THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON FRIDAY 9 DECEMBER 2005.

ROYAL HOBART HOSPITAL SHORT-TERM WORKS PROJECT

Dr PETER LESLIE, CHIEF EXECUTIVE OFFICER, ROYAL HOBART HOSPITAL; **Mr BRUCE WOLFE**, DIRECTOR, CONRAD GARGETT (ARCHITECTURE) PTY LTD; **Mr ROY CORDINER**, CONSULTANT, **Mr KEN MOORE**, PROGRAM MANAGER, ROYAL HOBART HOSPITAL AND **Mr PAUL GEEVES**, ROYAL HOBART HOSPITAL DEVELOPMENT PLANNING WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome, gentlemen. Mr Cordiner and Mr Moore are fairly familiar with the processes of this committee. We are informal about how we proceed, so we will take your evidence. Roy, you may need to provide the explanation as to the two messages.

Mr MOORE - I am happy to do that. As we have discussed on our site visit, the project was originally envisaged as a two-stage project. Work was to be done on the theatres initially and then some other works later. Because of the practicalities of looking for a much better and more cost-effective solution we then proposed that the project be done as a single stage and therefore the second submission overrides the first.

CHAIR - Thank you. With that, whoever is going to lead off in the submission, please, and then we will come to questions at the end of your total contribution.

Dr LESLIE - Mr Chairman, you and the committee members have had a chance to read the documents but, very briefly to summarise, this is a project about providing space in a very tight hospital situation. Essentially it is a single-stage project, as has been stated, known as the infill building - to give it a name. It is about four levels of construction, the first two offering flexibility in terms of office space and so forth, but level 3, as the committee has inspected, providing needed space for a paediatric intensive care area and the neonatal intensive care area at level 4, giving space to the perioperative unit and particularly the construction of two new operating theatres and a series of moves that will give storage space and flexibility for efficient operation in the building.

I might ask Bruce to outline on the plans how that fits together.

Mr WOLFE - I might refer to the plans in a little while. There are six planks, I guess, to what we tried to achieve in meeting the functional requirement and one is the operational efficiency. There are a number of demands which we, through a highly interactive process with the staff at the Royal and other members of the Health department, worked through with a number of options to get a highly functional outcome. The second plank

was looking at impact during construction and that is part of a brief; trying to get a solution that results in minimum impact on the rest of the hospital whilst you are addressing the issues at hand. The third was planning to minimise additional infrastructure needed so that I guess that flows into value for money but what I mean by the infrastructure, there are stairs and lifts; if we could possibly use the existing stairs, the existing lifts, so that we could spend our money on providing additional floor area to satisfy these demands rather than putting the money into other things that did not.

Amenity was important. The existing hospital of course is not the greatest provider of amenity for all spaces. Our looking at this infill building is to provide a greater amenity, to provide better use of natural light and to make a more open plan for the hospital.

Buildability had its challenges within that site and we would be addressing that through the way we stage the construction and in fact how we may utilise other procurement methods.

Value for money: we are looking at a very straightforward construction method and very economic use of materials and structure, and regarding the whole-of-life cost, which is perhaps the most important part of costing, we are looking at a long-life, low-maintenance type of facility and one for which, even though its life may be limited for other reasons, the cost of running the units, the cost of operating the building will be as low as we can possibly get it.

If we could look at the functional response to the requirements - and you have all visited the site - I will go to level 3 first which is the paediatric intensive care and neonatal intensive care -

CHAIR - Mr Wolfe, can I just interrupt - and I am sorry to stop your flow - but if there is anything in particular you want to bring to our attention, for the purposes of Hansard, rather than just pointing to a facility you might be descriptive of it if you in fact want us to have that on the record.

Mr WOLFE - Level 3 is the first level that you viewed from H Block and then went to inspect and the existing perimeter of the building follows that line. I am not sure quite how I am going to refer to that for Hansard but if I can refer to one of the plans in the submission. The infill building is this portion that obviously enlarges all of their facilities quite considerably and provides a much more open operation. It gives them greater bed numbers in response to the demands that were outlined and more room for each bed which, as you saw from the visit there, is awfully overcrowded at the moment. We are approaching the recommended size for those beds and certainly with the way that they are serviced, they will be a lot more operationally efficient and the whole unit will be much more operationally efficient.

As you can see, by using this area, adjacent to the key services that provide into that area, it becomes at the end of the day a highly efficient planning solution to an operational unit. The staging will become important as we work mainly in the outside area first and then join the two sections together but there will be transitional stages in getting from what they have now to the final solution.

Questions while I am going along may be worthwhile.

CHAIR - Yes, by all means.

Mr WOLFE - Moving to level 4, the theatre block - that is the area we saw second when we came in through the front reception area. The two new theatres, as part of the infill building, are described in the report as largely for emergency and link very effectively with the upgrade of the facility going all the way down to the new emergency department, thus providing a very focused centre for emergency cover. So the two theatres described, and the preparation areas, are very close to theatre, close to reception and adjacent recovery.

We have additional works to make the existing theatres operate more successfully. As you saw from the end of D Block closest to F Block, there are constrictions for traffic for the movement of trolleys. We are going to ameliorate that by some minor modification works to existing walls, but largely in the relocation of one of the theatres to a position where it doesn't obstruct the throughput of traffic. We can then utilise the area in F Block for those services that are not clearly highly functional to the theatres - change rooms, offices and meeting rooms. The change rooms may be at a later stage but the meeting rooms, offices and storage, in particular, will move into the top floor of F Block.

The other two levels, levels 1 and 2, which are not shown on this plan but are in the report, being in this area obviously central to the hospital, central facilities are being provided, such as offices and training rooms. The training rooms are sorely needed by all areas of the hospital, as are the offices, both to retain and attract staff.

Basically, it is a plan that concentrates our effort in one area; by stacking the development in four floors we limit the impact to the remainder of the hospital.

CHAIR - Thank you, Mr Wolfe. Is there anything further you need to add without the assistance of the plan?

Mr WOLFE - No, I am happy to answer questions.

CHAIR - Are there any other submissions that need to be led at this stage before we go to questions?

Dr LESLIE - Perhaps if I can make an emphasise to add to what has just been said, having been to theatre. The proximity of the two new theatres to that link down to the Emergency Medicine Department, close to theatre entry point holding recovery bay, is of great importance for efficiency out of hours, when the whole of the theatre is not being activated. That is a very efficient solution to the challenge in terms of providing extra space. I would like to emphasise that from the point of view of the overall efficiency of operation of the hospital.

CHAIR - Thank you.

Mr MOORE - I would like to talk about the procurement process. It is a fairly complicated site to get to so we are proposing a managing contractor model whereby we involve the contractor in the very early stages of the proposal to ensure that its buildability is maximised, that we gain the inputs of the contractor in telling us how he can get

materials into the site and so on. As a result of that, we are proposing to access the site via a tower crane, which will be able to lift materials from Liverpool Street, right over C Block - the old original hospital building - into this building site. The managing contractor provides an overall service of, as I have said, managing the contract while the works are done under subcontract arrangements and are tendered in appropriate packages as we progress through the project.

Mr STURGES - In relation to the tower crane, is that going to have any implications at all on the existing work going on with the Department of Emergency Medicine, if you are going to erect that at the Liverpool Street side of the building?

Mr MOORE - In the proposed managing contractor model, we have looked at a range of options as to how we might set that up. It is clear that the only way we can do it is by appointing the existing DEM contractor - that is the company contracting for the emergency department - to undertake the managing contractor role. In talking with them about how that site could be accessed, a key factor was to ensure that it didn't in any way disrupt the completion date of the emergency department. In fact, there is quite a significant window of opportunity for us to install a tower crane on the DEM site and build around it and then take it out again prior to completion of the DEM, so it actually works very well.

Mr STURGES - I wanted to get that on *Hansard*.

CHAIR - Just before we proceed, I know I speak for Mr Sturges and Mrs Napier, who were able to undertake the site visit. Mr Hall couldn't join us. That was, as was our tour of the DEM some months ago, incredibly revealing as to the challenging circumstances in which you work and it helps focus our attention on the plans we have before us. Thank you for providing that visit this morning. It was extensive and gave us an insight into the challenges of the site.

Mr STURGES - I will frame the question to Dr Leslie, but he may care to deflect it. You spent a bit of time talking about how the infill building is going to interface with existing services and new services from the DEM, and how it will complement existing infrastructure. Would you care to elaborate a little more on that for this part of the inquiry - the dovetailing effect, the synergies that exist?

Dr LESLIE - A critical relationship exists between an emergency department and the areas of the hospital, such as the operating theatres and the intensive-care ward areas, for critically ill patients who need to be rushed there for definitive treatment. The solution in this plan is the recommissioning of a lift that is already in place and development of that lift to enable direct access from the basement level, where Emergency Medicine is, up to the operating theatres, and also ready access to the intensive-care ward. That is a critical relationship; it is a time-critical relationship in an urgent medical situation. I think they are very important. There is less of a relationship, obviously, with a neonatal intensive-care ward; that is more related to the midwifery unit, although the paediatric intensive care that we have included in these plans also has an important relationship to Emergency Medicine as well. Other members might like to add to that, but I think this is a critical relationship. If you don't get this right you create problems and complexities, but I think this is readily solved, as you have seen, where that lift is relation to theatres and so forth.

Mrs NAPIER - What happens if you end up with a malfunction in the lift in terms of that relationship? I can see the central role of that lift but if you end up with a malfunction, which you sometimes can in lifts, what is the back-up plan?

Dr LESLIE - There are other lifts nearby. You will have noticed that there are the four lifts close by that are regularly used in terms of access from the other floor areas. Other members might like to comment further.

Mr MOORE - There are a range of lifts available. There is another large lift in the public area of C block as an alternative, which we actually used today. The new emergency department will also access the lifts in A block and H block, at each end of C block. If your question related to what happens if the lift breaks down with somebody in it, I think the answer is provided with the usual emergency call systems, but I would say that anybody who is being transferred from DEM to theatres would have appropriate monitoring and support systems with them. That is why the lift has to be of a larger size, to cope with the number of people who travel with critically ill patients.

Dr LESLIE - As pointed out in the visit, that lift will be a dedicated lift for transport of these patients. The other lifts are used for other purposes and by the public as well.

Mr STURGES - And they are there as a safety net?

Dr LESLIE - Yes, they are there as a back-up.

CHAIR - In the last of the drawings in the set, the lifts are still in very close proximity to the dedicated lift to which you refer.

Dr LESLIE - Yes, really just a few metres away.

Mrs NAPIER - I noticed this project was called a 'short-term works project'. In the very good briefing when we had a look around we know that there is considerable pressure on staff to do the job that they do. In your submission you indicated that the physical nature of the hospital is a relatively small percentage of the cost of the hospital if you take it over time. Throughout this document it keeps on talking about a 10-year period. Even in the comments that Bruce made he said that the building will be built to last but that its life might be limited by other factors. Is this seen as just an interim solution while we wait for phase B of the investigation into what the future of the hospital might be? As I understand it, it is being done by Conrad Gargett (Architecture).

Mr MOORE - The short-term works project is an outcome of phase A of the Royal Hobart Hospital development planning study, of which Bruce's company, Conrad Gargett (Architecture), is the lead consultant. That study is looking at the overall long-term needs of the hospital and evaluating a whole range of options for solving those accommodation needs. We realise that it is a major project and it will take some time to resolve in terms of developing appropriate service to the remodel, looking at options, site options and so on. Any new major proposal would take some time to implement. The hospital has urgent problems, as you are aware, right now and so these are seen to be short-term works in solving the immediate problems as quickly as we can while we are looking in the longer term at more sustainable solutions. The planning study is being

done in two phases. Phase A was a very short study with the objective of looking for some quick solutions.

Mrs NAPIER - Would it be possible for the committee to have a copy of phase A?

Mr MOORE - I believe so.

Mrs NAPIER - How long are we likely to be waiting for phase B to be completed, or do we already have it?

Mr MOORE - For phase B, we hope to deliver a report of a general nature in January. It is a very complex subject, as you can imagine. We are just looking at the very broadest aspects of it at the moment and have already seen a need to extend the scope of it somewhat in terms of ensuring absolute efficiency in delivering hospital services and making sure they integrate with other types of health services in the community.

CHAIR - Is that the study to which you refer on page 6, the one being undertaken by J W Group?

Mr MOORE - No, the J W Group study is looking at the operation of the theatres, just the actual process.

Mrs NAPIER - That is the patient theatre management system?

Mr MOORE - Yes.

Mrs NAPIER - When you look at the site there is not much left on the footprint, is there, and you are basically, as you say, infilling. To what extent has either phase A or phase B considered the potential to just knock some buildings down and then rebuild on site? We had a bit of a discussion on this on the way but I thought it would be useful to get that on the record.

Mr MOORE - It is a point well made and certainly Conrad Gargett (Architecture) are looking at those broad options, whether there is scope to make major changes and redevelopment on the existing site or whether there are alternative sites which can offer more effective transitions to a new facility. Clearly, the hospital facilities are aged, inefficient, do not really align themselves with modern hospitals and they do need major redevelopment. We are very constrained by space. If you think of the original C Block building, the 1930s building, it was designed in an era before airconditioning yet its floor-to-floor height is echoed through the whole hospital because the buildings were built to line up. You can imagine that that is not conducive to building flexible facilities which can easily be altered to suit changing technologies and so on.

Mrs NAPIER - I notice that in one of the buildings that we were going through we came to the connection with the university. This phase A study presumably has looked at the interface with the university, but is phase B also going to look at the implications for the university and the Hobart Private Hospital, as much as for the Royal Hobart Hospital?

Mr MOORE - It certainly has to. The relationship with Hobart Private is a critical one on that site, which will need detailed investigation and resolution. The university has its

own plans as to its future, which may involve us gaining access to much larger areas of the clinical school building and indeed may involve them eventually exiting that building. That in itself could be an opportunity for demolition and starting from that part of the site or it may provide us with a suitable decanting space to allow us to redevelop in another part of the site. You can imagine, it is a very complex range of options that we are trying to assess and, at this stage, we are probably still at a fairly early stage.

Mr WOLFE - In terms of the actual physical planning, at a very early stage, and in terms of other options analysis there is a lot more work in that area to be done. The statement that you opened with 'not much room for a footprint' is one of the biggest challenges in redeveloping the existing site. All the buildings on the site are very heavily utilised so to create a footprint is a very difficult exercise and decanting is an expensive procedure because, if they move out, then you want them to move back in again. Ken alluded to the university building as a building that could be moved out of at some stage and then demolish there. That is quite true, it does allow a footprint, but once again that is a challenge because it is not a very good place for a new building, for the hospital it could be a decanting building and then that would be an additional cost. In short, it is a very complex issue, both building on the existing site and decanting.

Mrs NAPIER - Does phase A, which resulted in this - and phase B - also pick up adjacent building opportunities, whether it is off Argyle Street or some of the other streets? It seems that the police precinct might be an interesting possibility. I am sure they wouldn't think so.

Laughter.

Mr WOLFE - We look at sites beyond the existing campus for possibilities both for decanting or redevelopment.

Mrs NAPIER - You say January is the period in which it is likely to be available?

Mr CORDINER - It is really just an interim report to the department, and then to the Government. There is a lot more work to do after that, when we get some direction from government as to which of the developing options are affordable and fit into the correct budget context within the department's own management framework as it evolves. As Bruce was mentioning earlier, the service profile of the hospital is connected to the other secondary and primary health functions of the department in the southern area. It is a complex subject. I think the focus of the work to date has been on the demand side, looking at the service profile and the functional brief before too much work is done on the master planning side of the various options. It will have to be pretty robust because there is a lot of interest in it obviously.

Mrs NAPIER - We are saying this has at least 10 years. Does what we are currently looking at cater for the demand projections over the next 10 years? Is that why we are calling it a 10-year project?

Mr CORDINER - I would say that what has been done is maximising what we can do at the moment on the site. The projections that are being done now in the phase B service study will reveal some more of this and possibly it might result in transition works. In other words, if you took the prison project which started planning in 1999, it will be completed

in 2006. There is at least a seven-year time frame to build something, so it could well be that new demands arise which have to be responded to in a similar sort of manner than less urgent works.

Mrs NAPIER - Presumably you are taking the ageing demographic and -

Mr CORDINER - Yes, and the change in medical practice and technology and all of those things. I think we would say it is a holding pattern until a new direction is decided, and then there is the whole question about how you get from where you are today to where you are going in the future and how many steps you need to take to get there and how affordable it can be within the State context.

I think at the moment the report we are putting up to the department will be an internal report really saying, 'Look, this is where we've got to thus far, could we have some direction?' - policy direction effectively. At the moment it's a technical effect.

Mrs NAPIER - It would be fair to say that the first part of phase B is a concept or possibilities analysis, that we should have an indication of whether a greenfield site is going to be required by January or February?

Mr CORDINER - No, I do not think it will be that quick. We would have a substantial amount of information about the various options but the options analysis and comparison will only be done after we get some direction as to where they want us to go, what refinement of those possible options are necessary in terms of budget and government policy requirements. I think it would be a bit quick to say we would have something come out in January, but we are looking at the stakeholder communication process at the moment and we want to make sure that there is a much broader communication process in place so we can have some interim advice going out to a lot of people who are interested. We are seeking support from a similar sort of consultancy that we had on the prison program to make sure that we are connected properly with all the people who have an interest in it.

Mrs NAPIER - Regarding the patient theatre management system that you speak about, when I was reading the submission it said that there is an obvious and necessary response to an unacceptable and growing waiting list for elective surgery, which we all know about, and there are also inefficiencies in the perioperative unit, patient and theatre management systems. What are we looking at here in terms of management systems? Is it IT based?

Mr GEEVES - There is an IT component but there is also a process-flow component. At the current time patients go through a lot of steps to get into the facility, have an operation and go out again. J.W. Group is a consultancy from Victoria who we have engaged to process, map and redesign some of these processes so that not only do we develop some capacity with the building works, we also develop some efficiencies with the way we work within the building. That is basically what that is. There is some reliance on IT services but a lot of it is just mapping these processes, taking out all the steps that are either a barrier or non-valuing adding and streamlining that process a lot more. We are tackling this issue of getting people through the theatres from two different ways.

Mrs NAPIER - When we had a look at the new DEM, which I think is an impressive redevelopment, there was capacity built into it - whether it was going to be optic-fibre cable or whether it was going to be done cableless; I am lost for the name of it at the moment - in terms of developing systems for information exchange, moving not so much to a paperless hospital but to streamline some of the information exchange, the record exchange. What is built into this current development or are we waiting until this management system work is done to decide what would be built into it?

Mr MOORE - I think there are two issues there. One is the infrastructure - that is, the fibre-optic cables and things that are put in place. This extension will be appropriately serviced with fibre optic or the high-end copper connections. The other side of it is the software, which is another issue again.

Dr LESLIE - If I could just add, there is less reliance on information systems and technology in an operating theatre, which is a physical procedure environment, than in an emergency department where you are bringing information together. The emphasis of that study is work-flow re-engineering of patterns of how things are done. Certainly the development that we are talking about, the infill building, will enhance that and provide efficiencies which you have been able to see and experience on the tour. We have two separate lines of engagement to provide activity throughput and productivity to theatres, both physically in terms of this project and in re-engineering of the work flows within the space.

Mrs NAPIER - So it is more to do with work flow than information exchange?

Dr LESLIE - Yes.

Mrs NAPIER - This morning I went into the new X-ray Hobart and I was really impressed that everything was up on the screen and being interpreted by someone in Queensland, and then the information came back.

Dr LESLIE - All very digital.

Mrs NAPIER - Yes, it was just amazing.

This patient theatre management system, is there a report on that?

Mr GEEVES - There is. We've gone through the process of extensive interviews and data collection and we are in the process of developing the re-engineered process map, I guess you would call it, with some pilot projects that have fallen out of that. The consultants will be providing a report to the hospital executive towards the conclusion of the project, which will be towards the end of this month or early January.

Mrs NAPIER - So it is not done yet?

Mr GEEVES - No. It is more to map it, rejig it, pilot it and then roll it out further if the pilots work. We have a number of projects done.

Mr HALL - Unfortunately I missed the on-site visit this morning because of a prior commitment. I presume there has been consultation with staff the whole way through and their reaction to date has been favourable, I take it, or unfavourable?

Mr MOORE - Not always.

Laughter.

Mr HALL - Well, you might elaborate further for the purposes of *Hansard*.

Mr MOORE - Certainly. It is an ongoing process. These plans before you are subject to minor changes to make sure we make as many people happy as possible. Clearly, a project such as this has inherent compromise. It is not a perfect solution and we have had lots of feedback. Some of it conflicts, so we have to manage our way through that and get the best result for everybody.

Mr HALL - What are the main issues that are outstanding at the moment?

Mr MOORE - Nothing major is outstanding at this point, as I understand it. There is discussion about how big storerooms are going to be, how they are going to relate, where the door is, minor functional detail issues. We will be resolving there as we work into the room data sheets and every feature in every room will be mapped and specified.

Dr LESLIE - Everybody wants as much space as they can possibly get, particularly in a tight hospital setting. The neonatal area has gone through a lot of consultation work by the staff in the area - the medical and nursing staff. There are some compromises and workable outcomes there. I have been impressed from the outside, as the CEO, to see where that has got to. There is a lot of equipment in the theatre and they might like more room for storage and so forth, but I think we have a practical outcome. There is obviously further consultation and refinement required for the details to be completed.

Mr HALL - Turning to an engineering issue, has the lifting crane contributed significantly to the cost here? I notice that you have a completion date of, I think, December 2006 because of the unusual circumstances in which you have to work. Do you think that will be compromised or are you confident, providing that this committee gives approval, that you can meet that target?

CHAIR - I had a question along similar lines. What percentage or inflation of the costs has resulted due to the constraints of the site?

Mr WOLFE - I will have a go at that. Before the opportunity arose for utilising a crane from the front of the site, from the DEM site, the logistics of building the infill building were very difficult. We would have to gain access via the back of the private hospital and then double-crane equipment, double-crane materials, into an area that is already constrained and then lift. The utilisation of the crane from the front alleviates a lot of those on-costs. Whilst we still pay a premium for building on a very tight site, it is less of a premium than if we had tried to construct it with access from the rear of the site. To actually put a percentage on the cost of building it there rather than on greenfield site is a bit difficult because a lot of the cost is in the way it interfaces with the existing buildings. Tentacles reach out from the planning that we do into the existing buildings. Airconditioning

systems don't just stop at the wall; there is a little bit of feed into other areas. When we refurbish on one side of the building there is a bit of refurbishment that has to happen on the adjacent side, so it is a little bit difficult to say what are the impacts of it being in such a tight and crowded site. Certainly there are great advantages in both cost and time in being able to access it from the DEM construction site rather than from the area at the back.

Mr HALL - Will the particular difficulties with the site cause any problems with that completion date of December 2006?

Mr WOLFE - We believe that that is achievable at this time.

Mr HALL - On page 7 of your submission it talks about the growth in elective surgery waiting lists being slowed by the use of weekend and after-hour sessions and by the use of private sector providers. Overtime to reduce waiting lists is not sustainable because of impacts on staff, et cetera. Do I read into that that current staffing levels are very tight? Could you in fact make more use of the existing theatres by having more staff to play with? Is that possible or is recruitment difficult?

Dr LESLIE - Recruitment is difficult. It is everywhere that you go. With more staff and with re-engineering we believe we can increase throughput in terms of the elective work, so it is really a multipronged attack on activity and throughput and flow both for urgent emergency cases and elective work.

Mr HALL - So you are confident that, once these new theatres come on line, you will still be able to recruit those staff?

Dr LESLIE - Yes. Good new facilities help attract staff to an area. You don't just build it for that purpose alone but good facilities make a good working environment for the team and that will help attract staff in itself.

Mr STURGES - The percentage of emergency work in the theatres as opposed to elective surgery - what was that figure again?

Dr LESLIE - It is about 40 per cent, which is a very high percentage in any hospital. It is quite a high proportion that comes through as emergency work. Of course that arrives on the doorstep as it comes and you have to then adjust because it is urgent.

Mr STURGES - Whilst I acknowledge that and I acknowlege there is only so much you can do with resources available, but would the new theatres allow better ease of management if they are approved, will that allow better ease of management of the current blockage that you get as a result of the high percentage of emergency work?

Dr LESLIE - Yes. That will enhance that, partly because of where it is situated, the efficiencies that you will have been able to see right at that front critical point near the lifts. So you can operate the theatre out of hours, in the middle of the night or at weekends as a very efficient unit and also during the work day, when you have elective work going on with the dedicated theatre right there, those cases are able to be more efficiently processed. So it enhances the efficiency by the physical positioning of that emergency theatre.

Mrs NAPIER - You currently have seven theatres?

Dr LESLIE - Yes.

Mrs NAPIER - So you will have nine functional theatres under this design -

Dr LESLIE - Yes, that is correct.

Mrs NAPIER - as compared to eight that you would have had if you had gone for the previous configuration?

Dr LESLIE - Yes.

Mrs NAPIER - I was interested in the comment that the growth in elective surgery waiting lists is being slowed by the use of weekend and after-hours sessions and by use of private sector providers. What does that refer to - the cardio work?

Dr LESLIE - No. We have contracted using private facilities at times. It is only a small proportion that we do to help work through waiting lists.

Mrs NAPIER - So you use other people's sites? Is that Hobart Private?

Dr LESLIE - Yes, and occasionally Calvary.

Mrs NAPIER - Coming back to the point that Mr Hall raised, in terms of the design of the facilities that we have under this plan, if the recruitment problem could be overcome, it would be possible to operate basically for longer hours, beyond cleaning requirements, of course?

Dr LESLIE - Yes. It opens up one of the blockages that is in the hospital, which is the access to theatres and so forth. It creates a more efficient activity and allows increased flow and throughput in working through the waiting lists.

Mrs NAPIER - What would be your current cancellation rate?

Dr LESLIE - I don't have those with me, but I could take that on notice.

Mrs NAPIER - I guess there are always cancellations if there is a major multiple emergency.

Dr LESLIE - Yes.

Mrs NAPIER - My other question is in relation to the neonatal paediatric intensive care units. How many units are there currently and how many will this provide?

Dr LESLIE - You have caught me unawares. I will have to read back through. My mind is a blank, I'm sorry.

Mrs NAPIER - But you might be able to clarify that for us?

Dr LESLIE - Yes, I can clarify it.

CHAIR - I made some notes while we did the visit to the neonatal unit. My understanding is that it is a very high occupancy unit. You currently have a capacity of 16, but even last weekend there were 28 in terms of demand and therefore you had use Calvary hospital's services and Hobart Private. So my understanding is that your current capacity is 16 in neonatal.

Dr LESLIE - We have 10 and six and we occasionally try to squeeze more in because they are a bit smaller than adults, but we have also had to use, particularly the other weekend when we were totally clogged, the facilities at Calvary. That is not for the intensive care of course because that is the only paediatric neonatal intensive care area; that is for the special care areas.

Mrs NAPIER - What are we going to have in this new design?

Mr MOORE - There are 15 special care nursery beds and 11, which includes the two isolation rooms which can be used multi-purpose.

Mrs NAPIER - Are we saying that currently there is a capacity for 16, but the new design will provide the capacity for 26?

Mr MOORE - That is correct.

Mrs NAPIER - And 11 of those will be in the intensive care?

Mr MOORE - Yes.

Mrs NAPIER - My understanding is they are pretty ancient ventilators that they are using in the neonatal area. Do you have a promise from the Government on improving the quality of the ventilators that are there?

Dr LESLIE - There is a separate equipment bid associated with all of this work for all the specialised medical equipment and it is not seen to be part of the building works as such.

Mrs NAPIER - I accept that equipment is usually separate but there was a comment in the submission somewhere that says there is a guarantee in relation to the operating theatres. For example, the Government said, 'I will get you the stuff and I will get you the equipment that is needed to be able to make sure that these additional two theatres are operational and functional' - and I thought that was great - but I did not read that in relation to the neonatal and paediatric intensive care units.

Dr LESLIE - There is an intended program, and I can't give you the details here of replacement of equipment obviously for neonatal or intensive care. I don't have the details with me here at this stage.

Mrs NAPIER - Would it be possible to provide the committee with that information?

Dr LESLIE - Yes.

Mrs NAPIER - I read in relation to the operating theatres that they will not only have the physical shell of the building but the equipment will be there. We saw that storage was one of the issues associated with the reconfiguration of the site but I didn't read that in relation to the neonatal/paediatric areas and I guess I would have been reassured if there was a reference to that in there.

Dr LESLIE - We can get the answers.

Mrs NAPIER - If you would be able to provide some information, that would be appreciated.

There was a question I asked as we were walking through the hospital and it came from the fact that I was informed that there is some concern at the LGH in relation to occupational health and safety and the impact of what I think are called surgical plumes. It is like a smoky gas that is exuded from some of the equipment and I am hearing that there are some concerns about the occupational health and safety implications for nurses. I just wondered if you could give us an update, for the record, on what systems exist in the Royal Hobart Hospital and whether upgrading is required and is being entertained in this redevelopment.

Mr MOORE - I am not aware of that having been raised at the Royal as an issue.

Mrs NAPIER - And I haven't had it raised with me either, it is just that it had been raised with me about the LGH.

Mr MOORE - Certainly the new operating theatres will comply with the latest standards of airconditioning.

Mr WOLFE - Yes.

Mrs NAPIER - Are we saying that it hasn't been reported as an issue at the Royal Hobart Hospital that we know of?

Mr WOLFE - Not that I am aware of.

Dr LESLIE - It is not an active issue at the hospital and it hasn't been.

Mrs NAPIER - There haven't been any reports or anything?

Dr LESLIE - No. The issue is that obviously the airconditioning and the systems in place they are not domestic airconditioning systems so that adds to the cost, as you will realise.

Mr WOLFE - All the services will be to Australian standards and to the Department of Health standards as well, that is the New South Wales standards for areas and things like that. I guess our challenge is that we have to limit ourselves to the area where we are building rather than try to fix the entire hospital and if things were developed at different stages and have different ages it would have been relevant to the standards of the time. We are definitely designing all of the new areas to reach the current standards.

Mrs NAPIER - As I understand it, the operating theatre area that we were in was redeveloped in 1996, could it be then that the exhaust extraction system was addressed at that time?

Mr WOLFE - Sorry, I don't know.

Mr GEEVES - I can comment on the airconditioning. The airconditioning went through an upgrade around Christmas time last year. Prior to that there were shared services between a number of the theatres and individual temperature control was difficult. Over the Christmas break we extended the closure -

Mrs NAPIER - That is right, surgeries were closed down, weren't they.

Mr GEEVES - and we separated out each operating theatre and gave it its own supply and return air and its own temperature controls.

Mrs NAPIER - I think that solves the problem.

Mr CORDINER - Prior to that, in 1996 when we upgraded the theatres, that whole level above and all the plant was replaced - all the air-handling units. New chillers were put in, so it was completely refreshed and further adjusted by that next project.

Mr STURGES - I want to come back to the background and again for the record I want to refer to the very comprehensive report that has been provided to us. My colleague has been quite rightly making mention of issues associated with the existing footprint and the space that is available, and the limitations as a result of that space available. I refer to page 2 of the report, under a subheading 'Background', from the Hospitals and Ambulance Service Division at the Royal Hobart Hospital and submitted to this committee -

> 'A decision to lease out the former Queen Alexandra Wing, now operated as the Hobart Private Hospital, removes some 8 500 square metres of floor space and negated the gains made from that redevelopment. Consequently the Royal Hobart Hospital continues to suffer from insufficient floor space to adequately accommodate its services and to manage the 'churn' creating by evolving service delivery models and medical technologies'.

Mrs NAPIER - I am interested in that issue, too, because it now is being raised as a major concern that that space is being lost. Was it identified as a potential consequence of the lease out of the Queen Alex and what has changed for us now to be dealing with the problem of the impact of that lost space?

Mr GEEVES - Elective surgery waiting lists, the change in the population demographics, and the increased requirement for services - I guess there are a number of issues that are now showing up.

Mr MOORE - I think the issue appeared, from my understanding of it, as soon as the building was leased to the Hobart Private. All the functions that were contained in that facility were then transferred back into the Royal, so all the space gains of building the new B block wards were lost. Everybody was jam-packed in and a whole lot of

compromises in terms of accommodation had to be made just to facilitate that move, so the crush and the resentment I think came virtually straightaway. Since then it has been a compounding issue, of course.

Mr STURGES - That is why I wanted to get that on the record, to put this redevelopment process into some form of perspective.

CHAIR - Any further questions?

Mrs NAPIER - There is a very useful graph on page 5 which shows in terms of a typical hospital life-cycle expenses. Capital expenses are quite small - 6 per cent, to which we referred earlier. What time frame is that established over?

Mr CORDINER - I think that was done as a net present value analysis of whole-of-life costs, so it probably was done - and I am guessing because I extracted this from a value management reference - for 20 to 25 years and brought back to net present values. It said that your continuing cost of staff, at a 6 per cent real rate of return today, would be this whereas the cost of the building with all its expenses would be that. I think that is how they come up to that sort of analysis. We have done similar analyses for other projects. In making budget submissions for the prisons redevelopment program we analysed operating costs and capital costs, doing options analysis and referring them back to net present values. In any building it is almost always a much more significant element. Six per cent is very low for most buildings but it comes about, I am sure, through the cost -

Mrs NAPIER - The relative cost of everything else.

Mr CORDINER - the relative cost of services. In prisons, for example, your operating costs are lower, staffing instruction is lower. I think in schools you would find it would be midway between. Hospitals are right at the top end of that equation, and that includes capital and operating at 6 per cent.

CHAIR - I come to the matter of your expectation of retaining the current contract to Hinman, Wright & Manser; you need Treasurer's approval for that, I understand. Has anything progressed in that area since this report was produced?

Mr MOORE - I have put a proposal to the minister and the Premier suggesting that that is the most appropriate and cost-effective way to procure the works. I have support from both of those areas, obviously subject to the project in gaining the approval of this committee.

CHAIR - There is some good detailed information in your report regarding the case load and how that has built up somewhat of recent times because of the mismatch between supply and demand delivery capability. You indicate on page 7 of your report that over the last two months the waiting lists for elective surgery had ballooned by 200. Has that been a consistent escalation over, say, the last six months or was that just a blip?

Mr GEEVES - Over the last couple of months it has gone up. Over the last 12 months it was increasing at about 25 to 30 patients a month; a steady increase regardless of what we do at the other end to remove them. I can't quite recall the reason that we had such a big

issue over the last couple of months, but all it has done is put 200 on top of the next 24 a month.

Dr LESLIE - It has been a step-like rise, for a reason I haven't been able to ascertain.

CHAIR - If there has been a step-like rise, and if we see a continuation of that, then you are confronting some substantial challenges with regard attention to elective surgery delivery, I would have thought?

Dr LESLIE - It has stabilised. The latest figures show some stabilisation but there is obviously a need in terms of increasing the throughput and access to elective surgery.

CHAIR - What is the staff recruitment strategy to deliver on-the-ground services if this project is approved?

Dr LESLIE - That is obviously important because there's no point in having a facility if it can't be used. We are developing strategies for recruitment in advance - at this stage obviously we are talking 12 months ahead - for manning both of those areas. I believe there is medical recruitment continuing in the various specialties. Nursing recruitment is always difficult anyway for specialised areas such as neonatal intensive care because we can't get staff who are working in a neonatal intensive care area elsewhere in the State; this is the only one here.

Mrs NAPIER - Are you doing that? Are you providing opportunities for upgrading skills?

Dr LESLIE - We are developing that so that we can move in that direction. That is being looked at in parallel. You need to prepare for that a year ahead of the added capacity.

Mrs NAPIER - What about acute care? You might have the additional ICU beds, but if you don't have the acute care nurses then you can't use the beds.

Dr LESLIE - We're following that as well.

Mrs NAPIER - So you're doing that as well. In-house training?

Dr LESLIE - Partly that; all sorts of strategies are being pursued because nursing staff levels are a problem wherever you go. It is no different here in Tasmania. All of that is moving in parallel and well ahead of time in terms of the building.

Mr GEEVES - Discussions are already under way with Deakin University with regard to training theatre staff. There is an ageing population. One of the issues that has been identified is that if we are going to staff the theatres then we need to train people because trained people aren't available. We are looking at educators and running an in-house course. In the meantime, we are engaging Deakin and various mainland universities to provide us with that level of skill.

Mrs NAPIER - When do you think they are likely to start?

Mr GEEVES - I'm not sure of the dates but it is pretty soon.

Mrs NAPIER - Once you have these additional theatres in place and the other associated facilities, what does your modelling show as to what you should be able to do with the waiting lists?

Dr LESLIE - I haven't got that myself but if the other members of the team have looked at the waiting list issues and the impact -

Mr GEEVES - Given the current rate of growth and the theoretical throughput, about 1.5 theatres or 1.3 theatres will maintain the waiting list at 3 500 ad infinitum, so the additional capacity we get out of the other 0.5 of a theatre will go to reducing that. I can't tell you either how many years it will take to reduce it to nothing.

Mrs NAPIER - Can you run me through that again?

Mr GEEVES - We had a look at the growth of the waiting list as it stands -

Mrs NAPIER - Growth in demand, yes.

Mr GEEVES - and we had a look at throughput based on your average case length. It is very variable so it is a little bit rubbery. However when we did that it appeared we could maintain the waiting list steady, without any growth in the elective surgery waiting list, with 1.5 theatres.

Mrs NAPIER - With an additional 1.5 theatres.

Mr GEEVES - Hit 3 500 on the list and there it stays. The additional capacity in that other half a theatre or the other half of time available will reduce it, but it is a bit difficult to tell you how much it is going to reduce it by over how long.

Mrs NAPIER - So it is likely that you will have to continue using other private providers to try to get it down?

Mr GEEVES - We shouldn't have to. We may occasionally but it should be that the additional capacity you get will allow us to get the waiting list to start moving in the other direction. It is probably not going to move fast but it will start reducing.

Dr LESLIE - We should also perhaps go back to the earlier comments that were made about the re-engineering project that is being undertaken in theatre, which is to take our existing resources and improved patient flow in terms of the systems that are better in place there, so this is a two-pronged attack, not just facilities and expansion, but improved efficiency and throughput in the flow.

Mr GEEVES - The review processes are looking at things like patients being ready to go on time at 8.30 a.m. rather than there being a delay and then somebody falls off the other end or reducing the turnaround time between patients in theatre so for every 20 minutes you save between patients you are going to have another patient onto the end of the list, so it is those kind of things that we are looking at as well.

Mrs NAPIER - The other part of this project was offices and training rooms, as I understand it. I know there was some work being done on moving people off site to areas outside

the hospital rather than being on the physical imprint. What has actually been moved off site and where?

Mr MOORE - I think the simple answer to that is very little.

Mrs NAPIER - Okay.

Mr MOORE - To be realistic, there aren't that many people who you can move off site. If you are taking people away from the workface then it is the time they spend wandering backwards and forwards and being unavailable because they are in an office that is off-site. I am one of the people who moved off site.

Mr GEEVES - I'm the other one.

Laughter.

Mr MOORE - But it is very hard to actually move things off site.

Mrs NAPIER - Just some administration planning.

Dr LESLIE - A lot of these offices will be used for medical staff. We have a program of recruitment but it is just having offices for them to work from is very tight. They obviously don't just sit in an office, they are out in the wards and outpatient areas or operating theatres if they are surgeons but it then provides a base and that also helps in terms of recruitment to have those facilities there.

Mrs NAPIER - You haven't moved any of your clinics or anything like that off site?

Dr LESLIE - No.

Mrs NAPIER - There was some discussion about using - I think it is called the police building, isn't it -

Mr CORDINER - The Capita building. I don't think that has progressed.

Mr MOORE - No, it is not an ideal sort of building for that purpose. We have looked at a whole range of options around the city. When things come up the agents come and talk to us because they know we are out there looking for suitable accommodation but finding the right sort of accommodation and having it available when we need it and then looking at the potential costs of fit-out and lease and so on is a very complicated process, as you can imagine.

Mr CORDINER - I think there was a knock-on effect too with the Capita building about where the occupants of the Capita building would go.

Mr HALL - I notice on page 17 of the submission you talk about planning and building approval and it says that a development application to the Hobart City Council is required. Have you lodged one yet?

Mr MOORE - No, the paperwork is ready to go.

Mr HALL - So, given that the Christmas period is coming up and you are talking about an on-site construction commencement of January 2006, are you confident that things are in place with the people at the Town Hall, that you have covered off on most bases there?

Mr WOLFE - Our town planner has spoken with people to ease the passage when we do lodge but we are really restricted to lodging before we have approval.

Mr HALL - Could you explain to me two items that are small in the whole context of project costs: decanting, $246 000? What does that mean? Also, post-occupancy allowance of $150 000, can you explain that, please?

Mr WOLFE - Decanting occurs when we are working in an existing space and putting those same people back into that space after it is refurbished, having to move them twice. There is work done that isn't necessarily the final product but it is work done enabling the final shift into those areas.

Mr HALL - And the post-occupancy allowance? Wouldn't that sort of thing normally go into contingencies?

Mr WOLFE - There are some contingencies that are design contingencies along the way. Once that design contingency has elapsed, that is generally when construction starts, and there is a construction contingency, particularly in a building like this where we don't know for sure what we are going to find when we break open walls and when we try to put footings in locations in the ground that is already covered by a building. So there is a contingency for construction. The post-occupancy is where demands change during the life of the construction, as health planning is something that is continually evolving, so there are issues when people move into those spaces where they want to adapt it yet again to specific needs. This is going back to an earlier question: we have had a lot of interaction with the staff. This building is a particular shape because of the way it is. If you started to build it from scratch it wouldn't be like that. We needed a lot of input from the people who are going to operate it to make sure that it responds to their operational methods as well as best practice methods. At the end of the day, I am sure there will be things that they will want to change because the facility affords them new ways of doing things.

CHAIR - Can I just make an observation with regard those questions that Mr Hall has raised revolving around the timing of construction and so on. I just indicate to you, for your future reference, that there is no legislative impediment in your group, or any group, taking the risk of going to planning approval and tendering and so on contingent upon this committee's approval. So if you need in the future to walk that path then you are at liberty to do that; there is no constraint on you. It is a risk you take and if this committee subsequently rejects a project, you have spent money going to an development application or whatever. I just want to make it clear to you that there is no restriction on you doing that and in fact we took a conscious decision some time ago to allow proponents of projects, if they have everything in place, to go to tender or call for tender submissions prior to the consideration of this committee. Then if that is a risk you run and we don't approve, everyone accepts those risks.

Mr CORDINER - Thank you, Mr Chairman. We had anticipated that by talking to the secretary. In this case it will be a negotiated tender, so we would be not letting the contract until such time as we had your approval.

CHAIR - That's fine.

Mrs NAPIER - On page 8, third paragraph, Dr McDougall - this is in relation to NICU cots and special care nursery beds. Dr McDougall recommended the provision of 15 special care nursery beds at the Royal Hobart and a further 17, 4 and 7 for the LGH, Mersey and the North West. Are those 17, 4 and 7 in place at the LGH, Mersey and North West, or are they still to be upgraded?

Dr LESLIE - I can't answer that

Mrs NAPIER - Thank you.

CHAIR - I was going to ask exactly the same question because it is a component of your submission and it recognises the need for those special care facilities around the State, not just here. You seek to deliver the 15 here but it seems to me that if the others are not in place then, consequential to Dr McDougall's report, I would presume they are desperately in need and therefore the department should be giving some attention to that. However, it is not part of our consideration regarding this project.

Mrs NAPIER - Will we be able to request a bit of information about that as an update on the status of that?

Dr LESLIE - We could get those numbers. There certainly will be beds there.

CHAIR - That is particularly, Dr Leslie, concerning the 17, 4 and 7 for elsewhere in the State - and the 15 you intend to deliver with this project.

Mr CORDINER - Mr Chairman, could I raise a quick matter. It is about the program; it would be really very helpful to the project if we could get an early determination from the committee. I am always saying this with projects. I always wonder why they don't start submissions earlier, but it would be really helpful if we could.

The second thing was that Mrs Napier asked for a copy of the phase A report. Certain matters in that report I think would be connected with phase B rather than phase A alone. I am afraid that if we seek approval to submit that to the committee from the department it may cause a delay, so what I would like, with your approval, is to extract whatever we have in that report connected to the decision to do this project and forward that to you. We would give you the extracts. As I say, the report did have a bit of a wider context, as I recall, relating to some of the wider options for the future. I don't think they are relevant insofar as they were never properly assessed but they may, going on the public record, give rise to concerns and then have adverse reactions.

Mrs NAPIER - I accept that phase B is still under way.

Mr CORDINER - It is really in the melting pot at the moment.

CHAIR - Entirely reasonable.

Mr CORDINER - Thank you.

CHAIR - Can I just indicate to you that we consider the project in the north-west on Monday.

Mrs NAPIER - When do you want this to begin construction?

Mr CORDINER - We would really like to have your approval by Christmas so that we can finalise the negotiations with the managing contractor and get construction started as soon as we get planning approval. We need a building application, so I think at the end of January we would have to -

Mr WOLFE - I would like to reinforce that there is a window of opportunity that exists with the placement of that crane concerning the DEM project.

Mr MOORE - Subject to the committee's approval of the project, we can get the crane in place by varying the DEM contract to put it in place. We can do that fairly quickly and facilitate an early commencement of work.

Mrs NAPIER - So does that actually mean that the same contractor is going to build this project or does it mean that they will just be the lead contractor in charge of the overall site? So you will still go out to tender on that?

Mr MOORE - Yes, he will tender all the packages and only participate in the work itself if he is one of the tenderers that closes the tenders with us, so he is really just a management fee.

CHAIR - Thank you once again.

THE WITNESSES WITHDREW.