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PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

Scottsdale North Eastern Soldiers Memorial Hospital Redevelopment

*Presented to His Excellency the Governor pursuant to the provisions of the Public Works Committee Act
1914.*

MEMBERS OF THE COMMITTEE

Legislative Council

House of Assembly

Mr *Harriss* (Chairman)

Mr *Hall*

Mr *Best*

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By Authority: Government Printer, Tasmania

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INTRODUCTION

To His Excellency the Honourable William John Ellis Cox, Companion of the Order of Australia, Reserve Forces Decoration, Efficiency Decoration, Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia.

MAY IT PLEASE YOUR EXCELLENCY

The Committee has investigated the following proposal: -

Scottsdale North Eastern Soldiers Memorial Hospital Redevelopment

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

BACKGROUND

Need for the Project

In 1999 the Australian Health Ministers endorsed *Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians*. The Framework provides guidance for communities and organisations in improving the health and well-being of people living in rural areas. The Scottsdale North Eastern Soldiers Memorial Hospital (NESMH) redevelopment is designed within this and the *Tasmania Together* Framework for setting Government policy priorities that identify where service delivery may be improved. The Scottsdale NESMH redevelopment aims to provide a facility with an approach to health that focuses on preventing poor health by promoting healthy lifestyles that engender a sense of community, encouraging participation.

During 2000-01 the Network Project was established, aimed at consolidating the disparate Primary Health services into key multiple-service delivery sites in order to achieve the following benefits:

- Opportunities for greater efficiency;
- Co-operation between related and compatible services, for the benefit of clients;
- Improved asset utilization;
- Asset change on certain sites to match service need and respond to service change;
- Integrated and achievable management regimes for facility maintenance and operation; and
- Integration with other services and like opportunities, in each case from a total site perspective. Client amenity is a key propellant in this regard, as is the ability to integrate various services that a single client may need to access and the improvement of individual case management.

Through this process, the redevelopment of Scottsdale NESMH was identified as a high priority. Health Needs Studies were completed in 1998 and in early 2004. To address the wider Health and Community Support needs identified in the area, a partnership between the Hospital and Dorset Council was established. The Community Health services are accommodated in various sites around the Hospital and Council Chambers.

Existing Facility and Services at Scottsdale

Scottsdale NESMH was constructed in 1971, with the James Scott Nursing Home Wing added in the mid 1970s. The internal layout of the building does not provide functional working units for the multitude of services now offered from the facility. The building does not meet several Best Practice Health Service Delivery and Safety standards, nor does it meet contemporary Occupational Health and Safety requirements for staff or clients in both the current Acute and Aged-Care sections. Such inadequacies include ensuite which are too small for assisted showering and the lack of disability-

accessible toilets in the expanding community service area. The Hospital presently has 23 Acute beds and provides Accident and Emergency treatment, Ambulance services, a maternity unit, Physiotherapy, Occupational Therapy, Community Health services, Radiology, a dental service, as well as other visiting services. The Operating Theatre remains in use for one day a month, when a visiting surgeon travels to Scottsdale to provide service to local clients and reduce waiting lists.

NESMH is situated on a large site, conveniently located on the perimeter of the Scottsdale shopping and local Government precinct. The location provides ready access for the public arriving on foot or by private transport. There are two private medical practices in the town in close proximity to the Hospital. The population catchment area for the NESMH equates to over 7000 persons, with the Hospital located an hour from Launceston. Scottsdale is a relatively isolated community which depends heavily on the Government to provide the range of services required as the demand is not sufficient to support many private sector providers. The overall aim of this project is to provide a new and integrated facility that combines the functions of a hospital, residential Aged-Care facility, Community Health and Primary Health services that contribute to the community in the improvement of health and well-being through the delivery of co-ordinated services.

This project will see the redevelopment of the existing Hospital to enable the provision of comprehensive, accessible and integrated services to individuals and communities within the catchment area.

Required Expansion and Upgrade of James Scott Wing

The Aged-Care section of the facility provides 24 high care residential Aged-Care beds, accommodated by 16 single bed wards and two four-bed wards. However, the two four-bed wards do not provide a contemporary standard of accommodation and will not satisfy the Commonwealth Aged-Care accreditation standards to be achieved by 2008. The 2003-04 Australian Government's Aged-Care approvals round granted five additional high care

residential licences. These licences will be revoked if not activated by the end of January 2006. Therefore the project proposal includes the closure of the two four-bed wards and the creation of 13 new single bed wards compliant with contemporary Aged-Care accreditation standards.

The Value Management Working Group, as well as key community and Department stakeholders, identified the redevelopment of the James Scott Wing as the highest priority. Present lounge, dining and activity areas for patients are inadequate and will require significant redevelopment and expansion to accommodate an additional five patients and provide appropriate treatment and amenity. Public access into the current James Scott Wing is poor, because of the location of the existing public entrance, which requires people to walk through the Acute Care Hospital wing to visit residents of the nursing home.

Existing Facility Plan

The location of Accident and Emergency away from the Nurse Station and Acute wards is of particular concern. The treatment and observation of patients in Accident and Emergency reduces staffing in the vicinity of the Acute wards. Nursing staff in Accident and Emergency are unsupported and isolated. This presents a significant hazard for both staff and patients, especially during the evenings and night shifts. During such times, nurses often need to leave the Acute ward to meet people at the building's front entrance. Also of concern is the present location of Physiotherapy, requiring external clients to travel through the Acute wards to receive treatment. As such, the relocation of Physiotherapy closer to the public entrance is desirable.

Functionality

In-patient lounge areas, bathroom and toilet facilities are in need of refurbishment and do not meet contemporary standards. Many of the ensuites in the Hospital's residential and Acute areas are not big enough to allow for staff-assisted showering or for patients who need mobility aids. The

Nurse Station is inadequate in meeting the needs of the staff and visiting doctors and students. There are insufficient work-benches and the area does not allow vision into the Acute wards and offers limited general space. Some specific services require replacement. The nurse call system is inadequate, as it does not provide monitoring capabilities and is situated within 1970s bedside lockers, which also require updating. Building and engineering services require replacement, including the emergency warning and intercom systems required for emergency evacuations.

Redevelopment to Accommodate Expanded Community Health Services

The current focus on Primary Health Care services at Scottsdale requires greater integration of Community Health services within the Hospital. In particular, this necessitates improving public access to a central reception point that directs people to the appropriate services. In order to promote Primary Health focus through community education and community development, client interview and meeting rooms need upgrading. Visiting and resident Allied Health professionals also require access to treatment and consulting areas.

Consultation

The original project brief was prepared in 2001 through the Department's Network Project, in consultation with the various Divisions responsible for providing and co-ordinating Primary Health and Community Services. This project brief was reviewed and updated in 2004 in consultation with representatives from the Hospital and the Aged-Care and Rural Health Branch.

Project Co-ordination Structure

Detailed stakeholder consultation commenced immediately following the appointment of the project architect, Bullock Consulting Pty Ltd.

The Project Control Group has been meeting on a regular basis in order to reduce the consultation phase, allowing rapid documentation and procurement of the project. This approach was identified during the initial consultation phase to maintain the project momentum to effect tendering of the project in July 2005. The tender date is based on working back from the desired completion date of January 2006, which is necessary to ensure activation of the additional Aged-Care bed licences. The time-line for this project is extremely tight. As such, efforts have been made by all members of the project team to ensure diligent consultation has occurred with all stakeholders and wider community groups.

Consultation with On-site Stakeholders

In addition to representation on the Project Control Group through the Stakeholder Representative (Maureen Nichols, Director of Nursing Scottsdale), consultation and information sessions were held with on-site staff and Aged-Care residents. Preliminary plans have been displayed on-site and further information sessions will be held.

Value Management Workshop

Consultation culminated at the Value Management Workshop, where all desired project outcomes were tabled, discussed and then prioritised. Several desired outcomes were identified that fell beyond the scope of the available funds at this stage. The consultation incorporated all the desired outcomes into a future plan, with the understanding that the funding for the expanded scope may not eventuate. The early design stage allowed where possible for the inclusion of longer term goals in the plan. This consultative approach has resulted in a design that allows the majority of desired higher priority outcomes to be resolved with consideration given to how the lower priority outcomes may be achieved in the longer-term.

It should be noted that at the Value Management Workshop, the need for phasing out the existing four-bed Aged-Care wards and the provision of new single-bed Aged-Care wards (eight replacements and five new) was identified

as the highest priority. It was also recognised that the existing Aged-Care patient facilities were inadequate and that accommodating additional patients was not viable without significant expansion of existing lounge, dining and patient amenity rooms. The stakeholders expressed a strong desire for the redevelopment of James Scott Wing to be designed without compromising quality due to budget constraints. It was acknowledged that this would limit the remaining funding available for the redevelopment of the Acute and Community Services section of the Hospital.

Following from the Value Management Workshop, the Project Team used the information gathered regarding stakeholder priorities to review the preliminary designs. The final schematic design maximises value for money by achieving most of the improvements considered to be either essential or important for the Acute and Community Services section of the Hospital without compromising the quality of patient accommodation and treatment at the James Scott Wing. Participants at the Value Management Workshop did not rank the provision of accommodation for consulting and Community Services in the two highest priority categories because of a belief that accommodating additional services could not be achieved without compromising the provision of existing services. However, with the refinement of the design, the high priority needs of the existing services have been addressed within budget and the provision of accommodation for consulting and Community Services has been achieved at relatively minor cost through the consolidation and rationalisation of existing building usage.

Final Design Plan

The Value Management Workshop prioritised the outcomes and from this a design plan was formed, achieving the high priority items within the available budget. Independent of this project, consideration would be given to the Department seeking additional funding to undertake the lower priority items at a later date. With additional funding notional at this stage, the schematic design was revised in line with achieving the maximum value from the

approved project funding, with the undertaken works to be consistent (as far as practicable) with the long-term design. Some minor compromises have been made but the design submitted for approval provides an economical solution to the maximum number of desired high priority outcomes without constructing redundant work. The main improvements provided by the proposed design to the James Scott Wing are as follows:

- 13 new single wards with shared ensuites;
- Upgrade of six existing dysfunctional ensuites to meet current standards;
- Expanded patient lounge and dining areas;
- Provision of a room for Diversionary Therapy;
- Expanded Nurse Station;
- A secure courtyard;
- New emergency warning information and nurse call systems; and
- Improved entry.

The main improvements provided by the proposed design to the Acute and Community Services section of the Hospital are as follows:

- Relocation of Accident and Emergency closer to the Nurse Station, including additional capacity for three beds that can function as observation and recovery beds;
- New emergency warning information and nurse call systems;
- Expanded Nurse Station;
- Creation of ten new single wards with shared ensuites to replace seven existing sub-standard double and single wards;
- Renovation of existing public toilets for disabled access;
- Creation of four new consulting rooms and the relocation of Physiotherapy closer to reception;

- One of the consulting rooms (Room No. 119) will be fitted with large double doors to enable it to be used as an expanded waiting area when not required for consultation; and
- Additional office space for Community Services.

The principal difference between the proposed design and potential long-term design for the facility is the re-organisation of the Acute Section to improve the grouping of functions for the increase of operational efficiency. This requires the relocation of the Kitchen, Operating Theatre, Birthing Suite and X-ray.

PROJECT COSTS

The current project budget is advised as:

Construction	\$2,982,000
Art in public buildings	\$40,000
Furniture and equipment	\$130,000
Post occupancy fit out	\$20,000
Professional fees	\$295,000
Contingencies	\$307,000
Total Project Budget	\$3,774, 000

The completion of the project as detailed in the proposed schematic design is expected to require the expenditure of the full project budget of \$3,774,000.

EVIDENCE

The Committee commenced its inquiry on Wednesday, 13 July last with an inspection of the site of the proposed works. The Committee then returned to the Council Chambers, Scottsdale whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Ms Maureen Nichols, Director of Nursing, Scottsdale North Eastern Soldiers Memorial Hospital;
- Ms Sophie Legge, A/District Manager, North East, Aged and Rural Community Health;
- Ms Siobhan Harpur, A/State Manager, Aged and Rural Community Health;
- Mr Andrew Smith, Bullock Consulting;
- Mr Garth Murphy, Bullock Consulting;
- Mr Bill Cochrane, Project Manager, Capital Works, Corporate Services; and
- Mr Ben Moloney, Project Manager, Capital Works, Corporate Services.

Background

Ms Harpur provided the Committee with the following background of the project:-

I will tell you a little bit of background, first of all a little bit about Rural Health in the broader context, then about Aged, Rural and Community Health, which is the area of health that we are part of, and then Scottsdale itself.

In terms of Rural Health services, there is obviously a much smaller agenda and a State agenda for Rural Health services, which has been changing probably in the last decade with the Healthy Horizons Framework as one example which was initiated

by the Australian Government in 1999 in trying to look at some of the needs for rural Australians and their health needs. One of the goals in the Healthy Horizons Framework which we are still very much working to is the goal of developing flexible co-ordinated services, and certainly with the redevelopments where we have those opportunities in Tasmania, we look to the opportunity to make health facilities an opportunity to bring services together in a flexible and co-ordinated way. The Tasmania Together goals are also being reminded of, with five and six in particular being of particular relevance to us. Goal five is to improve health through the promotion of a comprehensive approach to a healthy lifestyle, and goal six is to improve the health and well-being of the Tasmanian community. Again by the Healthy Horizons we get delivery of co-ordinated services.

Just to give you a context for ARCH itself - that is the acronym by which Aged, Rural and Community Health services is most commonly known - we provide a wide range of different types of services, in-patient, residential Aged-Care and Community Health services, and that is a list of the types of facilities we have across the State. We basically have about 35 facilities on the islands, right through the State, down to the island at the other end of the State, down to Bruny. We have ten district hospitals, five multipurpose services or centres, and 15 Community Health centres, and then we also have arrangements with five councils or NGO sites where we provide Departmental funding but the services are managed locally by either councils or, in the case of Longford and Swansea, by a non-Government organisation. ARCH itself is managed in five districts, so Scottsdale comes into the north-east district. There are the north, north-east, south, south-east and north-west making up the whole, and regional bits have their own management.

To bring us back locally to Scottsdale itself, there was a Health Needs Study first of all in 1998 in Scottsdale, which was updated both in 2003 and 2004, and all three of those would have given some of the background to the need to redevelop this facility. We have a range of health facilities over and above the in-patient Acute and Community Services that are based at the facility itself, one of which is a partnership we have with Dorset Council to provide Regional Health Services programs, which is Australian Government-funded, and the Community Health services provided through that are based around the Hospital itself and out of the Council Chambers. There are other Departmental health services that visit Scottsdale, and one of those is Family and Child Health, and one of the opportunities of the redevelopment of the facility is to bring some of these services together.

What we were aiming to do in approaching this redevelopment was to provide a new and integrated facility that enables us to provide comprehensive, accessible and integrated services to individuals and communities within the catchment area, and the aim of the project is to provide a facility that is more than the Hospital itself, so it combines the function of the Hospital, the Residential Aged-Care facility, but also provides the opportunity to substantially improve the facilities for the Community Health services that contribute to the community in the improvement of health and well-being, so to provide an integrated and co-ordinated overall facility.

I think that just gives you a little bit of background to then move on into the design itself and the overall approach.

Project definition

Mr Smith provided the Committee with the detail of the project:-

Basically, in summary, we are confirming that the investment in the infrastructure is appropriate to support improved health facilities for the area, and is consistent with departmental strategies and management plans that are in place. The design has gone through a range of valuation stages, reiterations on the design and involvement with stakeholders to ensure that what is being put on paper and being put out to tender is suitable for this area and for the needs of the community, and that what we are trying to do is value for money. They have been the main aims of the whole process.

We will start with our budget. Construction is bordering on the \$3,000,000 mark in round terms, and then there are other components that make up the total budget. As you can see there are buildings, there is an allowance for furniture and equipment. There is the fit-out, which is a small component for the facilities in operation. There are some funds available within the budget for minor works that are needed. There are professional fees. There are contingencies initially to cover design changes, but long term, once it is out and being constructed, any issues that arise on site. That basically gives you the total budget of \$3.7-odd million. Within that at the moment there is a nine or ten per cent contingency which the consultants were not able to use and some of these other items basically are outside. So the main building is approximately the \$3 million.

Going back a step, that budget originally was a total of \$2.9 million and then with the increase in building works additional funds come on line later... There is a fairly large impost on tendering at the moment where tender prices are increasing rapidly, based on the buoyancy of the construction market, which makes it difficult for

estimation to occur, but also difficult for budgets that have been approved in prior years to when the project commences.

The main focus of the redevelopment and the design approach is to make sure that the facility can remain in operation while the works are undertaken, so that has been a major part of our approach collectively as a project team...

Zone A is the new extension generally to the James Scott Wing, with the majority of the works occurring outside the existing building line, which allows the contractor to make a good start and get a lot of work under way before they even enter into the existing facility. So that is a good, sizeable portion of the project which will attract contractors to make a good start and get on site and make a good presence on site. There is a small section at the tail end of that initial zone where they will take over some bedrooms, and presently there is scope for those areas to be relocated within the Hospital where there are spare bed areas available.

Once Zone A comes on line that is contractually handed over to the facility as a separate portion on the building contract, so it has to be fully functional before any works are handed over in the next stages. That allows complete access for the residents and staff and services for 14 new bedrooms as part of the extension, and what that means is then in Zone B four bedrooms and some of the existing wards can progressively be upgraded with capacity in the new section to take care of the residents. The main aim there is that by February the additional five aged-care bed licences are to commence...

Zone B is basically the balance of the James Scott Wing, which is the high priority which was determined at the value management workshop, and there are smaller areas that occur within the

Hospital progressively, and some of these areas can commence. So Zone C can commence while B and A are under way. There is a schedule of when things can occur, so obviously we need to grab the new Emergency before we can put Physio into the old Emergency, so there is a sequence that has to be followed. That has been explored, and basically it has been rationalised. The priority is the James Scott Wing additional beds by February, and then the other zones can follow on, based on a reasonable time period for the contractor not to put on increased tender costs for too short a time factor...

As part of the design process we have looked at the flexibility of the current requirements, plus through the process an overall long-term plan was looked into. The current funded aspects of the long-term plan keep being designed with an overall view kept in mind, so funding later projects that come along can occur with minimal disruption.

A big issue for the James Scott Wing is to make sure it complies with Aged-Care standards. Four-bed wards become non-compliant in 2008; we must have single beds, though shared ensuites are okay...

The other part of the brief and process is to try to achieve areas where additional services can be offered and delivered from a central location, so to bring Child Health into the facility and to attract other visiting consultants to that area.

As part of the approach, the main aim with value for money was to try to achieve, where possible, relocation functions without building work involved. Looking at a global planning approach, we were able to reposition functional areas in the existing facility where possible so that the facility can operate in a better fashion and

have a clearer definition of public areas and Acute hospital areas. At the moment it is fairly disjointed.

Again, the Aged-Care standards and improvement and expansion of accommodation use the existing parts of the building where possible. It is a large building at present and by consolidating usage and a large extension, with the exception of the bedrooms that needed to be added and new licences and to convert four-bed wards, most of the project has been contained within the current arrangement...

The existing facility was constructed in the early 1970s and has had some additional work done and some extensions to the James Scott Wing were added. The age of the building and the design approach at that stage and construction techniques, mean that it is a fairly robust and solidly-built structure, minimising building work to that part of the facility where possible and obviously reducing costs and maintaining value in the budget to be expended in other areas. As standards have evolved, it is well below areas to do with occupational health and safety, sizes of rooms, and ability of staff to assist. With current electrical requirements we have protection zones and there is a whole range of areas where the building has fallen behind what was deemed to be contemporary standard.

Accident and Emergency is currently located, as we saw on our tour, well away from where the nurses' areas are. There are difficulties there with staffing, observation, safety for staff and also being able to deliver services to the public. The Ambulance service currently is occupied there, leading into the Accident and Emergency area. The Maternity unit is located there. Physiotherapy is at the far end of the Acute area so the public needed to traverse the building, if they are coming in from the outside for consultant-type services to do with a physiotherapy

appointment. The Occupational Therapist is in a small area in the James Scott Wing.

There are several small office areas in the vicinity for the Community Health nurses. They are scattered around, using left over areas, there might be two or three people sharing an office.

Radiology was recently upgraded and it was deemed, during the value management, that that should stay where it is. In the long term and in current plans that we are looking, it its location suits the plan, so that was deemed to be a valid reason to be there.

There is a small existing Dental service near the front entry which, again, suits the planning and should be part of the public consultation area. It is around the central waiting room.

As to visiting services, there are offices and small areas that we use at the moment which really need to be consolidated into a clear, defined area facility so that it is clear, if you are going there for a certain function, that you know where to go to. There is an overlap of functional areas. Some offices are used by more than one person.

The Operating Theatre in our planning was identified as being of a very minimal use in the current services provided. Previously it may have had high usage. There is a very large area of the facility on the outskirts, planning-wise, and it would be better suited as more of a service part of the facility, like a kitchen or something along those lines, but funding-wise it wasn't deemed appropriate in this current plan to relocate the kitchen. Long-term, as the Operating Theatre becomes redundant with centralising of surgery in key facilities, that is a large area of the facility that will be available. That would then allow some other upgrade works to

occur. In summary, the planning is looking at current needs plus making sure that what is put in place under this approved budget can be easily added to later.

In summary of the project, the original proposal was in 2001 and funding was approved three or four years later, which is where the additional funding had to be sourced based on the increase in constructions costs that occurred. The health standards and needs of the community have changed over that time. Since the start of the project in January, we have been involved in the design and discussing with stakeholders and community on several occasions as to what their needs are and what their wishes are for this new development.

As part of that, several issues that weren't part of the original brief have come on-line. They have been, where possible, incorporated. Generally, there has been an increase in the size of the new Aged-Care beds to comply with current standards. We have been able to upgrade six additional Aged-Care ensuites so that they can be used. Currently they are not even used because they are dangerous to staff and residents.

Mechanical services - there are areas in the facility that are approaching the end of their life, like the heating system in the James Scott Wing. It is not functioning. We have been able to address some of those issues. A complete upgrade of fire safety and fire protection in the whole facility was deemed a high priority. Where possible we have created single-bed wards to replace existing double-bed wards.

A recent additional item for the budget, which was not part of the original scope, was that new electrical standards required a higher standard of protection for patients in the James Scott Wing, and in

six outside. Previously only the key treatment Accident and Emergency areas had adequate protection, which means that a lot of the existing wards had to be rewired so that they are safe...

We have met on a regular basis... We have had generally weekly meetings and, where suitable, fortnightly meetings to ensure that issues can be raised and put out for comment and fed into the design process. We have had several sessions on site with the stakeholders and that has included presentations to the Aged-Care residents and their family members so that they are all aware of what is happening. We have had staff sessions. This basically ended up in the value management workshop where all the items that were described and put forward as "this would be desirable," were tabled, given a priority, weighted, and then taken away and the project group is able to rationalise the final brief for the project so that we can maximise what was being delivered with the available funds and to achieve the highest priority items.

Some areas that were shown in the long-term plan as being Hospital wards and ensuites in several years' time will be ideally used as offices or support areas. Obviously we would not treat it as a high priority to upgrade those ensuites, so we are looking at upgrading key areas and there is no wasting of the funds on areas that don't suit the total planning of the facility...

We have 14 new single wards in the James Scott Wing with shared ensuites that meet current standards for both disabled and staff assistants' access. We have installed equipment like grab rails, nurse call systems and those sorts of items. Privacy is another major aspect. Even though the ensuites are shared, they incorporate systems like the nurse call so that if a resident is using the ensuite from one side, the door on the other side locks, so

there is enough privacy and direct access between bedrooms by one resident is prevented.

We are looking at expanding the patient lounge. At present the central lounge in the James Scott Wing provides dining and lounge facilities for the whole area for all the Aged-Care residents. We have added five additional residents and already it is difficult on some occasions with the current numbers. So we are basically converting the main central combined area to be a dining area and then providing additional lounge areas scattered around the facility. As to the privacy issues, when we have residents who may have difficulties with eating, or other ailments, often smaller, more intimate lounge areas that are sheltered from the public view are better and provide privacy.

Whilst the Nurse Station was deemed a low priority and, as discussed on site, the staff would rather see the residents looked after before the staff are given new facilities, we have managed very effectively to increase the size of the Nurse Station in the James Scott Wing.

Another issue is the area that currently leads directly out into the open. We have provided a courtyard area which will be planted out and landscaped so that the residents can wander through and around the facility and the staff will know they are safe.

The whole facility gets a new nurse call system, fire detection system, and that incorporates warning systems and intercommunication, with medical emergency staff carrying portable phones to talk to other departmental areas without breaching fire doors and smoke doors. So there is a full inter-communication system.

We are putting Accident and Emergency in a position close to the Nurse Station to make sure that the problems that are currently there with staffing and observation can be addressed. We are enlarging the Nurse Station so that there is adequate room for the numbers of staff, the functions required and, again, for the privacy aspect. We have upgraded in the order of 10 beds so that they are single beds with a shared ensuite, complying with current standards. We are renovating the existing public toilets off the foyer to comply with universal access requirements - that is, disabled access provisions. We are reorganising and basically re-badging doors to create a central area for consulting rooms so the public come to a waiting area and then are directly led into offices and rooms for Physiotherapy, Dental, X-ray, Podiatry, Speech Therapists et cetera. It is a one-stop sort of area for the public. Areas that have become available in the planning process can be used for support areas for offices which again has been a valuable exercise for the budget; areas with minimal work can become a functional improvement for the facility.

All the way through the design process the value for money has been a high priority. Based on the level of funding, the issues with the increases in building costs, we were mindful to maintain as much of the high-priority items as we could for the available funds.

We followed this through into the construction process and the approach to how we would build the new additions to the facilities and looked at how we renovate areas. Previously I mentioned that the facility was fairly robust. It was constructed using wet trades and traditional techniques of brickwork and block work, which is a slow and time-consuming process and with the current building climate you really need to have a faster technique of erecting a building and allowing it to be wrapped and occupied so that the services can be installed. We are looking at lightweight,

suspended concrete floors on steel work that can erected quickly; more domestic-style framing of roof structures so that the building can be wrapped and made weatherproof in a short time to allow all the services and fit-out to commence.

At the moment with design documentation we are aiming to tender in the next week or so, subject obviously to approvals. The tender documentation is in the final stages. Advertising is mid-July and, all going well, we will award the contract by the end of August. These dates have basically been set in place from January this year to achieve January 2006 as a priority for bed licences.

In summary, the redevelopment will provide the local community - there are 7 000-odd people in the area who rely on this facility - with an upgraded facility that meets contemporary standards and allows delivery of Health and Community Services. The Project Control Group has carefully addressed the design issues. We have involved the stakeholders and we have done what we can to make sure the project is delivering what is intended. We are recommending that it is providing value for money for the community and for the State in the approach and what we are delivering for the budget.

Community Health Services Provision

The Committee questioned the Witnesses regarding the provision of Community Health services from the Hospital, specifically current provisions and future improvements on these. Mr Smith responded:-

We have a local semi-retired radiographer... As part of the nurse floor and fire protection upgrade, communications [and Telehealth facilities] are being provided to the consulting

areas. The current standard of network wiring is all that is required for Telehealth to be plugged in anywhere in the Hospital. It is a standard network...

The Committee questioned the Witnesses about the provision of Dental Care and Respite for young people with a disability from the Hospital. Mr Smith responded:-

At this stage, it was identified as part of a future master plan for the facility. It was extended and provided with more storage space. Apparently the corridor area running past it leads to the existing board or meeting room, which is at the moment being maintained. Long term that corridor would disappear, which would provide some 20 per cent increase in size for that small dental area; they could take over the corridor, plus some storage facilities that are being looked at. At this stage, in the current budget and the prioritisation of what was required in the Hospital in the James Scott area, that was a low priority. The upgrade works that are being documented, if you like, have kept that environment for any works occurring nearby. So there is scope in the long term for something to happen there if funds are available, but at this stage no work is happening... At the value-management workshop the overall cost that was tabled was in the order of approaching \$5,000,000 for the whole facility, incorporating all the works. The funds that are available at this stage are in the order of \$3,000,000. But there are a whole lot of other things that are involved. With dental, you would really have to explore a layout for it and then have it costed. It is a bit hard when you don't know whether it is adding another chair or adding five chairs.

[In regard to the provision of Respite care for young people with a disability,] I suppose, as a starting point, the aim of the redevelopment is to consolidate those sorts of functions to a central location. The overall guidelines for the project were to achieve that. As far as a dedicated respite bed is concerned, at this stage there is nothing in the plan that says, "I'm definitely a Respite bed" but by upgrading some of the existing wards in the Acute section, and even the provision of the office near the James Scott Wing new entry which we are constructing there, that can link into the first ensuite. Even though the door isn't indicated, we are providing in the documents that a doorway is built and plastered over basically so that, if a door is needed for that function, a door can be fitted. But by converting the two and four-bed wards to singles with access to a shared ensuite, then depending on demand and patient numbers in the facility, there is privacy available and rooms can have that dual purpose. I suppose our prime approach has been where possible to have flexibility in the usage of rooms. The Respite function can occur in either the Aged-Care rooms or in the Acute area... Again, it is supply and demand. If the Hospital is full and there is an incident, a flu outbreak or something, obviously Acute beds would be a higher priority than a Respite bed. Where available, I am sure they would be utilised.

Courtyard Facilities

The Committee questioned the Witnesses regarding the courtyard facilities at the Hospital, specifically in relation to the safety of Aged-Care patients, whether it would be enclosed. Mr Smith responded:-

Yes... Currently that is used as the major entrance. Under the redevelopment that will not become the major entrance. The one that we looked at when we were in the corridor... that is

being provided with a small awning for a lot of weather protection for drop-off from vehicles. The courtyard is being fenced and made secure with a decorative-style fence, and linked to the nurse call system. There is currently a laundry activity with storage of dirty linen for collection from the Launceston Linen Service that occurs in a small part of that courtyard, so that activity needs to be retained by having a locked, secure courtyard. The gates can be unlocked by nursing staff through the nurse call system and monitored so that the residents are safely contained... The side of that courtyard, the James Scott wall that bounds that courtyard, at present is a utility area with bathrooms, storage and pan rooms. That now becomes a lounge area which opens out into that courtyard, so it provides residents with a degree of dementia a small area through the courtyard into the lounge, and it provides another secure area as an outside space. There have been some incidents that we were made of aware of with people wandering around the facility after hours, so with the new extension, basically there are safe courtyards so that the residents have a bit more privacy and can feel a bit more secure.

Occupancy Levels

The Committee questioned the Witnesses regarding the occupancy levels of the Acute Care wards and whether Acute Care beds could be used for Aged-Care services. The Witnesses responded:-

Ms NICHOLS - I think it is about 65 per cent at the moment. It has varied between 65 per cent and perhaps 70 for the last few years... The Aged-Care beds are in a separate wing. I think

we will be losing a couple of these if it goes further down the track.

Mr MOLONEY - We are seeing a reduction. With the addition of the five Aged-Care beds, we are also seeing in parallel a reduction of the Acute beds from 23 to 20 at this stage... It is a balancing act to offset, but it is appropriate given the current level of usage.

The Committee questioned the Witnesses in regard to how often the facility is full and whether it is ever used for overflow from the Launceston General Hospital. Ms Nichols responded:-

I did do the figures. There were about 20 occasions over a 12-month period where we didn't have any beds. So we have 100 per cent occupancy on 20 occasions in a 12-month period... [In regard to overflow from the Launceston General Hospital,] not necessarily overflow. We take pre and post-surgery, especially when they need a hip placement or following surgery, so there is no real primary surgery. Occasionally we have taken aged-care people waiting for placement.

The Committee questioned the Witnesses as to the current and future arrangements for surgery at the Hospital. The Witnesses responded:-

Ms NICHOLS - At the moment we have Amanda Young who visits once a month... The Theatre that is there now there used to be for major surgery, so it is a lot of space there for four or five hours a month. The type of surgery that we do could be done in a much smaller area and without all of that equipment that we have with a primary theatre.

Ms LEGGE - And a room for sterilizing, of course, we don't do that any more. That is done in a central location, obviously, for best practice and safety.

Ms NICHOLS - We don't do general anaesthetics, which we did in the past. The chance of getting a GP with the appropriate anaesthetic requirements in a rural area like this is fairly remote. Those days are long gone.

DOCUMENTS TAKEN INTO EVIDENCE

The following document was taken into evidence and considered by the Committee:

- Department of Health and Human Services – Submission to the Parliamentary Standing Committee on Public Works – Scottsdale North Eastern Soldiers Memorial Hospital Redevelopment, July 2005.

CONCLUSION AND RECOMMENDATION

The Committee was satisfied that the need for the proposed redevelopment of the Scottsdale North Eastern Soldiers Memorial Hospital was clearly established. The facility fails to meet current requirements in terms of Occupational Health and Safety and Aged-Care standards, posing risks to the physical and emotional well-being of both patients and staff.

As the major health care provider in an isolated community, the Scottsdale NESMH needs to offer a variety of health services, including services as diverse as Accident and Emergency treatment, Aged-Care and Diversionary Therapy. The proposed works would reorganise the layout of the Hospital,

relocating similar services into the same areas and allowing more direct access to these different sections.

Accordingly, the Committee recommends the project, in accordance with the documentation submitted, at an estimated total cost of \$3,774,000.

**Parliament House
Hobart
5 September 2005**

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