

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT SMITHTON COUNCIL CHAMBERS, SMITHTON, ON TUESDAY 6 FEBRUARY 2007.

SMITHTON DISTRICT HOSPITAL REDEVELOPMENT

Mr PHILIP MORRIS, ACTING STATE MANAGER, AGED, RURAL AND COMMUNITY HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES; **Ms SHARAN MCLAREN**, ACTING MANAGER, SMITHTON DISTRICT HOSPITAL; **Ms CHRISTINA HYDE**, NURSE CONSULTANT, SMITHTON DISTRICT HOSPITAL; **Mr TIM PENNY**, ARCHITECT, PHILP LIGHTON ARCHITECTS; AND **Mr BILL COCHRANE**, MANAGER MAJOR PROJECTS, FACILITIES MANAGEMENT BRANCH, DHSS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - I declare the hearing open. We have apologies from Mr Best and Mr Hall.

Mr STURGES - Just for the record I indicate that Mr Best was quite upset that he could not be here today, but a Devonport alderman, Mr Rodney Barden, passed away last week and Mr Best is attending his funeral today.

CHAIR - We have one document - the submission from the Department of Health and Human Services. Before we move into hearing the witnesses, I wish to thank you for the site visit. It is always important for the committee to see the existing facility - whether it be a roadwork or a building - and then we can visualise more clearly how the proposal fits as we proceed through the hearing. Tim, Bill and Philip have been before the committee on a number of occasions, but the ladies have not. We conduct the proceedings in a pretty informal sort of way, so it is a very relaxed process to enable the best possible exchange of information to occur. Philip, I believe you are leading the discussion.

Mr MORRIS - I just want to give a brief overview of the context of rural health services. It will only take a few moments. I am not repeating what is already in the submission, but just trying to flesh out a bit more of the background. I want to talk very briefly about rural health services, about the Aged, Rural and Community Health Program, under which Smithton District Hospital sits. I will also need to mention the primary health services plan, in which the department is engaged at the moment and then talk about the links of that plan to Smithton.

I guess in a policy sense the big picture thinking on rural health comes from the Healthy Horizons framework. This is a Commonwealth/State jointly supported policy framework and we view what we are doing in rural areas in Tasmania as under that framework. In particular I wish to draw your attention to the goal of developing flexible coordinated services. I think that is our objective here at Smithton. The Tasmania Together process also has goals relevant to what we are doing here, particularly improving health through

the comprehensive approach to healthy lifestyle and improving the health and wellbeing of the Tasmanian community through the delivery of coordinated services.

Our particular program is involved with a large number of inpatient residential aged care and community health services around Tasmania. They are in two or three major groups. We have district hospitals and Smithton is one of those. We have five multipurpose services or centres providing very similar services but with a bit more emphasis on coordination and there are different funding arrangements. Quite a large number of community health centres are also scattered around Tasmania. We also provide funding to several either local government and/or non-government organisation sites to provide particular services.

So the Smithton development is part of a much broader program directed at community health services and this particular service here at Smithton is very characteristic of the mainstream of those in the sense of providing inpatient services and community health services. The distinction is that it also provides an accident and emergency response, partly due to the fact of its location - it is an hour or an hour plus out of Burnie. Also of course up to now it has been providing residential aged care but, consistent with a policy direction we have had for quite a few years now, wherever there is a viable local aged-care provider that is capable of taking on more of an aged-care role we transfer our services to that provider and that is exactly what is happening here. We are very pleased with this opportunity and we think it will be very positive for the future.

I just want to mention the primary health services plan because obviously the department is engaged in two major planning processes at the moment, one looking at acute clinical services and the other one looking at primary health services. The primary health services plan is now under way, as you would all be aware. It is due to report in the next few months. I guess whilst it has a number of themes, it is particularly looking at sustainability, service quality and access. We are facing the challenges, with which again you would probably be familiar - our ageing population, the rise in chronic conditions in the population, our ageing work force, recruitment and retention issues, rising demand of costs and on the other hand, increasing focus on quality and safety. In both those plans I mentioned, the clinical services and the primary health services, there will be a lot of work looking at the linkages between acute services and community services, including district hospitals such as Smithton. So one of the focuses in the future will be addressing that.

Regarding the implications of all this to Smithton, first of all there is a statement in the primary health services plan initial documents which talks about local services being central to preventative approaches creating healthy and supportive environments, supporting independence and quality of life for people with long-term health needs. That is going to be a role of the Smithton district health services. The transfer of residential aged care to the private provider is consistent with sustainability. It makes sense where you are trying to recruit nurses and run a health service in a rural area. Why on earth would you have two providers providing the same sort of service? Clearly it makes sense to consolidate that in the one spot. It is more efficient; it is more sustainable. It is also, most importantly, we believe usually far better for the residents as well because they are in a facility which is dedicated to providing care in a homelike environment. One of the challenges for us in integrated facilities is to provide a homelike environment for the people in that part of the facility. Whilst you are trying to run an accident and

emergency, acute inpatients are down the other end, and you saw that at Smithton this morning. You have to make some compromises. So there are some good care outcomes by having a specialist aged-care provider.

We are also in this development improving our community health space. This is consistent with the idea of access and primary health. I think we all feel that whilst inpatient services can be an important part of the health service delivery model, they are by no means the whole picture. We have to be far better oriented towards working in a community sense, not putting all our eggs in the inpatient basket. So the thinking behind this development is to take the community health services which are out the back, down the bottom of the site, and put them right up to the front. That is no accident. That means that it is a representation of our desire to put community health more up at the front of what we are doing. We are also trying to keep our space flexible wherever possible because things are going to change in the future. Some of you may have heard Bill or Tim earlier this morning talking about putting computer wiring everywhere. That is part of the infrastructure which will help us juggle things in the future, whether it is new technology, whether it is reconfigured space. We are trying to have a longer-term view that what we have now might have to be adapted in the future. We are also trying to adjust our services to the population, to its needs and to its characteristics. There is definitely a need for aged care here, recognising that transferring to Emmerton Park we need to look more at our community health services and how we can make those more responsive to the population.

There is already some community involvement in what we do but we think probably in the future we have to do more there and involve the community both in advisory-type roles but also become involved in our actual programs. There is a good community connection between the existing services and the citizens of Smithton and Circular Head. We think we could probably build on that further.

In summary, that is what we are trying to do here at Smithton - provide a new and integrated facility that enables the provision of comprehensive, accessible and integrated services to individuals and communities in this area; better integration by changing the configuration of space; hopefully better efficiency and effectiveness in the way we have organised our internal services within the building; and we hope to enhance our contribution in the community towards health and wellbeing.

CHAIR - Thanks, Philip.

Mrs NAPIER - One of the areas that is coming up is access to dialysis. I know that in the north-east currently they are looking at what the load factor might be to see whether it might be possible to provide a dialysis service that can be accessed at the north-east hospital. It is not happening yet but I have had some discussions to see whether that might be possible. What is the load here for access to dialysis? Is there a consideration for those kinds of services rather than having people travelling all the way to Burnie, often three times a week?

Mr MORRIS - That is something that may be addressed in the clinical services plan. It is an example of looking at the interface between acute services and at a local area. The population here is roughly equivalent to that in Scottsdale, which is where I think you are talking about, and theoretically it is something that could be possible. The issues for us -

they are mostly quality and safety issues - would be ensuring that our staff here are trained, supported, that we have the right clinical environment, that we have the right equipment, that there is backup from the major facility to make sure that happens. In principle it is an example of the sort of thing we could do, yes.

Mrs NAPIER - I take it that the space allocation in this design could accommodate something like that in presumably the community health area?

Mr MORRIS - Yes.

Mrs NAPIER - What are the other trends that are occurring in terms of trying to deal with chronic disease management, which I suppose that area of dialysis picks up, in the area rather than people having to travel the long distance to the major centres?

Mr MORRIS - I think we are still in the early days of working out what we can do but it is a different model of thinking about chronic disease. It is about trying to give people information, resources, support and access to clinicians to enable them to manage their own condition and at times come in and get specific clinical interventions. We have to do I think a bit more in our community health area to develop programs. There are things like health coaching where a professional takes a role in with a group of people. There are specific self-management programs. Those are the sorts of things that I would hope we would be offering here in the future.

Mrs NAPIER - In terms of the input to the design of this, has there been a recent survey of the needs of people in the Circular Head area and how that is likely to impact on that community health model that will be part of this new structure?

Mr MORRIS - I am not aware that we have done a specific community survey on needs. There has been in the past a statewide health needs approach and some areas have done specific surveys. I think we are fairly confident that we have a reasonable appraisal of community needs because of the connections I spoke about earlier between the facility and the community. There is a fairly good interrelationship and what we are doing I hope in this development is that sort of metaphor of putting community health back up the front. So we have not done a specific needs analysis but my hunch is that what we are doing here is fairly commensurate in other similar areas.

Ms McLAREN - At the moment we do provide some chemotherapy services here but we can only give medications that have a longer life span because they have to be mixed and prepared in Burnie.

Ms HYDE - They actually come from Melbourne.

Ms McLAREN - Yes, and then they have to be flown over. So we try to keep people in the area as much as possible for their cancer treatments and that saves them some of the trips through to Burnie or Launceston.

Ms HYDE - We do have consultants. The pacemaker technician comes to Smithton as well as the respiratory educator, the lady who does all the follow-ups for people with chronic lung disease. I think quite a few of our specialists are now going to the doctors surgery

to hold clinics. I am not sure if it is going to be a thing of the future but hopefully some of our new consulting rooms might be able to be used for things like that as well.

Mrs NAPIER - The north-west hospital has a really good pre- and post-operation physio program that I think now runs in other hospitals too. Can you provide that here or is that offered through the GPs?

Ms HYDE - We have a physiotherapist I think it is Monday and Thursday so if they had a better facility they may well be able to improve that service. I think it depends also on their staffing but we would have to collaborate with the operating theatre team in that department, I expect.

Mrs NAPIER - There is not room for a physio area, is there?

Ms HYDE - Yes, there is. Some of our patients who come long term, such as our paraplegics, have asked if they can have some equipment in there that they could use to maintain their physical strength.

Mrs NAPIER - The disability issue then starts coming in, whether acquired or otherwise. Is that in that community health area in the plan?

Mr PENNY - Yes, it is. It is adjacent to the waiting lounge on the plan; it is diagonally opposite the nurse station. There is a group to the north there of an allied health/physio, a multipurpose consulting/oncology and a consult one. So they are multipurpose consulting rooms that can address the sorts of needs that you have been talking about.

Mr COCHRANE - One of the benefits in developing the existing space, and with moving the aged-care beds, is that we have quite a bit of flexibility in using those spaces for a number of allied and community health consulting areas, which will be booked on a sessional basis. We can have a numbers of visiting or dedicated services working from those areas.

Mrs NAPIER - If you were developing a greenfield site, would you necessarily have as much space to expand in?

Mr COCHRANE - I suspect we would have two or three fewer consulting rooms than we have in this model.

Mrs NAPIER - So there is capacity for programs to be run consistent with the community health and primary health care model that facilitate physio, pre- and post-op wellness and so on?

Ms HYDE - At the moment, the hearing-aid specialist has his clinics in our patient lounge room. The mental health team have their clinics in that small room without windows. We already need consulting rooms for those specialists.

Ms McLAREN - As you can also see on the plans, there is a big community health lounge area which will be used for education and community forums to help with our education program.

Ms HYDE - Nancy, our site manager, is very motivated in the field of health awareness. She would like to conduct a healthy-living program.

Mrs NAPIER - I agree about sustainability, quality and access, and avoiding travelling back to Burnie.

Ms McLAREN - We have a dialysis person at the moment, but he is managed by community health for at-home dialysis.

Mr PENNY - We are redeveloping the existing building, so we have that envelope to work within. The hospital will remain in operation during the redevelopment, so that presents its own challenges. We have to make sure that the staging is thought through. The conclusion of this project requires decanting the aged-care component, which is planned for April 2008. It is a multi-stage project that will take a couple of years.

In relation to the physical structure, we have an advantage in that it is a reasonably pragmatic building. It has a concrete frame so we are able to juggle walls and so on. Internal walls are not load-bearing, so we are able to replan with a fair degree of flexibility. The key planning aspects to be considered are the requirements of the community health services facilities and the change in practice after aged-care goes. The key elements are the relocation of accident and emergency and the relocation of the kitchen. At the moment the kitchen's location makes good sense because it serves both aged care and acute care. When aged care goes, the critical aspect of hospital planning is for accident and emergency treatment rooms to be accessible not only for acute care but also for the community. Those treatment rooms are used by more than just the hospital, as is the medical imaging. The nub of the development is the relocation of accident and emergency, and replanning the front entry so that it is visible from the street. The existing building has good corridor widths which we are able to utilise.

Regarding building services, the building has a fairly outdated reticulating hot-water heating system. This provides heating in the floor slabs and has passed its used-by date. We propose progressively to decommission it. Regarding ward planning, we have service areas at the back and are retaining the wards at the front. The plan requires good access of nurse care to bed areas. In the early stages we considered planing the ensuites as internal spaces in order to maximise external frontage, but on balance we decided it is better to have the ensuites on the outside edge so that you have a stronger care component for the rooms, for beds coming in and going out, and for 24-hour monitoring of each room. There are still the large windows, so that fantastic view and northerly aspect are not lost, though somewhat diminished. Once the hospital is up and running, and everyone experiences the spaces, I am sure they will be equivalent. At the moment there are problems with overload from solar gain in summer and excessive heat loss in winter. They are full height, curtain-wall systems and the lower panels are only aluminium. We propose to replace all the windows with double glazing. From the points of view of ESD and recurrent costs, we are attempting to introduce good energy design.

Regarding the detail of the rooms, the size of the footprint allows us to combine a large community space, which was always part of the original plan. The flipside of that is an adjunct space for the staff area, which can be partitioned off for in-house training. There are benefits in using the existing envelope. With the staff area we are redeveloping an

external space to the west, so that there is some breakout space for recreation - a bit of green space to get away from the internal machinations of the hospital.

As you saw, the administration is very fragmented and dysfunctional; reception, offices and medical records are all separate. We propose one point of entry and reception at the front door, with a direct link to administration. Medical records need to be accessible to nursing staff, both in and out of hours.

As a 24-hour accident and emergency facility, we had to consider out-of-hours presentations when the front door is not in operation. The intention is for presentations to go through the doors adjacent to the treatment 2 space. The nursing station will have good sight lines and access because in the evening there are only three nursing staff, and only two during the night.

Mrs NAPIER - That means they will come in on the southern side?

Mr PENNY - Correct. With acute care, the two-bed wards are adjacent to the nurse station, so the high-care areas are close to the nurse station. There has been extensive consultation as we have worked through the plan and this is reflected in planning of the nurse station, handover, medical prep and medical store to make sure they match nursing health practices. This is also evident in the relationship through to drugs and treatment rooms 1, 2 and 3.

Mr STURGES - On the site visit I was shown the education area. I was told there was a regular satellite hook-up with King Island. Where is that going and what improved facilities do you anticipate receiving?

Ms HYDE - I think it will be in the staff briefing room, which we can partition off from the staff dining room. It will be much better. The current room is too small and we need the larger room.

Mr PENNY - Given the reticulation of the data services, you are able to do video conferencing in most spaces, not only in the briefing space but also in the multi-purpose consulting rooms and the treatment rooms in accident and emergency.

Mr COCHRANE - We were very mindful to add flexibility to the staff spaces. It is difficult to recruit and retain staff, so one thing we factor into these developments is to upgrade the staff areas so that there are better time-out areas and amenities. Environmentally sustainable design and a more energy-efficient heating and cooling system were also important. All the heating will be thermostatically controlled and on timers, so we will not be heating the community health area when it is not being used. There will be a saving to the hospital's budget. Also, the new staff areas are much better than the existing areas; we think that is very important.

Mrs NAPIER - You propose to put the toilet and bathroom complexes on the sunny side, where the view is. One of the appealing things about the current hospital is that, even if you are feeling poorly, the community comes to you through the view. Has a cost differential prompted this or is it an attempt to reduce heat loss and so on?

Mr PENNY - It is a balance of all those factors. Part of it is internal planning so that the space is functional, bearing in mind beds going in and out past the ensuites. All the ensuites will meet disabled access requirements, which are important these days. Formerly, you could get away with smaller areas. Cost effectiveness was also a factor given that toilets and ensuites are highly serviced with hydraulics, pipes and so on. This is an existing concrete slab, so having to cut through that and add pipes was a consideration. We also considered how much amenity would be lost in a room. On balance we think that the windows are still large, about 1 800 mm wide and full height. The view will not be lost. There is a change in the culture of experiencing the building, and that was also taken into account. After weighing all of those factors we came up with this as the preferred model.

Mrs NAPIER - They are shared between the two units?

Mr PENNY - Correct.

Mrs NAPIER - In the unit on the north-west it appears that the facility precludes the window, or am I misreading the design?

Mr PENNY - No, that is right. The end ward has the window out to the west and to the green space immediately adjacent to that.

Mrs NAPIER - So basically, that room loses the northern aspect -

CHAIR - But it has the balcony as an addition.

Mr PENNY - That is right.

Mr COCHRANE - In support of what Tim is saying, one of the issues that the architectural team noted when they were doing the initial inspections was that a lot of the time they had to draw the blinds and close the windows up completely to keep the sun out on a hot day. The size of the windows we have here are equivalent to what we have at Queenstown, George Town and Deloraine. We are certainly not short-changing our residents at Smithton. I was a little concerned about that, so when visiting George Town I purposely measured the windows and found they were the equivalent size to what we will have at Smithton.

Mrs NAPIER - In a way it is a similar kind of design.

Mr COCHRANE - Having them out there means that you enter the room into a big, wide space; you do not go through a narrow corridor. It draws the space in for the resident if you have the ensuites out on the corridor side. I guess there are pros and cons for both.

Mrs NAPIER - I noticed that in the notes it said that birthing will occur in one of the three spaces created for A&E. Am I reading that correctly? Could someone talk to me briefly about the intention in relation to birthing facilities?

Ms HYDE - The birthing facility will be in treatment room 3. That will have the birthing bed, which can also be used for other cases as well, but it has been designed as a birthing bed. We will also have the resuscitation facility and the humidicrib in case of an

unexpected delivery. We have already discussed oxygen piping and so on to the areas we need for baby resuscitation. So there will be a room dedicated to delivery.

Mrs NAPIER - I guess that was my question. I don't know whether we will head in the direction of increasingly using midwives. I have a view that we should - other countries do so I don't see why we shouldn't - because the doctor never gets there in time to catch the baby anyway! The midwife does all the work. That has happened to me twice - and I have only two kids! I wonder whether the birthing facility will have all the appropriate backup facilities that you need in it.

Ms HYDE - Actually, it will be better than the one we have had - we have had an ensuite - and it will be dedicated to that very thing - birthing.

Mrs NAPIER - Is it likely that there would be enough space for a sleep bed for someone accompanying the mother-to-be?

Ms HYDE - I am not sure.

Mr PENNY - Yes there is. It is more an operational question of whether you want to run it like that.

Mr STURGES - Let me assure you, Sue, from my experience, you wouldn't want to be sleeping if you were the father!

Mrs NAPIER - I was just interested in whether there was an appropriate area if someone wanted to stay overnight for a 24-hour labour, or whatever it might be.

Ms HYDE - We are quite good at being creative, so we could certainly accommodate a person if that situation arose.

Mrs NAPIER - The important thing is that it is going to be developed as a birthing suite that can be used for something else, if need be.

Mr PENNY - If I may enlarge on that a fraction more - through the consultation those sorts of spaces are recognised as needing to be multipurpose, so equally that space, when it is not being used as a dedicated birthing area, has the capacity to be used as a consulting room. You will notice in the far corner there is some joinery, so it can be used like a doctor's consulting room as well as a treatment room and birthing suite.

Mr MORRIS - It is very practical. Could I also point out that at the moment the birthing service is on an emergency basis - we are not doing planned births there at present due to a range of factors. Looking to the future that may change. At the moment we are dealing with emergencies - unplanned events.

CHAIR - Just to address that a little further: in answering Sue's questions, I think either Sharan or Chris said that you would love to -

Ms HYDE - The midwives at the hospital would be really excited if we could take up that service again, but unfortunately we do not have enough midwives to service 24-hour

periods, but we are still looking after patients antenatally and postnatally. When our new service starts, we will have more community participation as well.

Mrs NAPIER - I think you were telling me that in the hospital you are trying to provide opportunities for midwives to spend more time back at Burnie to get more training -

Ms HYDE - We have been hugely supported by our larger service centres and they are quite happy for us to be part of their team. When they do not have the university students we will fit in between those times and our site manager is happy to support us. She will pay us to go to Burnie and spend a week working with them.

Mrs NAPIER - The other question I had in terms of facilities was in relation to the dental facility, which is part of 7B. As I understand it, this submission says that 7B might have to wait, depending on budget. Hopefully this can fit within budget. The aim is to have 7B go ahead, is it not?

Mr COCHRANE - Yes, absolutely. I don't consider that finding that money will be all that difficult. Should it not occur, Oral Health Services presently operate in their own dedicated facility in the town, as do child health facilities. But without pre-empting any approvals, we have lodged a bid for the additional money in our capital investment program. Whether it will get out of the department in the current environment, I am not sure. It depends on what the competing priorities are. But certainly we have recognised that there is a shortfall and we have requested additional funding.

Mrs NAPIER - So in a project like this within the control of Health, I presume that Health owns the facility that is currently used by Oral Health Services here in Circular Head?

Mr COCHRANE - Yes.

Mrs NAPIER - So is it possible for you to look at the possibility of a sale within budget? If you sell the current facility can you invest that money back into this project?

Mr COCHRANE - Yes. If we divest ourselves of an asset that is surplus to requirements, the funding goes into the Crown Land Administration Fund and we get that money back at the end of the financial year. Subject to the approval of Treasury, we can redirect it towards this project. We have done that on other projects where we have actually redirected the proceeds of asset sales into the capital program.

Mrs NAPIER - What is the view of the community about whether the Oral Health Services should stay where they are or be incorporated within the community health services?

Mr COCHRANE - Oral Health Services themselves are very keen to move into the new facility. Their present facility, while okay, is starting to get dated and this would certainly be an improvement for them. Child Health Services are in a very nice facility in the middle of town -

Mrs NAPIER - Which they own?

Mr COCHRANE - I believe so; I couldn't say that was so absolutely, but I would be very surprised to find that we did not own it. We own most of them.

Mrs NAPIER - Okay. Presumably there would be some advantage staffwise to have dental health services located in a community health centre?

Mr COCHRANE - We have a dedicated receptionist - it is better for way-finding; it is better for control of people who are waiting; it is better for the staff to be working in an environment where there are other staff around them for safety issues. That is also relevant to our child health nurses as well.

Mr MORRIS - I think that refers back to what I was talking about earlier - the notion of at minimum co-locating things on the one site is absolutely vital. More importantly, trying to coordinate and integrate those services is what we are striving for. Looking ahead to the future, it makes no sense to have things spread out all over the place; we have to bring them in together because of staffing, building and sustainability issues.

Mr COCHRANE - And case management issues as well. If someone comes in with a particular health issue, the clinicians can talk to each other and look at a holistic approach to that person's care. From that perspective, it is much better for them to be in a 'one-stop-shop' if you like.

Mrs NAPIER - Especially with something like dental health, so that you can avoid waiting for the teeth to come out.

Ms HYDE - There have been several incidents where the dentist has had a client who has had an adverse reaction. It is quite frightening for him to be the only practitioner there, whereas in a hospital setting there would be all the emergency equipment on hand that might be required. I think that would be a big positive step for that department.

Mrs NAPIER - You mentioned, Tim, that the aged clients would be decanted in 2008. What progress has been made in relation to the expansion or development of Emmerton Park to accommodate such clients?

Mr PENNY - I have forgotten what date was in this document -

Mr MORRIS - I think it was February, but now it is April - I think.

Mr PENNY - Yes, they have let the contract and work has commenced on site. It is reasonably tracking in accordance with this document; there has been a little bit of slippage to get things established on site.

Mrs NAPIER - I have only one more question. On page 17 you refer to the fact that the light and power services have had their day, and that you will also need to replace the hot and cold water systems. How do you tackle the issue of energy conservation - trying to get minimal recurrent costs as well as efficiency? I have heard a number of gentlemen saying that it would be better to use air recirculation systems as part of your heating complex, which has recurrent cost advantages in terms of energy. I might give you some of the documentation some day and you can give me a run-down on what you think.

Mr PENNY - I would be pleased to do that, but in relation to this project we do have some limitations in the existing building. The intention is that we are stepping down the

existing inefficient hot water system because it is running through slabs, it is not insulated and all those sorts of things that they did as normal building practices back in the 1960s. In terms of energy conservation, what we look at is whether it is about heating and cooling and where the principal costs are. In this building obviously it is basically heating and cooling associated with those systems. In the design process we go through a bit of an analysis. On one side you have the functionality requirements, such as air conditioning being provided into some of the internal spaces, which are workspaces as well as treatment areas, and generally then we try to step down the extent of servicing. For instance, in the acute bed wards we have provision for heating but not cooling because they are naturally ventilated - you can open the window.

Mrs NAPIER - The heating is individually controlled per unit?

Mr PENNY - That is right. Obviously that is set on thermostatic controls. Part of what we are doing is then relooking at how the energy comes in and overloads and thereby requires cooling, and how to manage the heating. In this instance we are insulating and double glazing new external walls, thus stopping excess heat coming in in summer or losing the heat you already have in winter, which is particularly relevant in Tasmania. Our consultants modelled that for us through the various software programs. With things like lighting you put in smart controls. In areas where lighting is not required out of hours they switch off. It is not that sophisticated in that they are sensor-controlled and all that sort of stuff because this is a 24-hour operation generally for the hospital component and it is a very small component of that.

This building has an advantage in that it has the slab in the ceiling, so in effect we have thermal mass which, once it warms up, provides a passage system. So it is about controlling the amount of loading you get from the windows, for instance. That is one of the things that we have considered. I think you will find that by reducing the amount of north/north-western sun which, in Tasmania, is historically the problem, reducing that in-component and then controlling it is where we get the energy benefits.

Mr PENNY - In terms of the split systems, they are efficient to run. I am not an expert to talk about those. My electrical consultant is probably better, but what I can say is that what you trade-off against efficiency over the long term - seven to 10 years - is that they do need a slightly higher degree of servicing and maintenance.

Mrs NAPIER - Yes, the switching system.

Mr PENNY - That's right. But it is way more effective than a fully air-conditioned system which requires air handlers and chillers and coolers and a whole lot of infrastructure with that.

Mrs NAPIER - It just spreads the germs anyhow, I reckon.

Mr PENNY - You also have discrete managing here because you get pockets, so you don't have to built up a big asset. You have systems that look after the treatment area, you have a system that looks after the air handling for the kitchen and a system that looks after the dental area. So in terms of being individualised - of controlling and managing them separately - you are able to do that.

Mr STURGES - User-friendly and also good for maintenance.

Mr COCHRANE - That is one of the aspects we look at in some of our rural areas; we try to keep the system as simple as possible for that process, having specialist maintenance people attend.

Mrs NAPIER - To accommodate demand.

Mr COCHRANE - Yes.

We have made a conscious effort with all our district hospitals these days of keeping those energy-efficient processes in place. In a lot of earlier developments we might have said, 'We can't afford it, we'll have to take the double glazing out', and that's false economy. So we just make sure that they are retained.

Mrs NAPIER - So you do take in account the recurrent?

Mr COCHRANE - Absolutely, yes.

Mrs NAPIER - I will bring in one system you might have a quick look at it and explain to me what the difference might be; a system that there is quite some enthusiasm about and that a number of people are using at the moment. That explains it well as to how the recurrent funding is being taken into account and accommodating change.

CHAIR - Any further questions? Any further comments from anybody who has made presentations this morning?

Ms McLAREN - I just mention our heating system at the moment. In wintertime the hot water system going through the floors, for the aged-care area we are having to set that on 26 - 27 degrees to keep it warm enough for overnight but then we have nice sunny days and we are in sweltering heat during the day. To have a system that works will benefit. At present the poor acute end has to put up with our temperatures as well because we can't control -

Mr STURGES - That's the beauty of the one system, the double-glazing and so on.

CHAIR - Thank you one and all for the submissions which you have made and the answers you have provided to our questions.

Mrs NAPIER - There was one quick question.

CHAIR - How come this always happens?

Laughter.

Mrs NAPIER - It says on page 11 that you have tried to stay within budget and that you have been able to 'provide most of the essentials'. I would have thought that in a design like this you would have put in all of the essentials. Which essentials haven't you provided?

Mr COCHRANE - We talked earlier about a fully air-conditioned system right throughout the building; that is not required under the Building Code of Australia, and for the reasons we just mentioned for maintenance and upkeep it can be more of a problem. We looked at the site holistically, took a master planning approach and said, 'Okay, where would we start and where would we finish'. We are not doing anything in this development that will prohibit any further developments. Yes, we would have liked to spend a little more money on site works and possibly provided some additional parking, possibly spent some additional moneys in the old community health area, but those issues did not have the same level of priority as the work that we are currently doing under the main building. It does not stop us from coming back and doing some of that work in the future, but at this point in time we are able to account for all our highest-priority issues.

Mrs NAPIER - One area that I didn't see on the plan, and you might well have in mind, is pedestrian access. Where you have the car parking space and you have a car drop-off under the new front entrance, there didn't seem to be an accommodation for the fact that quite often nowadays you paint a pathway where pedestrians can go and cars can go for safety.

Mr PENNY - There is a footpath that runs down parallel to the side of the building. It is just that problem of coming in from the street going across a car parking space to the front entrance. No, we hadn't put any designated footpath zone per se from the street.

Mrs NAPIER - It seemed very car focused, that's all.

Mr PENNY - I guess that's the nature of the presentations to the hospital.

Mrs NAPIER - Thank you.

CHAIR - Thanks once again. We appreciate your presentations and we now require you all to leave so we can deliberate.

THE WITNESSES WITHDREW.