, thanks Chair.

CHAIR - Okay. No worries. Well thank you for -

Ms RATTRAY - We certainly appreciate your interest in this very important facility. It is well noted.

CHAIR - Thank you for attending.

Mr GOLDMAN - Just a further point, something that I recall from Yes Minister -

Ms RATTRAY - There is no Yes Minister here.

CHAIR - I do not think this a hospital without patients but nevertheless.

Mr GOLDMAN - Exactly. Is there enough allocation for the extra staff?

Ms RATTRAY - Very good question and one that I asked as well about that extra staff.

Mr GOLDMAN - I know you could have it like the Yes Minister program, the most efficient and hygienic hospital in the region and we do not have any patients.

CHAIR - No, that is right. Well that is why it is efficient and hygienic.

Mr GOLDMAN - Yes.

Ms RATTRAY - Well it definitely has patients because I saw some in there this morning when I had a look.

Mr GOLDMAN - Oh yes, well I know. I have been in there myself. Been a patient there and my wife has as well.

Ms RATTRAY - And just out of interest I spent the day in Deloraine yesterday as their local member, and I was told very clearly that the Mersey hospital should go nowhere. It should continue its services and if I do not make sure it does, it will be look out next year when I am up for re-election.

CHAIR - Well, there you go. We will just have to see how that pans out when we have our meeting. Okay. Thank you.

THE WITNESSES WITHDREW.

CHAIR - The department, if you could all come back please?

Ms RATTRAY - Thankfully you took those questions down, Chair?

CHAIR - I did.

Ms RATTRAY - Richard would have heard them anyway.

CHAIR - Oh well he has. I am pretty sure of that.

Ms RATTRAY - Thank you Mr Goldman.

CHAIR - So, you have heard the questions from Mr Goldman, sorry the observations from Mr Goldman and questions from Mr Martin. So are the upgrades only for elective surgery or are they for acute emergency upgrades as well?

Ms BROWN - Elective surgery.

CHAIR - Elective surgery only. Will the additional beds be opened and is there enough allocation for extra staff?

Ms BROWN - So there are no additional overnight beds. But there are additional day spaces. It is a term I guess. We will - it allows for more patients at the end of the day which I guess is what you are asking. So, no additional overnights but definitely we can see more day surgery patients.

CHAIR - How many extra additional day patients will it provide for in percentage terms?

Ms BROWN - Well, we are looking at an additional throughput of about 25 per cent by the time it is all finished.

CHAIR - So, I hope that answers the question. Okay. Unless there is anything else that you wish to add as a result of hearing the witnesses? We always have four questions or five questions actually at the end of each of our hearings and we need to have an understanding as to whether this is or is not the case. So, does the proposed works meet an identified need or needs or solve a recognised problem?

WITNESSES - Yes.

CHAIR - It does? Are the proposed works the best solution to meet identified needs or solve a recognised problem within the allocated budget?

WITNESSES - Yes.

CHAIR - Are the proposed works fit for purpose?

WITNESSES - Yes.

CHAIR - Do the proposed works provide value for money?

Ms RATTRAY - In other words, are they gold plated?

WITNESSES - Yes.

Ms RATTRAY - They are gold plated?

CHAIR - The honourable member is referring to the standard of the works and you might care to answer that. Are they gold plated or are they -

Mr RAINBIRD - Not physically gold plated but they are at a high standard.

CHAIR - Thank you. Are the proposed works a good use of public funds?

Mr RAINBIRD - Yes.

CHAIR - Thank you very much for attending today. Thank you for your time and for the information presented. We cannot do it without submission. As I advised you at the commencement of your evidence, what you have said to us here today is protected by parliamentary privilege. Once you leave the table, you need to be aware that privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you have said to us today. Do you understand that?

WITNESSES - Yes.

Mr RAINBIRD - On behalf of us, thank you very much, nice to meet you all.

Ms RATTRAY - Thank you very much.

The committee adjourned at 3.06 p.m.