

**THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT  
THE MEANDER VALLEY CENTRE FOR HEALTH AND WELL BEING,  
LANDSDOWNE PLACE, DELORAINÉ, ON WEDNESDAY 9 OCTOBER 2002**

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**DELORAINÉ DISTRICT HOSPITAL**

**PIP LEEDHAM**, DEPUTY DIRECTOR, PRIMARY HEALTH, COMMUNITY POPULATION & RURAL HEALTH DIVISION, **ROD MELDRUM**, DISTRICT MANAGER NORTH, AGED RURAL AND COMMUNITY HEALTH, **LESTER JONES**, SITE/NURSE MANAGER, DELORAINÉ DISTRICT HOSPITAL, **SCOTT CURRAN**, PRINCIPAL PROJECT ARCHITECT, ARTAS, **PETER ALEXANDER**, MANAGER CORPORATE ASSETS, CORPORATE SERVICES DIVISION AND **BILL COCHRANE**, SENIOR PROJECT MANAGER CAPITAL WORKS, CORPORATE SERVICES DIVISION WERE JOINTLY CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

**CHAIR** (Mr Harriss) - Thank you very much. Each of you has met the other committee members - most of you would know Mrs Napier who joined us during the inspection tour. We are in your hands for the first part of the presentation, so it is over to you.

**Ms LEEDHAM** - The formal part of the presentation will be presented by myself and Scott. The other members of the group are here to answer any questions that may arise throughout the presentation.

What I particularly want to cover is why there was the need to redevelop the facility. Lester has already covered some other things, so I will flip through that quite quickly. I am also going to talk about what services are currently provided, what some of the objectives of the redevelopment are and how they are consistent with *Healthy Horizons*, which is a nationally-agreed framework for improving the health of rural, regional and remote Australians. In particular this complies with goal four of *Healthy Horizons*, which is to develop flexible and coordinated services.

You have a picture there of an aspect of the facility - looking at it from the north. I will move on. Lester covered the fact that it was constructed in the early 1960s, its high-maintenance weatherboard exterior and the problems that that creates, difficult access and entry and poor amenities for patients' visitors and staff, and I think some of those things were clearly demonstrated on the tour of the facility.

I think one of the delights of this project is the extensive community involvement that exists in it and it is not just the department recognising that the building is past its use-by date. It is the community recognising the value of health and community services and wanting to create a precinct that links it with education and ambulance services.

In Delorainé there has been no purpose-built community health area within the hospital and a whole lot of the other community health services are actually located all round the town, in

particular family child health services. We have a range of visiting services, in particular, the psychiatrist and the social worker. I do not think Lester pointed out his office. When you went in the front door, his office is to the right. That is the room that is used for those visiting services. You saw the waiting area. His office is shielded by curtains but they are a bit transparent - I think that is the best way of describing it.

**Mr JONES** - It's a goldfish bowl.

**Ms LEEDHAM** - Yes. For some of these services that are provided, they are particularly sensitive and people would like to maintain their dignity and privacy. That is not possible in the current configuration.

He clearly presented to you the inadequate waiting areas that exist. There is obviously limited off-site parking. It is particularly difficult for the frail aged to try to access their relatives or even access the services - you saw the steep decline they have to come down and try to get up as well - and congestion can occur, particularly when we only have one entrance to the facility.

It is the shared access that is probably the biggest concern of all. That is the ambulance access, that is the general access for patients, the general access for clients getting into the facility, for visiting services. So if you have a number of visiting services here, you have a number of people waiting to see them, plus visitors wanting to visit relatives in the hospital.

The other thing that Lester did not mention is occasionally that is used for the mortuary attendants to remove a dead body. The other exit to the building is what we saw going through the store, so you can imagine trying to get a gurney out that door with a dead body. It is not the nicest and in a small community, where people know one another, it adds to the stress and trauma of those events.

Poor patient amenities - as Bill pointed out to you on the tour, it does not meet any of the building code standards now because of the size of the corridors or the width of the doors. In particular the treatment room which you saw is not conducive to occupational health and safety standards. You can only cope with one trauma victim at a time and there is no other place to appropriately maintain other trauma victims. It is also that huge lack of privacy, having a treatment room right in the middle of the facility. Trauma arrives at all times of the day and night and it can be particularly disturbing to other patients in the hospital.

Cramped kitchen facilities - I think you spent quite a bit of time in the kitchen explaining those problems so I do not think I need to dwell on that, other than it is really difficult to maintain the food safety standards and it is a busy kitchen.

**CHAIR** - The Secretary has just made a valid comment to me that even though we have had the site tour, if there are things that you need to highlight - you have just mentioned Lester spent some time in the kitchen with us and explained the cramped facilities - if there is anything you want for the record to be highlighted for us to refer to at some future date -

**Ms LEEDHAM** - Okay. I was not wanting to repeat stuff that had already occurred.

**CHAIR** - Likewise we might want to get on the record some of the questions we might have raised on the site inspection if we wish to pursue the issues.

**Ms LEEDHAM** - Do you want me to go back and reiterate that when we talked about the poor patient amenities, the problems that that creates for lack of privacy, particularly with intoxicated and noisy patients needing to pass through the corridor to access the treatment room? The poor treatment room - the implications that that has for occupational health and safety - and even for safe practice in actually treating trauma victims. The narrow corridors create problems for staff. If you are trying to move people around on trolleys, it is not the easiest because of the width of the doors. Nor do the width of the corridors or the width of the doors meet current building standards.

Cramped kitchen facilities - the inadequate kitchen facilities make it really difficult to meet food safe standards. It is a busy kitchen, it provides meals on wheels, over 5 000 meals per annum. It is also now providing meals for the day centre as well as for the patients who are in the hospital. As Lester said, when the building was originally built the kitchen was an afterthought. It would have been built as a kitchen just for 20 patients in the hospital, assuming that it had full occupancy. There would not have been any foresight 40 years ago of the growth of this site and the range of services that would be provided from it and obviously the benefit of expanding the range of meals that are provided.

**Mr MELDRUM** - If I can also add that we no longer construct our kitchens with wooden cupboards and wooden shelves. Generally we use stainless steel.

**Ms LEEDHAM** - The other huge problem is limited storage. That is just one aspect of the storage. Because a lot of the in-patients of the hospital are people awaiting placement or it is being used as a step-down from the LGH, there is a significant need for mobility aids - wheelchairs, frames - and there is nowhere to store those. Once you start cluttering corridors and rooms with those it then starts to become an occupational health and safety hazard for staff as well as for the patients.

There are ongoing maintenance issues which again impact significantly on infection control. There are leaking windows and ceilings, particularly in the sunroom area in the northern part of the building as it is exposed to westerly weather. The frames leak and so there are all sorts of problems in keeping that room warm in the winter, let alone keeping it cool in the summer. The lifting tiles, as you can see, make infection control difficult. This building is actually past its use-by date. The cost of trying to maintain it is lost money when we could be using it more effectively if we had a modern building that is far easier to maintain.

If I get on to the services, at the moment what is provided from the facility is 20 in-patient beds. Patients are admitted to those beds by the local GPs and at the moment there are five GPs who have visiting rights to the facility. This facility plays a significant role in transfer from the LGH. It is half an hour from Launceston, it is 20 beds, and so it provides a beneficial step-down role. There are really good protocols that exist between the LGH staff and the Deloraine staff so that

the patients who are transferred are patients that this facility can cope with. At the moment, you can imagine this facility could not cope with clients with wandering dementia.

This facility plays a valuable role in providing accommodation for long-stay patients awaiting placement in nursing homes and we all know the dilemmas we have at the moment with the significant waiting times for nursing homes. It actually plays a valuable role in the broad health system so it is not just a facility for this community, it is a facility for the broader health system in the northern region.

The other centres that are provided on the site is the day centre, which is conducted in this building; there are a range of community care services - nursing, personal care and home care; oral health services; children's dental services are provided from the existing building and physiotherapy visits one day a week. It should be a visit three days a week but we have staff shortages in the recruitment of physiotherapists and consequently the service has had to be reduced to match the ability to provide the service. The day centre works two days a week and it provides services for approximately 22 clients at the moment. The other benefit of this building is that it is a meeting room for the community, so it serves a dual purpose.

Getting to the day centre facility - and I guess this is a really good example of community involvement and community desire to get a service up and operating - a day centre operated in Deloraine some time ago in the senior citizens hall but it was recognised that that really was not appropriate - it did not have appropriate wheelchair access nor was it conducive to all of the activities that can occur within a day centre - so the community got together and raised money through the Home and Community Care Program. Organisations like Apex, Tas Alkaloids, the Pratt Foundation and the Rotary Club all donated money to build this facility, plus the State Government contributed a proportion of that money. It was done in a way that would fit with the future redevelopment of the site and was to build on the services that could be provided from the site.

Part of what led to that, too - and I guess, Greg, you probably know more about this than Lester and I do - there was a community development fund that the Meander council actually accessed and they employed a community development officer who did a needs analysis in the area and that work led to the desire to have all of the health services co-located in this precinct because of its being adjacent to the schools and to the ambulance service and hence the push to get everything up and going.

This is a wonderful demonstration of community involvement in the facility but also a community that has embraced the future of health services. This is not a community that is clinging to its past and saying, 'We want a hospital', it is recognising that to improve the health and wellbeing of the community you need to have a whole range of primary health services as well and they needed to be co-located on a base for those services to be provided from.

The project objectives were obviously to improve the patient comfort and amenities for inpatients, it was to improve community access, it was to co-locate a range of services on one site and it was to attract new services. Once you have proper consulting rooms it is much easier to say to visiting services, 'Yes, there is a need in this community and here is a facility that

you can work from'. Some services are reluctant to move into communities unless they can meet their standards in delivering the services and, at the moment, you would have to agree that the existing infrastructure is not conducive to services needing standards of privacy and dignity.

We might move on. The challenge then was to design a facility that obviously provides a quality environment for the patients, visitors and staff, facilitates community access and involvement, and encourages services to work together to provide coordinated care. I think we have come a long way in health as we tended to view services as being separate little services and they did not actually work together whereas what really came out of the development of *Healthy Horizons* was how if we are going to appropriately meet the needs of rural communities all the services need to work together and they are to be co-located in a way that facilitates that. This was the challenge that was presented in this project: how do we design something that would enable us to do that.

The other challenge is that we need to do crystal ball gazing when we are developing these facilities and we should not just develop them for what we know now; we need to design a facility that is flexible enough to meet future needs. The needs of health services have changed. Years ago we did surgery and we delivered babies and various other things in country hospitals. Quality and safety standards now do not enable us to do that; far better if you move to a major hospital for those sorts of treatments.

The other thing we needed to do was to maximise access to new technologies such as computers, videoconferencing and networking of computers.

The benefit we have got out of this project is something that is going to co-locate all health and community services. It is going to encourage integration of existing services and it has the potential to attract new services. I think I reflected on that a bit earlier.

What I want to do is to hand over to Scott; he is going to talk about the design response.

**CHAIR** - Mr Curran, you might just keep in mind, if there is any particular point you wish to make, that we are looking at diagrams and Hansard certainly isn't.

**Mr CURRAN** - Okay.

One of our first considerations in the design of this building was to look at the community that we were designing the building for. Deloraine is a fantastic community; we have worked with them previously. They are very practical people, they are very enthusiastic, they know what they want and they know what they need as a community. One of the things that we didn't want to do was to give them a building that wasn't any good to them, that they could not take ownership of. We have had a fairly exhaustive consultative process with the local community to ensure that everything we were giving and everything we were proposing was what they wanted. They also had some fantastic ideas that we were able to incorporate into the design of these buildings as well.

We were very lucky also on the first day that we were here for there to be a function in this room and to witness elderly people trying to get out of their cars to access this building. It is very difficult for elderly people or people with a disability or even people who are in recovery mode from an operation to walk on an incline or a gradient or to have to walk down steps to access a building. Parking up on the street in Landsdowne Place and accessing the front of the community centre is very steep and there is a risk that people could fall. One of our prime objectives was to make the buildings accessible to people. There was also a strict requirement on us now to meet the disabilities code; that is also an important consideration in the siting of the buildings and gaining access to them.

As part of that access we determined, as we went through the site, that to enable us to keep this community health building and to build a new hospital we would need to split the two functions and to have separate access to the two functions. What we are proposing to do is to develop a car park on the lawn directly out in front of this door, so cars can enter directly off Landsdowne Place - can drive straight in here. We are going to develop this car park so that the elderly have direct access into the community health centre, either through this door or the main entry door on the other side. With the access for the community health centre, they also require access down into the hospital. A lot of the functions are also associated with that. People come here, they meet and gather and then go down into the hospital for other treatment such as physiotherapy, so they need to be able to get down there and access it relatively easily. What we are proposing is that we redevelop a new path, which is down the side of where we walked previously. The old path runs down the side of the building, underneath the trees and then across this area. We are proposing a new disabled access down this side to meet the disabilities code.

The other important factor when you arrive at a hospital is that you can easily identify the entrance, and that was also another important consideration when we were considering access. We are proposing to form a new access off East Barrack Street, down in the bottom corner of the site - excavate a large section of the site out between East Barrack Street and the existing roadway. We will be keeping the retaining wall that is closest to this building and demolishing the other one and excavating out of the bank, forming a batter around this area and developing car parking spaces, a turning circle and entry access in through this area. I will talk more about the services a little later on.

The other consideration we had as part of our design response was to look at the existing buildings to determine whether or not we could use the buildings. One of the most important things in developing a new hospital or a new building of any sort now is to maintain maximum flexibility of that building so that any future needs that may arise out of that building are able to be catered for. A major restriction of the building type that we have at the moment is a lot of load-bearing internal walls, which make it very difficult for us to increase the size of wards. We need to take out walls, install lintels, prop, brace, do all sorts of things, which becomes very costly and expensive.

The external fabric of the building is weatherboard, with timber windows. We would need to replace those to try to minimise the long-term maintenance of the building. After considering all those things, it does not become economically viable to try to refurbish a building of this era and

of this type. So the decision was then made to demolish the existing buildings and to start with a clean palette.

Our approach when designing this building was to try to maximise the sunlight and the views on the site and to make all the spaces within the building as special as we could, given that we had some patients who were here for short-term recovery and some who were here for longer stays. One of the most important things that we felt as a group was that each of those rooms should be able to access sunlight for long periods of the day, so the decision was taken not to put any wards on the southern side of the building. One of our prime design considerations was that everybody, every room, every patient in the hospital had an opportunity to access sun so that in winter, when we have those cold mornings but we have sun, they were able to open their curtains and allow direct sunlight into their room - to be able to sit and enjoy the sunshine.

The other crucial thing for us as well was to try to separate out the services. We heard previously that there are problems with servicing the hospital. Hospitals have lots of activities going on: garbage delivery, food delivery, Meals on Wheels pick-ups, ambulances arriving, patients arriving, visitors and guests arriving, people coming for day treatment. A lot of activity goes on and one of the other objectives was to try to separate those activities out so that they did not cross over one another and try to alleviate some of the congestion that is currently occurring in the main entry. The decision was then made to try to separate out a couple of those services and a couple of those functions. What we have done is to separate out the ambulance function, which is at the front directly off Landsdowne Place - to utilise this driveway we have at the moment, the ambulance would come down the driveway, turn into here and then reverse back into the ambulance bay that is between the hospital and the community health centre. Also in this area we have located the kitchen, primarily because of the functions and the servicing that are associated with it, to enable food deliveries to go to that area, to enable deliveries of detergents and disinfectants and all those other things that arrive, to allow pick-up for Meals on Wheels. We have allocated a space over here so all those functions can occur and not block the entrance to the ambulance bay.

We have also separated out the accident and emergency entry, which is over on this side with the ambulance bay, so that cardiac arrest, cuts from a drunken person late in the night, are all separated out from the very public face that we have on the entry here. The main entry is off East Barrack Street, provided with new car parking. There is a drop-off point in this area here - and that is basically where visitors would arrive, it is where you would come for day treatment, to see the dentist, to see the physio, to see the local GP.

Also when we were looking at the design, an important thing for us was the aesthetic of the building. What we wanted to do was to create a homely environment for these people who live in a rural environment. We did not want to create a modern building with lots of glass and steel that they weren't accustomed to. We looked around the local surrounds and what we would like to do is to use some of the existing elements - the gables, the pediments, the shapes of the roofs, the building materials - and incorporate them into this building so that we have a building that truly belongs in the middle of Deloraine, that patients can associate with. Our aim is to make the rooms, even though they are hospital rooms, as functional and as homely as we can

possibly make them so that the community can take ownership and these people can really feel that they have a place to go to.

We are using brick veneer construction, metal roofing, aluminium-frame windows to try to cut down the maintenance on the building so there is very little ongoing maintenance that needs to be done on the exterior. At the moment the weatherboards need to be painted, timber windows need to be replaced - all those things that are ongoing maintenance that require additional funding.

The interior of the building is all non-load-bearing construction so that in the future, if the needs change throughout the hospital, there is an opportunity to demolish walls and to move walls so that larger wards or larger areas can be created. We have also located the ensuites on the exterior of the building to enable the servicing of those ensuites to be a lot closer to the exterior of the building. Some hospital design incorporates the ensuite on the corridor side. We have deliberately not done that this time because as soon as we put an ensuite into the middle of the corridor it cuts down our flexibility. The effort to demolish a toilet or shower is much greater than an effort to replace a timber plasterboard wall. We are looking at locating all our services down the corridor and then feeding off into all the rooms; that will also help to give us maximum flexibility. We are looking at having separate controls in each of the rooms as well. We spoke about heating before; each of the rooms will be individually heated by a ceiling heater. We are putting sliding glass doors into each of the wards to enable patients to physically walk out onto a veranda so they can sit outside. If they are not able to get out of bed, they are able to pull back the sliding glass door and experience the exterior.

It was mentioned that it is incredibly cold in winter and very hot in summer. We have created a large overhang on the face of the building to enable patients to sit out in the sun but also to enable this hot westerly sun in the middle of summer not to shine directly into these rooms. Because of the low nature of the sun in winter the sun will come underneath the veranda and shine on the windows through the areas here.

Each of the ensuites complies with the disability code; they have all been designed for a wheelchair to be able to manoeuvre around within them. The doors to the wards are a door and a half to enable the beds to be moved in and out more easily. We have a combination of double and single wards. At the end of each of the buildings we have created a small lounge/dining area that will enable patients to sit with their relatives, have something to eat with them, and to maintain their lives as normally as you can when you are in a hospital environment.

Another feature of the design is that on the back of this spine, as we are calling it, which is the corridor, are put all the things that do not require any sunlight penetration - things like storerooms, servery room, the laundry, disabled toilets, dirty linen/clean linen - all those functions that do not require that they take up our valuable northern orientation with the sun.

Lester spoke before about not having the facility to have someone stay in one of the bedrooms. What we have done is created a bedroom here that is a little bit larger and enables a camp stretcher or a fold-out bed to be placed in the room, so if that need ever arises they are able to do that. Videoconferencing or telehealth is in the staff room and also in accident and



emergency. The kitchen is in the bottom half of the site, which is close to all of the accessing. That is pretty much the hospital part of the development.

In association with the hospital we have also designed the day facilities - dental, physio, GPs, X-ray consulting - all those functions that the public access externally on a day-to-day basis. We have also tried to separate those out slightly to enable the hospital to function as a hospital without the other facilities impinging on the way that the hospital runs.

Another important consideration for us while designing the layout of this was the staffing of the hospital. I think the original master plan that was done some years ago spoke about having a series of buildings across the site to accommodate those functions. One of the decisions that was taken early was that we combine all of those functions so that we enable staff to interact with each other all day. They can move through the hospital and all of these functions are under one roof which enables all of that to happen - staff interact, patients interact and the public are able to come in and access these facilities as well.

At night, when the building is shut down, accident emergency entry would be through the back of the building which is in close proximity to the nurses station. This enables the hospital hub, if you like, to operate at night while maintaining some quieter areas at either end for the patients.

It may be worth having a look at this diagram before we move on. This is the site plan of what we propose the building to be like upon completion. This is the existing ambulance building here off Landsdowne Place and the existing community health centre. This is the new car park that we are proposing to develop in this area off Landsdowne Place with access directly into this building. This strip of trees that we have through here at the moment is the asphalt driveway that runs down through here. This is the new car park, the excavated bank and the new entry into the hospital.

Another decision that we made with the roof of the building was not to have a great big high roof but to create a series of smaller roofs so that we could create a village-type atmosphere with the building rather than having a great big building under just one roof. By having these smaller roofs we have been able to keep the height of the building down and generally keep the scale of the building much smaller than it would be if you put a bracket roof over the top or a single span roof.

This is the loading bay in association with the kitchens, ambulance entry, and we have been able to provide some additional car parking down in this corner of the site. We are looking at developing paved areas off the front of these buildings to enable patients to go out and interact in this area here in both those spots.

Lester spoke about storage being a major factor. We had incorporated some storage into the hospital but it is necessary, with the amount equipment that he has, to provide a new storage shed in the back corner of the site. It will be for wheelchairs, beds - all the things that we are not able to accommodate inside the hospital here at the moment.

To build a square metre of storage inside the building is between \$1 000 and \$1 100 per square metre. We felt that it would be a lot more cost-effective to build a new storage shed away from the existing building, which we could do for about \$700 per square metre. This obviously helps us with our budget and making our money go a lot further within the hospital.

In all of these rooms that are through this area we are looking at using natural ventilation through the use of skylights. We are using natural ventilation through all of the hospital except for A and D and the treatment room that would be airconditioned. The kitchen has a kitchen exhaust and also has cooling fans, and we are relying on large volumes of air flowing through that kitchen to enable it to stay cool. I think that is pretty much all I want to run through.

The timetable for the redevelopment - the construction period for the two stages of the hospital is approximately 12 months. At this stage we would be looking at breaking the construction into two stages. The first stage would see us building 12 beds with eight beds operational through the existing hospital, and we break through this corridor just down back behind the first wall on from the staff room. We are able to operate the existing hospital while we are building this new wall through here. The kitchen function is going to be relocated into an area adjacent to the front entry office. All of the side access will be down through here so the hospital will be able to function off the existing driveway and off this area here for the first six months while we are building this stage. The next stage would be to open this section of the hospital, which would see the kitchen operational along with accident and emergency and 12 beds. The second stage would then see the completion of the rest of the wards - another eight beds - with all of the day-to-day functions through here and completion of this car park through this area here.

**Mrs NAPIER** - What's your time frame?

**Mr CURRAN** - On each stage?

**Mrs NAPIER** - Yes.

**Mr CURRAN** - Six months for each stage; 12 months for the total construction.

**Mrs NAPIER** - You will do the whole thing in 12 months?

**Mr CURRAN** - Yes.

We are currently looking at tendering the project prior to Christmas - all the approvals will be in place - and hopefully starting in the beginning of January after the builders come back from their Christmas break. We would be looking at completing the building in early January or February 2004.

We have been doing quite a bit of work on the budget since this report was prepared and we have been working very actively on trying to source a number of different materials that will enable us to get the same sort of finishes and the same sort of quality that we are looking for but at a reduced cost. I am able to report that we now do not have a shortfall of \$71 000, that we

are now back on budget and those small changes to items such as carpet, vinyl and ceiling materials will enable us to pick up that \$71 000.

**Mrs NAPIER** - What is the full budget figure?

**Mr CURRAN** - The full budget figure is \$2 450 000.

**CHAIR** - Thank you very much for that concise explanation of what is intended here. It might be opportune now, before we move to any further presentations or questions, that we break for morning tea. Are there any other presentations to be made to the committee?

**Ms LEEDHAM** - No, that is the end of presentations. We are open for questions.

**CHAIR** - Thank you very much for those two presentations. They were both very concise and have given plenty of detail for the committee now to examine the evidence you have given, or the submission you have made.

**Mr BEST** - Just a couple of questions; one is in relation to new services. I think I read somewhere about podiatry. Could you give us a brief outline of what new services you are contemplating?

**Mr JONES** - We recently put a submission in to Home and Community Care and were successful in that. We sought expressions of interest for a podiatrist to provide a podiatry service on an ongoing basis and we are looking at them at the moment, so there will be podiatry services. Family and child health are looking at co-locating into the facility. There are a number of other services that have expressed an interest in using the rooms - for instance, a rheumatologist who currently is using the physiotherapists room will have a clinic. There is potential for a dermatologist. There will be rooms for the aged-care assessment team to have an interview room to interview people who are looking at going into a nursing home. There will also be the general purpose consulting rooms, services such as incontinence, wound-care services. There is also the John King Hearing Clinic currently here but the room they are using is not particularly suitable; they will be able to use those facilities. A range of others have indicated an expression of interest.

**Mr BEST** - The other question I had was in relation to the site. I was interested to know a bit of background into the decision making to redevelop the site as opposed to a new site. I imagine the existing ambulance service may be one.

**Ms LEEDHAM** - One of the things that led to all this was the establishment of the Deloraine Health and Community Care steering committee and also there was a needs analysis that was auspiced by the Meander Valley Council that looked at health needs for this particular area. One of the strong findings that came out of that was recognising that this was a prime site and wanting to see all the health services co-located on this site because it is adjacent to the schools and the ambulance service. It is also adjacent to Grenoch, which is the nursing, so it is like a precinct of related services. Hence, you have the community saying, 'This is the area that we want to use for the site' and the decision was made, 'Well, what do we do with the existing site?'.

**Mr ALEXANDER** - If I can add to that, in a general sense, if we go to another site, apart from a general disruption to the community, because in a lot of ways they are used to this, there are site acquisitions costs and that can include a lot of service costs and things like that, plus you also end up with the problem of what to do with this site. Old hospitals have caused us a lot of problems in the past, not the least of which are on the north-west coast. You also have issues through the transition and, as you can see, this is staged so that we can continue to use it through that. My interest is from the facilities point of view.

**Mr HALL** - There probably aren't too many suitable greenfield sites around Deloraine, either; they are very difficult to find.

**Mr ALEXANDER** - And relatively flat as well.

**Ms HAY** - You have taken us through some of the measures that you will need to consider if you are only utilising half the hospital while construction is taking place for that six months. Just for the record, and just in case I missed anything, you are going to be moving the kitchen to where the lounge is at the moment. How can the hospital function ? Will you still be having all the facilities now offered in those 12 months?

**Mr ALEXANDER** - Yes, we will.

**Ms HAY** - How?

**Mr ALEXANDER** - The kitchen is being moved to an area adjacent to the reception area. There was a single room that we've turned into a kitchen and a nursery area that serviced that single room, so there will be a space there to regenerate the meals that will be transported out from the Launceston General Hospital for that six months that the kitchen isn't operational. School dental services will still continue to run from where they are; physiotherapy will still continue to provide services from where they are based. The second stage of the project, school dental services, will be moved into the dental vans that they use in some places. They can provide services in there for six months whilst their surgeries are being built.

**Ms LEEDHAM** - There has been a whole contingency management plan developed to cope with the different stages. Whilst the services will continue to be maintained, there is obviously going to be reduced bed capacity during that period.

**Mr MELDRUM** - The contingency plan has also identified the risks associated with continuing operation during the period of redevelopment, the same sort of risks we are currently facing at Campbell Town where we are still occupying buildings and delivering services while there is a redevelopment going on. We have a document to that effect which we could table if the committee feels that that would be useful.

**Ms HAY** - I would, if that's okay.

**Mr MELDRUM** - We have an updated version of that. A couple of the dates have changed because of the delays to this -

**CHAIR** - So you will forward us an updated version?

**Mr MELDRUM** - Yes.

**Mr HALL** - I really like the design of the hospital, especially separating the services on the southern end and the wards on the northern end and taking advantage of that tropical winter sunshine in Deloraine.

*Laughter.*

**Mr HALL** - Scott, just in terms of scale and the floor area, what is it in proportion to the old hospital?

**Mr CURRAN** - I can show you on this drawing. The red line you can see around there is the line of the existing hospital and this is the overlay of the new plan over the top of that. This corner of the building stretches right down level with where the existing day room is at the moment and we push right back up into the corner through the retaining wall - up where dental currently is. We push right down to the far extremes to where the fence and the large trees are, and we actually occupy a small section of the back of that existing residence. So in terms of area, we are above the area that we had on the old hospital and that is basically the massing of that old one. We are in the same sort of approximate area but just stretching out a little bit further to enable us to maximise the sun that we have across the site.

**Mr COCHRANE** - The new floor area is 1 527 square metres and I think the old hospital is approximately 900 and something.

**Mr HALL** - So there is a significant increase. We talked about the time frame for construction. When do you expect to get a development application into the Meander Valley Council?

**Mr CURRAN** - As soon as possible.

**Mr COCHRANE** - We are basically waiting on the outcome of the hearing today to be able to proceed with the project.

**Mr HALL** - If the general manager, who is standing for the Meander Valley Council, gets there as an elected member he might have a conflict of interest.

**Mr JONES** - He certainly might.

*Laughter.*

**Mr CURRAN** - We have had preliminary meetings with the planning officer at the Meander Valley Council and everything that we have proposed so far has been favourably accepted.

**Mr HALL** - In terms of staffing, do you anticipate staffing levels will increase or stay about the same?

**Mr JONES** - Maintained.

**Mrs NAPIER** - In relation to the bed occupancy, you have currently 20 beds, and I notice you have five rooms in which there would be double beds per se, two single beds, as I understand it. For what purposes was it decided to make the breakdown into the single rooms and the five double capacity rooms?

**Ms LEEDHAM** - Based on need and the client mix that can occur.

**Mr MELDRUM** - I think Lester can explain. We were initially looking at 20 single rooms but then I guess staff had some input and -

**Mr JONES** - And community input. We had a community consultation - a day, in the afternoon - and members of the public came along to that. We had plans up for people to comment and certainly a number of community members said they liked sharing a ward. That surprised me, I had not thought that would be the case, but we often have a husband and wife come in - perhaps the husband is caring for the wife or the wife is caring for the husband. The carer becomes ill and they will be hospitalised together. We have had many instances where we - I will use a palliative care example - have existing double rooms and if we have people who are staying with us to die, often family members want to stay with that person so we can have that flexibility, I suppose, to use that as a palliative care suite over and above the suite that is allocated.

**Mrs NAPIER** - What percentage of your current loading would be stepdowns? As I understand it, you encourage people to go from the LGH or the Royal Hobart to country hospitals? What percentage of your patients are in that category? What percentage are those who have been identified as awaiting placement? What percentage are by means of accident referred by the local medicos or otherwise?

**Ms LEEDHAM** - I can give you some data that was sourced from the 2001-02 occupancy. If we are looking at admissions, there were 430 admissions for that financial year. Of those admissions, 312 were admitted by the local medical practice, 82 were transferred from other hospitals, 20 came in through the emergency area -

**Mrs NAPIER** - So they are basically walk-ins?

**Ms LEEDHAM** - Yes. There are six others - I do not know what is in that category - two from community care, two that have come from a law enforcement agency, remembering that this facility provides support to Ashley as well. There are a couple who have come from other hospitals - there are four there; there is one from a nursing home and one outpatient.

**Mrs NAPIER** - So in terms of those people who are awaiting placement -

**Ms LEEDHAM** - Sorry, I am just trying to find the list. Of the separations that occurred, eight were nursing home type; eight were social, so they could be either respite or awaiting placement; two were non acute; one was in for geriatric evaluation and management; and four were palliative care clients. So at the moment that is fairly small but, again, part of this is the way that the discharge summaries are written by the doctors. It is how the information is coded and we know that whilst this gives us some indication, it might not give us the full indication as to what is going on.

**Mrs NAPIER** - The reason I was asking it was, as I understand it as part of the plan to try to reduce the number of people occupying beds within hospitals and certainly the expensive hospitals to run, I take it that the cost of a patient would be cheaper in this hospital than it would be in, say, the LGH or the Royal Hobart. As I understand it, there is a new agreement between the Commonwealth and the State in terms of discharge policies. Some of course will be discharged directly into the community and others would be about stepdowns into cheaper facilities where you could deal with people after major surgery and so on. Is it envisaged that this facility would take on a greater percentage of people who are in that discharge category or in the waiting list category?

**Ms LEEDHAM** - One of the things that goes on, Sue, is that there is actually a protocol that exists between the rural hospitals in the north and the LGH around transfer of LGH patients to the country facilities. The big challenge in actually transferring those patients is having the capacity to manage them within the facility. I mentioned in my presentation the issues associated with dementia care and I think Lester could quite easily describe the very colourful example of someone who was transferred who was suffering from dementia who was able to walk out of the facility.

**Mr JONES** - He walked naked through the hospital.

**Ms LEEDHAM** - So there is that issue. The other thing that occurs with transfers from the major hospitals is support by their carers or their significant others and so it is often difficult to transfer an older person who lives in an urban area to a rural area. They do not want to go because of the difficulty that is going to be encountered by their significant others in visiting them. To transfer someone against their wishes is going to compromise their long-term care.

**Mrs NAPIER** - I raised that because initially when I heard what the occupancy was it sounded as if a large proportion would be stepdowns and people awaiting placement, although the figures you gave me do not necessarily suggest that. For that reason I think if you have what would appear to be a very well designed new facility which would be attractive for people to go to, people are more likely to be willing to transfer from intensive care settings into these settings. So how has it gone up to 20 beds?

**Ms LEEDHAM** - We have had 20 beds. Twenty beds is the historic number of beds that we have had here. We are working on a 70 per cent occupancy rate and when you actually look at the other data -

**Mrs NAPIER** - Is that historically established or projection for growth established?

**Ms LEEDHAM** - What - the 20 beds or -

**Mrs NAPIER** - The 70 per cent.

**Ms LEEDHAM** - Seventy per cent occupancy is what occurred in the last financial year and that has been consistent -

**Mr JONES** - Seventy to 80.

**Ms LEEDHAM** - Seventy to 80 per cent over the last couple of years. Obviously as we improve the range of community-based services that occur you are probably less likely to get admissions. So, again in a rural area, admissions will fluctuate. You also have similar staffing levels whether you have five beds or 15 beds. It is once you get over the 15 beds that you add an extra nurse to the shift. There are basic costs regardless of the number of beds you have.

**Mrs NAPIER** - I think we have quite an exciting new development here and I was trying to look at where this sits in the context of planning for these kinds of issues. Do we anticipate there would be increased occupancy of these kind of facilities if are trying to deal with the bed-stock issue?

**Ms LEEDHAM** - Certainly we see that a significant role for Deloraine to play is support to the LGH and stepdown, so that is why there was the decision to maintain the beds in this plan rather than reduce the bed stock. Whilst I said there were acute admissions, when you look at what is known as the DRG data - which are the diagnostic-related groups - when you look at the occupied-bed days for that area at the moment, the reasons that people are admitted to hospital are other facts that influence health status: aged greater than 80, aged greater than 75, chronic obstructive airways disease. They are all issues associated with older people who are using a far greater proportion of the bed days in that area. So you could think that while people have been classified as 'acute' they probably are stepdown from an acute facility. They have been classified as 'acute' for admission here but they are playing that role.

**Mrs NAPIER** - An area that has been looked at is the potential to provide medical support or nursing support within the context of the aged-care placement rather than having to transfer the person from the aged-care placement in your hospital; is that part of the plan here, too? It is a good decision to have a near location. Is that part of the plan?

**Mr JONES** - We do have a lot of admissions from these local nursing homes - Grenoch, Kanangra and Glendell. They do admit to us.

**Mr MELDRUM** - But they would be recorded as admissions by the GP, so within that big percentage -

**Mrs NAPIER** - In terms of the forward plan for this new facility, are we envisaging that it is likely that there would that kind of agreed outsourcing of nursing services for identified critical-case patients actually at the nursing home, rather than bringing them into the hospital? Is that part of



the plan? I know this is being discussed as a possible way of doing it; what I am interested in is the future plan.

**Ms LEEDHAM** - That has not been discussed at this point because there is not the need in this particular community for those areas. When a person in a nursing home has an acute intervention that requires a hospital admission, yes, there is a relationship between the nursing home and the hospital. But wherever possible they are encouraging the nursing homes, because they have nursing cover, to maintain those people within the nursing home facility.

**Mr JONES** - We do provide some consultancy in cases of palliative care. I visit the nursing home to set up that service for them and to give in-service education around syringe drivers so that the aged resident can stay in the nursing home.

**Mrs NAPIER** - The reason I ask it is that we have an ageing society; we are not going to be building another one of these in 20 years, and we are looking at what kind of infrastructure needs to be established to take account of the fact that we are going to get older and sicker, in effect, for longer periods of time.

**Ms LEEDHAM** - Certainly in the planning for this it is not intended to apply for Commonwealth nursing home licences to put in this facility because we recognise that both Grenoch and Kanangra are facilities providing aged care here, and what government wants to do is to ensure that existing aged-care facilities are viable, so I wouldn't want to undermine that. However, in the design of this building it is recognised that this facility does play a role for some people awaiting placement for aged care, so therefore it is a more home-like environment in some of the rooms rather than a high-tech facility.

**Mrs NAPIER** - A further question to that concerns dealing with wandering dementia patients. How does the design accommodate the security issues and the issue of trying to restrict the impact that it can have on other patients and nursing and professional staff?

**Mr JONES** - A lot of the nurse call systems have the ability to detect when a person is wandering. If you look at the northern or middle suite directly behind the nurses station, it is in close proximity to where nursing staff would be. You can set up a room or rooms so that a person can move around that room without setting off an alarm but once they step outside a given parameter, nurses are summoned to that area.

**Mrs NAPIER** - So the technology is built into the building for that?

**Mr JONES** - Yes.

**Mrs NAPIER** - The other question I asked was about the significant number of other services that could well be provided within the centre - which would make a lot of sense. In relation to dental services, is it anticipated that a dentist could be located here? What is currently available in the community?

**Ms LEEDHAM** - These will be dental therapists who are here. Dental therapists can treat children, but one of the projects we are working on at the moment is looking at how we can up-skill dental therapists in line with the changes to the Dental Act so that they can provide some adult procedures. However, for the provision of oral health services we are better off to have our dentists in the main centres: Hobart, Launceston, Burnie and Devonport.

**Mrs NAPIER** - If perchance in the future it arose that, much as you have local doctors who have visiting rights, you have dentists who have visiting rights -

**Ms LEEDHAM** - That would be really nice, but the shortage of dentists that we have in this State, both public and private -

**Mrs NAPIER** - So that is going to happen for the next 10 years?

**Ms LEEDHAM** - The national average that you should have for dentists is about 43 per 100 000; the average, both public and private, that we have in Tasmania is 23.

**Mrs NAPIER** - So if you take, for example, the situation that arose in Scottsdale that it was possible to attract a dentist, because there was already part of a dental facility there - and in fact in the end there was more work in one community than could be justified with a link with Break O'Day - is there an argument to say that there would be a real advantage in having a facility whereby this community could attract a local dentist who could not only provide both private and public services by agreement?

**Mr JONES** - At the moment we have 1.3 dental therapists. There are two surgeries; there is a dental therapist here every day of the week in one surgery, the other surgery is three days a week. There are weekends, out of hours and the days that that surgery is not used when it could be used by a private provider, and indeed we do have a private dentist who comes out once a month to use the surgery on a weekend. There is an arrangement with oral health for that. So there is flexibility there, and when we looked at the design we purposely included that second surgery, because I think the ratio of therapists to the child population is one dental therapist to 2 500 or something like that. We were keen to keep that second surgery so that we would have that option and flexibility if a dentist turned up and said, 'I'd love to use your facility'. We have a dental prosthetist who wants to use the surgery; there is a podiatrist who wants to use the surgery. It is suitable for those sorts of services.

**Ms LEEDHAM** - And certainly dentist surgeries are designed now so that they can be used by both dental therapists and dentists. They are not a different type of surgery for one particular type.

**Mrs NAPIER** - Could you point to which facility is the dental facility?

**Mr JONES** - There is a waiting area and a small reception area.

**Mrs NAPIER** - If it emerged into the future that there was this possibility of providing a location which had private dentists who could operate as much as the dental therapists - we can always

live in hope - where could extensions occur such that you could have them in an approximate setting and avoid the necessity to duplicate the sterilising room, for example, which I think is one of the more expensive set-ups, isn't it?

**Mr COCHRANE** - It is. Within the design, with some of these spaces, we actually have more consulting rooms available at this point in time than we have services to fill them. That was part of the design, to cater for future services. I think it would probably be more likely that we would use an existing space and perhaps fit it out as an additional surgery or a multipurpose room. In some areas like Campbell Town we have a space that is not only being used by dental, it also doubles as the podiatry area. So we have the capacity to have a room that is multi useful.

**Ms LEEDHAM** - Sue, I think if we had a private dentist and the public dental therapists, we would come to some sort of agreement so that you would only use the one sterilising room for both areas. There are all sorts of service agreements that would be in place. If we were to get a private dentist, we would probably then negotiate with them to do a range of public dental work as well.

**Mrs NAPIER** - Yes. I guess that is where I was coming from, too.

**Ms LEEDHAM** - Putting on another hat, from the oral health perspective, we certainly are looking at how we can contract with the private sector to provide some services to public clients.

**Mrs NAPIER** - I was just listening to the extensive array of services that, hopefully, are going to be provided. I have certainly seen the success of the range of services that can work at George Town, even in those decrepit old facilities of theirs. I started listening to the range of areas it involved and I asked myself the question of whether we have enough facilities for the potential for these other allied community health services.

**Mr ALEXANDER** - This a constant problem for us, balancing our future expansion against what we have there. They tend all to be visiting services, so they share consulting rooms. What we have done, in some cases, instead of making lots of small rooms so they have one each, we have made a bigger room with one computer desk et cetera and various lockable storage capacities so on different days it is used by different services. We are cognisant also that over a period of time those services and the proportion of one service to another will change, so we try to be as flexible as possible.

What we have done in our planning - you can be very generic about a lot of the design. There are very few specialist requirements - dental, where you have an infection control issue and treatment rooms obviously but for most of the others it is an office or a consulting room where things can be used very generically with a few passive security issues. For instance, in some counselling situations there is a tendency for a client to get violent so you need a separate egress and things like that, but the idea is to keep things as flexible as possible to allow for those changes.

**Mrs NAPIER** - Are we saying that this area along the back, the community health facilities, that the proximity to the retaining wall is such that it would allow for expansion at a reasonably cost-efficient level? Not that I'm suggesting we expand right now.

**Mr CURRAN** - The most likely spot for us to expand would be off the end of the existing building into the car park and the area there. We have a corridor down here and we would be able to locate services around that area. There was some flexibility around the two consulting rooms that we had there, if that was to ever change its configuration to enable some type of reception to be installed into the area, if the need ever arose, through there, but I think this is the most obvious place for any extension or expansion of that area.

**Mr ALEXANDER** - There are also issues of separation between areas of the hospital which are essentially open to the public at will and areas where you can invite the public in, as on a one-to-one patient basis, and areas which are really confidential, private areas. We tried to design around those and around the parameters of keeping ambulant outpatient clients away from the in-patients so they maintain their privacy, which means we try to concentrate that in one area.

**CHAIR** - The only point that I would like to have as a measure of the record is, Mr Curran, you have given your evidence about the fact that the original documentation which we received showed an overrun on the budget, and you made some comment that in fact you have been able to improve various areas and come in on budget.

**Mr CURRAN**- Yes.

**CHAIR** - The message the committee received from the Governor was for an allocation of \$2.45 million. Can you indicate to the committee just where your budget now sits in regard to that appropriated amount?

**Mr CURRAN** - We are on budget at \$2.45 million.

**CHAIR** - Okay. The documentation which we have in front of us indicated that you were hoping to trim maybe \$80 000 from the original estimates and therefore you would have come in at less than \$2.45 million, so at this stage things are looking reasonably tight, in fact, to come in right on budget. The only other point I would like to add - and then as a question - the contingency is \$95 350. From your experience, what generally would be the expenditure of the contingency? I wouldn't have thought there are too many difficulties with this particular site where the contingency sum would be used.

**Mr CURRAN** - I think wherever you have an existing building with existing services there is always a danger with what you are going to find when you demolish the building and excavate underneath. One of our concerns at the moment is probably the existing stormwater and sewerage connection. I think probably that is the thing most likely that would be expended as part of the contingency. The documentation that we currently have enables this project to be managed quite tightly on site, but I guess the contingency lies in site works that we need to do and the existing infrastructure that we currently have on site.

**CHAIR** - I guess you've been fairly tight with the contingency anyway because 10 per cent often is allocated as a contingency and you have only allocated 5 per cent.

**Mr CURRAN** - Five per cent is what we would normally allocate as a contingency.

**CHAIR** - I commend you for the design in terms of providing a decent living facility for the in-patients with the north facing et cetera, it just raises the question of the two rooms on the most northern extremity of the complex not in fact having that available to them, where their windows are facing east and west, and we have a solid wall on the north elevation of those two rooms. Is there any particular reason why they can't be treated the same as all the others and have that facility available to them?

**Mr CURRAN** - We were conscious of trying to maintain some flexibility in that room and with the location of the bed and with the location of the ensuites in that area, we felt that it would be best for them to view into the courtyards and to be able to be part of the activity that is generated in those courtyards and be able to view back and see people actually sitting outside their rooms on their chairs or whatever rather than viewing directly north, and we were concerned about the amount of heat gain that we were going to get basically through that end window. So there were a number of considerations inside to actually make that end wall blank, even though it does have a very good view in that direction and very good sun.

**Mrs NAPIER** - Could you put a feature window in of some kind, even if it was a smaller window? It seems a waste of a good wall if you have a north-facing wall and you do not get some sunlight from it.

**Mr CURRAN** - We have actually got glass windows in the end of that corridor wall and so as you are walking down that corridor you are still looking towards the view in the bedroom.

**Mrs NAPIER** - And actually view that patient.

**Mr CURRAN** - The prime consideration now is the location of the bed and being able to move the bed around in relation to the ensuite.

**Mrs NAPIER** - You could put a nice round circle window with stained glass.

**Mr CURRAN** - That would be the only one we have in the facility.

**Mrs NAPIER** - Structurally there is no reason why not.

**Mr BEST** - You don't anticipate with the location of the ensuites any particular shading problems with some of the rooms?

**Ms HAY** - Of the sun coming into the rooms and the ensuites being without.

**Mr CURRAN** - One of the things that we considered was having a large expansive window in each of those wards and it was a combination of a couple of decisions that led to us actually

placing the ensuite into that area. The size of the windows is equivalent to those double doors that we have there at the moment. We felt that the future flexibility for the hospital was also of prime importance to us and as soon as we moved those ensuites back into the middle of the building it takes away that flexibility so in the future whatever changes may occur, that was a crucial decision for us to be able to maintain that. We felt that with the size of the window that we were able to get into those rooms and with the sunlight penetration of winter and being able to keep it down in summer, what we were able to provide was going to be suitable for the use that we have.

There were other comments too about 'You're taking up part of the view' and they were all very carefully considered before we actually decided to put them into that location.

**CHAIR** - We thank you very much for the presentation and the delegation.

**THE WITNESSES WITHDREW.**