

THE PARLIAMENTARY COMMITTEE ON PUBLIC WORKS MET AT GEORGE TOWN COUNCIL CHAMBERS ON 24 JANUARY 2006.

GEORGE TOWN DISTRICT HOSPITAL REDEVELOPMENT

Mr PHIL MORRIS, ACTING MANAGER STRATEGIC DEVELOPMENT, AGED RURAL AND COMMUNITY HEALTH; **Ms EMMA REGENT**, ARTAS ARCHITECTS AND PLANNERS; **Mr SCOTT CURRAN**, DIRECTOR AND ARCHITECT, ARTAS ARCHITECTS AND PLANNERS; **Ms SOPHIE LEGGE**, ACTING DISTRICT MANAGER NORTH EAST, AGED RURAL AND COMMUNITY HEALTH; **Mr BEN MOLONEY**, PROJECT MANAGER CAPITAL WORKS, CORPORATE AND STRATEGIC SERVICES; AND **Mr BILL COCHRANE**, SENIOR PROJECT MANAGER CAPITAL WORKS, CORPORATE AND STRATEGIC SERVICES, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome. With all the Department of Health projects we have, you would be pretty much experts at this now. We will proceed in whichever way you want to share your evidence with us, and after that we will have questions. If it is convenient, we will keep it informal and questions may flow during your evidence.

Mr MORRIS - I will begin, Mr Chairman, with a very brief presentation from the Aged, Rural and Community Health Program's point of view. The George Town District Hospital is part of our program. Scott Curran from Artas will make a presentation also.

I would like to talk about three main themes: rural health services; aged, rural and community health, which is the program in which George Town District Hospital sits; and a bit on the characteristics of George Town. First of all, in terms of rural health services the national policy framework for rural health is a document called *Healthy Horizons*. One of the goals of *Healthy Horizons* is to develop flexible, coordinated services - and that is what we believe we are trying to do here at George Town. We believe that we already have made significant steps to do this, but obviously this proposed building program will significantly improve our capacity to that because we will be able to put everything on the one site. The other policy context for our services can be seen in Tasmania Together, where one of the goals is to improve health through promotion of a comprehensive approach to a healthy lifestyle. Goal 6 is to improve the health and wellbeing of the Tasmanian community through the delivery of coordinated services. Goal 5 is something that we are trying to emphasise more and more. We are interested in the wellbeing of the communities in which we operate.

Our program, as you would all be aware, involves a number of district hospitals, multipurpose services, community health centres and some sites that are run by councils or non-government organisations to whom we contribute funding for various services. You have probably been part of this process for a number of those over the last few years where we have had the opportunity to have new building or renovated building programs to improve our service capacity.

In George Town we have a 15-bed district hospital. This is on a par compared to other areas. We have a community nursing and home-care service. We have some visiting services - and I have listed a few there - we also have services in other locations, not in the hospital building, in relation to oral health and family and child health. We also have regional health services - and I will say a bit more about those in a moment. The great thing about the building, as you have already seen, is its location. It is very central to the town precinct and also to the medical practice, to the ambulance and to the university accommodation house. It is an excellent location and one which I would love to be able to duplicate in other places.

The interesting thing about George Town is that we have a partnership with the George Town Health and Welfare Committee to provide regional health services programs. These are funded by the Australian Government. The George Town partnership was I think the first one established in our program, back on or around 2000-01. That innovative partnership involves the community group, the George Town Health and Welfare Committee, which has received funds from the Commonwealth. They have then contracted us to provide those services for them, so they have had the opportunity to identify the range of services that should be provided but they do not have the responsibility of being the employer or the manager of those services. They contract that to us and we provide financial and service reports to them.

That partnership has been through its first four-year period and we have recently continued that program for the next contract period with the Australian Government. These services are quite interesting. They are not all available in other places through this sort of program. They include domestic violence and to my knowledge that is the only regional health service funded program. That provides some individual intervention as well as community education programs.

We have the child and adolescent mental health, which is a sort of counselling-based service. We have the young parents support service, and a kindergym, which involves physio and exercise programs for young children. It also involves parents attending and that is one of the advantages of the group. There are also some exercise classes and some health education functions.

Now, some of these services are based in the hospital and some of them have to use nearby premises but in a lot of cases the space is not really appropriate. You have seen the consulting rooms from where some of these services operate. They are too small and not really confidential and there are other issues with them.

So our aim here at George Town, as we consider this new building, is to have a new and integrated one-stop facility which combines hospital services along with community health and welfare services. This notion of a one-stop facility was one of the crucial phrases that emerged when we first started talking about this back in about 2000. I think it is a neat little phrase which encapsulates the idea that health and community health and community welfare services are all on the one spot so everyone knows where to go. The opportunity for those services to work together for the good of the community is clearly enhanced. I think the other thing about our aims for the future is that we want to, as the Tasmania Together goal alluded to, focus on wellbeing.

We want to try and strengthen our health promotion and community health approach and obviously again this one-stop facility will give us the capacity to improve our information for the community. It has already become known as a place where, if you want to know something about what is going on, you can ring the hospital or ring the centre. We also want to try and offer comprehensive and accessible integrated services - that is, services that are available to the community where they are working together. We want to provide those to individuals and to families in the whole community within this catchment area of George Town.

George Town is a community of a certain demographic. It tends to have more families. It is a younger community compared to some other rural or provincial areas of Tasmania and we would like to develop our family community health orientation. That is what we have tried to do with the regional health services program, so we are delighted with the opportunity to redevelop this site. It is clearly one that needs a total revamp. We are delighted that the money is available to help us to do that and we are very enthusiastic about this opportunity that it gives us for George Town. This is a significant area; it has 5 000 to 6 000 people, depending on how you count it, and it is clearly a community which has health and welfare needs. We want to be part of leading the service approach to meeting those needs. That is all I would like to say.

CHAIR - Thanks, Phil.

Mr CURRAN - As you have seen from the site, it is not a large site and there are certain constraints on us when we are looking to rebuild. There are a number of ideologies that we have followed through with the design of this building from other projects that we have done - Deloraine and Queenstown. One of those is that when we orientate the bedrooms we really want to people to have access to sun, to a view and to an outdoor area so that if they are well enough to get out of bed they have the opportunity to do so and if they are not well enough to get out of bed then they have the opportunity to lay on their bed, draw the curtains back and enjoy the view. That is one of the paramount concerns that we have with the design of the building. It is about trying to make the patient feel as comfortable as possible and also aid with their wellbeing. So that is one of the key principles around the design.

The other is that, with the integration of allied health and also with the hospital, we need to make it possible for those two portions of the building to operate together but still provide privacy for the hospital section and for patients in the room to make the allied health section easily accessible for people who want to access those functions. We also want to be able to close down sections of the hospital building; if for some reason a ward area was empty then that whole section could be shut down and mothballed so that we are not using electricity, basically making best practice of energy conservation. We also wanted a building that was easily accessible for every member of the public - young, old or disabled. Another key component was that vehicular access was easy to the site. We have looked at reworking the traffic movements. We also wanted a building that integrated in with the neighbourhood. It should not be a huge building that made a huge architectural statement but became something that locals could identify with and feel comfortable with. It had a homely atmosphere. It was able to serve the purpose that it was there for but basically became part of the community, which I think the existing hospital has. We have already heard today how important a part the community play in the building and also with the auxiliary. We do not want to lose any of those things with

the new building that we are providing. We want a good, modern functional building but we want to be able to maintain and provide those things that are synonymous with the George Town community.

We are basically leaving the entry where it is at the moment and creating some parking right at the front door so that people that are coming to visit can park right at the front door and have easy access. We are also creating a one-way access that comes back out and into Cimitiere Street. We retained the ambulance residence in this area here and we are looking at creating a new fence around there to give them privacy when this new development is completed. That will enable them to have a small backyard and easy access to the ambulance station.

We are creating some additional parking in this area here for staff, some secure parking through here for government and community cars, and also providing easy access. I am not sure if you picked it up but while we were having a cup of tea today in the staffroom there was a big truck that has to get in on site and empty the bin that is in this area here and then reverse all the way back out onto Anne Street. What we are looking at doing is providing easy access for delivery trucks, for rubbish trucks, for the gas truck, for every vehicle that has to come and service this facility to be able to get in and get out without blocking any of the traffic.

All the services - basically stormwater, sewer, electrics and water - have to be renewed across the site. We are basically in a two-stage process of demolishing everything that is on the site at the moment. We are doing this in two stages to enable us to keep wards through the older section of the building that we walked through today and also to enable us to maintain a function through the kitchen. Doing that enables us to have a working hospital while we are building the new section through here. Essentially this is a footprint stage 1 through here which incorporates the wards, dental, wards nurses station, back down through the kitchen and the service bay back down through here.

At the completion of stage 1 we will have all of these areas completed through here. It is about an eight to nine-month construction process and then this portion of the hospital will be handed back over. We will move into stage 2 where we will construct this section and do the carparking and the access areas through there. We separated the delivery points into basically two areas. One is that we maintain the ambulance access down this side here, which is important for the Anne Street medical centre. It was important that we had a synergy between the ambulance and the emergency area on this side. It was also important for us as well that we had a really clearly defined entry that patients, visitors, would be able to identify easily. They can walk up through here, come off the street on a flat level, come down on a path which is flat and then into the building on a flat area as well.

The blocks that I was talking about before have a series of bedrooms that are linked together. This would comprise one of the zones that we were talking about before, so if this area was not going to be used then effectively this could be shut down and mothballed and the rest of the hospital could be used.

We have a number of rooms that share ensuite. You will see as we move through the corridors that we have a number of areas that enable us to have storage for all those

things that you saw in the corridor - lifting frames, gas bottles - so those things basically disappear out of the corridors.

We have a series of different room configurations as we move through as well. We have a family room in here that has been designed for a family to be able to come and stay, or for members of the immediate family if somebody needs to have a room. A feature that we have incorporated now as part of our progression and review of facilities is to incorporate a handwashing basin into each of the wards and to also increase the number of handbasins that we have in corridors as well, which is something which we did not have in our previous designs. This has become necessary for the hygiene of the patients. They enable nurses or doctors, if they have seen someone in a ward, to wash their hands before they leave.

As I mentioned before, the design is also about trying to manage the orientation of the sun. A patient lying in the bed here will have access to the sun onto a verandah and visual access to some landscaping. This is about giving them a facility that aids in their recovery.

We have a number of single wards that share an ensuite and we have a number of double wards that also share an ensuite through here. We have a patient lounge in this area to enable the patients to sit and enjoy that view. We have medical records adjacent to the nurses' station.

There has been a lot of discussion about how this area through here should be reconfigured, discussion with the GPs that are next door, also with the nurses and with the local community, and that essentially has dictated the layout that we have through here. So we have the nurses' station through here and a handover room directly adjacent to the nurses' station. The treatment room has been moved adjacent to the nurses' station, with a viewing window to enable staff to view a patient being monitored. There is a sterile store directly off the treatment room and back through into the equipment store. An outside area can be utilised by staff or patients, once again looking out into these courtyards.

Then we move into the allied health areas. As you come down the access you arrive at the main entry. This has been a deliberate design to enable us to limit the amount of access points to the hospital. One of the problems that we have with the existing hospital is that there are a lot of access points at the moment and they are hard to monitor. It is hard to know if a door is locked so we are incorporating all of the security measures that we have had previously on our other projects. All of these sliding glass doors have reed switches on them which are monitored back into the nurses' station, so if a patient gets up at nine o'clock at night, opens that door and goes outside then that will be monitored back into the nurses' station. When the system is switched on they will be able to monitor and know if any of the external doors are actually open.

That leads us to this area here, which is the main entry point. If you are coming to visit somebody, if you are coming for the allied health services, you arrive at this point here, come into the entry and then go across to a section where you will be directed into parts of the allied health section. We have basically four rooms through here that are multipurpose rooms. They can be used as consulting rooms, meeting rooms or interview rooms. That is to give us a degree of flexibility with service delivery so that if we have

different services or functions in the future then they can be accommodated through that area.

We have a discrete entry point, which is a locked door, for patients who need to come to the hospital but don't want to use the front entry - people for drug and alcohol rehabilitation or someone who needs a discrete entry. We have waiting rooms, child and family health with a small play area for children, a mother's room, a baby-feeding room, a storeroom, and physiotherapy. Physiotherapy is being designed like this so that it gives us an opportunity for flexibility once again. There are three beds with screens so that if podiatry or another service is able to utilise that, if physiotherapy is not there, then it gives them the opportunity to do that. We have put dental into this area. Dental needs to have an area that is a little bit removed but is still accessible from the main door. They have a small waiting area. This is designed on a model that we have used previously. The Director of Nursing's office is in this area, in a nice discrete spot but still easily accessible for day-to-day functioning through the hospital. In the central position of the hospital we have positioned all of our services: stores, toilets, clean linen. All the areas that do not require sunlight have been placed through this area, with the exception of the reception and an office. Those offices will be given natural light and natural ventilation through the roof. It is set up so that we have two corridors on either side and all those services are accessed from one side of the corridor or the other.

All of the rooms have been designed to give us maximum flexibility. None of the walls inside the building are load-bearing. Any walls we have down through the centre of this area are on a column grid so that in the future, if in 10 years' time there is a need to change any of these areas, we have the flexibility to remove walls and reconfigure the area, which is also one of the other things that was part of our design brief.

We have a pan room and an office for the community car volunteers. We have a small laundry which does the tea towels from the kitchen. All the laundry is taken away and done offsite. Essentially they are the functions that we have included as part of this area. The wards are down through this area and then we have allied health over here. The wall that runs through here forms an important part of the construction and the staging. You can see that the line that comes up through here and moves back across and includes dental is part of the first stage. Everything that is on this side of the line is being built in stage 1; everything on the other side is being completed as part of stage 2. One of the main criteria is to try to keep the kitchen functioning. To enable us to do that, we needed to locate the kitchen in an area that was easily accessible for deliveries, accessible to the rest of the hospital but able to be built so that we can bring the kitchen on when we demolish that kitchen as part of stage 2. We have improved the staff facilities through this area as well. We have a staff lounge that opens out onto a courtyard space. We have a meeting room that can be used by the community. There is an acoustic bi-fold door that enables us to open up this area for larger meetings or for staff training. The idea is to get as much flexibility through this area as we possibly can. There is a small tea-making area here for the ladies auxiliary to be able to provide tea and coffee.

There are the offices for this department but they will use these areas over here as interview rooms. Security was an important concern for them as well and that is why they have been located here so that they have access to this discrete door, also access to these two meeting rooms and an emergency escape door back out into this corridor if that is required.

Then we go into general servicing of the hospital, which is basically an equipment store. We have an outside area to give us a bit of flexibility for storage. Medical waste, maintenance, dry linen, generator, oxygen and gas are all within easy reach of this delivery bay. We have a roof that comes over the top of this area here so that trucks can reverse back into here and the day to day activity can be done with a minimum amount of fuss. I think that pretty well covers everything on the floor plan.

Ms REGENT - As Scott mentioned it is really important for the wellbeing of patients to be able to interact with the outside, so these landscaped courtyards are really important for them, not only to sit in undercover paved areas but also to go out into the gardens and sit under a tree on fixed seating, either in privacy or with a few other people who might be visiting or with other patients.

There has been the use of eucalypts to provide shelter and there is also some timber seating and things around these areas. The trees also provide privacy from passers by and traffic et cetera, not only within these courtyards but also importantly along the front boundary of the hospital. That will also help to mute the noise from any traffic passing by as well.

There is a very unique rose garden which is currently at the hospital and we are looking to relocate that within those special courtyards by providing a lightweight timber pergola in this particular courtyard. We can relocate those plants but also add to that experience as it would work as a memorial walk. We can use the structure to put up plaques and things which could commemorate whatever needs to be commemorated, and also have flowering roses climbing across the pergola.

All the paths within the landscaped areas and across the outdoor areas are coloured concrete. They have been designed for universal accessibility, so there is a smooth transition between inside and outside. There is also a smooth transition between the main path and the carparking spaces. That has eliminated the need for kerbing and guttering, so there is no way to trip up if you are walking from your car across to the main entry. All these surfaces slope gradually away from the building as well so there is no risk of ponding against the structure.

In connection between our particular site and the adjacent ambulance residence and ambulance station, again eucalypts have been provided in an avenue between the two driveways. That means that surveillance is still maintained between the ambulance station and the new hospital and it maintains the connection between those two facilities as well. There is a connection in the form of a path across from the main entry of the hospital to the ambulance station as well. There is screening around the existing courtyard to the ambulance station and also down between the staff carparking area and the ambulance residence.

The staff lounge and staff areas open out onto an undercover courtyard and there is planting along that particular boundary. There are views from that boundary into an orchard beyond so it is a great place to sit and enjoy a break from a working environment. This particular space connects back into the internal courtyard beyond, again with coloured concrete paths and some private seating just to get away from the day to day grind.

Mr CURRAN - Thanks, Emma. As I mentioned before, in designing the elevations for the building we have tried to keep the roof level as low as we can and to integrate that in with the existing streetscape and to take elements from the existing streetscape. We have a series of skillions and gables that run across the site. If you are walking along Anne Street and then you turn to walk down the main entry we have raised this section of the roof. There is a colonnade that runs right along that path, so you are guided into the hospital. There is an opportunity for us to use signage at the main entry to direct people into that area.

We are looking at using brick through the lower section of the building, which helps us with the aesthetic in the area and also so that long-term maintenance is minimised. Above the level of the windows and the doors we have some lightweight cement sheet cladding, and also colourbond roofs that run through here. By breaking up the roofs and stepping them across the site we will get a nice interesting shape; it will gel in with the existing environment. It is a modern building but it has references back to the existing neighbourhood and streetscape. It also gives us an opportunity to provide a building with low maintenance.

This building has a lot of glass with views out into the courtyards. We are using the roofs to overhang to enable us to minimise the heat gain but also to maximise the views and to bring the courtyards and the green impact into those wards or into those bedroom spaces.

Mrs NAPIER - How much does that roof overhang? I was looking at those front rooms that face onto Anne Street.

Mr CURRAN - The roof overhang through Anne Street comes back to form a verandah. On the western side of the building we have quite a large overhang to protect from that westerly sun, so as the sun sets it helps prevent the heat going through that area.

The idea is for the landscaping to provide privacy and acoustic protection, with a fence down to provide security for people who are in this area. We are looking for people to feel comfortable enough to come out, use the sun, use this garden, interact with activity in through this area but feel safe as well. We have some high-level lighting to let light into the building. We have raised the roof in a couple of those sections to add some effect to public areas.

The materials are basically plasterboard, with some warm timbers. We are looking at using veneers along the corridors to protect the walls. Once again, it is something we have done in the last couple of projects. It helps with maintenance, protects the plasterboard and eliminates the need to come back and repaint and repair.

Mr HALL - Scott, I notice that the total budget is about \$6.1 million. Normally, when we have had projects presented from you, you have given a breakdown in costs in terms of contingency and those sorts of things.

Mr CURRAN - The latest cost estimate that we have, which was prepared on 12 December, shows that we are on budget for the total amount of money we have. I have a breakdown of them and I can provide that to you.

CHAIR - If you have it there, Scott, you can share it now.

Mr CURRAN - The total project cost is \$6 129 000 and the total constructions costs that we have at the moment are \$4 298 000. There are special provisions of \$1 406 000 and other project costs such as loose furniture, CCTV and other associated items of \$425 000. Taken into consideration in those estimates are costs for building stages 1 and 2 and costs associated with staging. That is all incorporated into the numbers we currently have.

CHAIR - Incorporated into all that costing is the demolition as well, as part of the project cost?

Mr CURRAN - Yes. That has been included as part of the staging of the project. There is an added cost in staging the project as we are doing, but to enable us to maintain the facility and the service we need to do that in two stages. At one stage we were looking at doing a three-stage development but we have now been able to bring it back to two, which saves us a considerable amount of money and also helps with the time line as well.

At the moment I have a design development contingency of \$212 000, a tender contingency of \$212 000 and a construction contingency of \$212 000 - so that is \$636 000 in contingencies built into our costs at the moment.

Mr HALL - So all those items add up to the \$6.1 million, or thereabouts?

Mr CURRAN - Yes.

Mr HALL - So we now have those on Hansard, and I am happy with that, Mr Chairman.

If I could just reflect back on the Deloraine Hospital, I recall there was a shortfall in regard to finishing off - landscaping, fencing and all those sorts of things. In your opinion, everything has been accounted for in this project for the George Town District Hospital?

Mr CURRAN - Yes. Part of the overall design philosophy - and I guess one of the lessons you learn as you go through - is that it is okay to have a design idea but you need to have the money to carry through with the idea. I am confident that, with the money we have and the landscaping that has been designed, it all has been allocated and accounted for in the budget we have.

Mr HALL - The Deloraine Hospital was a similar project of a fairly similar size. I can't remember the exact number of beds in Deloraine now. What sort of comparison is there in terms of cost? Can you recall that at all?

Mr CURRAN - You are testing my memory a little bit. I think Deloraine was under \$3 million but that was nearly three or four years ago. We have seen quite an escalation in construction costs since that time so if we were looking to build something of that size at the moment it certainly would be double the budget that we had when we did that before.

Mr HALL - In three or four years?

Mr CURRAN - Yes.

Mr HALL - Okay. Are you confident - I suppose the question should be to the department - given that there is a potential for a pulpmill in the Tamar and quite a bit of growth perhaps for George Town, that there is capacity in this new development to meet future needs.

Mr MORRIS - We have considered that. I guess at the moment we do not yet quite know what the impact of that mill might be. If you think of the need for inpatient beds then that is likely to be applicable to residents, people who end up living here for some time. The bed capacity of 15 we think is adequate. It is more than sufficient at the moment and we have the capacity to take more. In terms of emergency response, all the systems are in place now, and medical and ambulance and those systems I think could cope with more people.

With our other services we will possibly have to adjust those as we see what transpires. In a way that is partly what we want to do. We want to tailor our services to meet the needs of the population. If the population changes then we have some capacity through those allied health and additional rooms and facilities to meet that as required.

Mr HALL - On the inspection tour this morning we looked at the kitchen. Is there any increased capacity there at all? I spoke to somebody and they do local Meals on Wheels as well. Is there any increased capacity to do that community work at all or is that pretty well about the same capacity as we have?

Mr CURRAN - I think it is about the same capacity. The kitchen is based on the model that we used at Deloraine. We have had specialist advice from the gentlemen at the LGH who gave us advice on Deloraine and we expect the kitchen to be able to service the needs of this hospital.

Mr HALL - Where we are at in regard to the approval process with the George Town Council?

Mr CURRAN - The application has been lodged and the application has been advertised. I received a letter on Friday advising me that we had received one representation and that was to do with site run-off and also to do with the building being built to the boundary. We would expect to be having discussions with the council to see if we can resolve those issues with the representor in the next fortnight.

There are a couple of issues that we have. One is that we would like to be able to combine the function of the ambulance bay on that boundary -

CHAIR - On the northern boundary?

Mr CURRAN - Yes, on the northern boundary. That leads us into a couple of other problems that we have with fire and fire control under the BCA, also with the constraints that we have on the site at the moment, and also with the levels that we have in that area. I am hopeful that we would be able to resolve those.

Mr HALL - What is your best guess at final planning approval being given?

Mr CURRAN - It really depends on the council's process that they need to go through. They have asked me for an extension of time to coincide with their next council meeting, which falls towards the end of this month. I would hope we would be able to get those issues resolved and have that presented to the council meeting at the end of the month.

Mr HALL - Are there any other impediments that you know of that might hold up construction?

Mr CURRAN - None that have been raised with us. Essentially, we are looking at replacing all of the services, so we have accepted the fact that that has to be done. That is good in a way in that we have allowed for that in the budget and that is something that is not going to be unforeseen. I think the biggest issue that we have at the moment is just working through this representation that we have with the adjoining property owner.

Mr HALL - Just while we are talking about services, is reticulated gas available in George Town yet or are there any plans to use it at the northern hospital?

Mr CURRAN - No, we will be bringing in our gas through bottles.

Mr HALL - Okay. I note that you had a period of consultation. I think you had a public exhibition. Did you get much feedback from the community and indeed from the local medical practice in regard to the hospital?

Mr CURRAN - We have had a number of specific user-group meetings which have involved all the people that we are looking to bring on site, and people who are on site at the moment. That included the doctors and that played a large part in the redesign of that nurses' station and treatment area and storage facilities through there. Both Ben and I attended George Town on Show, where we had our documents displayed and I think they are the same documents that are in the council chambers at the moment. I attended on the Saturday and Ben attended on the Sunday. Probably 50 people viewed the documents while I was there and of the 50 people three made comment to me, basically being very positive about the development and looking forward to a new hospital. I am not sure what comments were made to Ben.

Mr MOLONEY - I guess very similar. Everyone was extremely supportive of it and very eager to see the project proceed. A number of issues were raised and suggestions made but I think we have addressed those in the documents. We have had discussions with hydrotherapy, radiography and accident and emergency and there were probably issues raised during that consultation. We discussed the various proposals and comments and people were, as I said, generally fairly supportive of what was being proposed.

Mr HALL - Anything from the local medical practice?

Mr MOLONEY - During George Town on Show I did not see any members of the local practice, or they did not identify themselves to me at that stage.

Mr HALL - At any other time have they had some input?

Mr CURRAN - Yes, they have been to two of the user-group meetings and they certainly made their point and had valuable input. As I said, we actually redesigned the building to accommodate some of their requests.

Mr MOLONEY - Prior to the current design we undertook a master planning exercise where representatives from the adjacent medical centre were invited and attended a workshop for consultation. There were a number of other information sessions and consultation sessions in George Town with them as well, in addition to the other stakeholders we consulted.

Mr HALL - What type of trees were on the front boundary? You talked about trees being planted there to mitigate noise and some screening.

Ms REGENT - The landscape architects have chosen trees local to the area. They have suggested small smooth-trunked eucalypts for the street frontage and also to the front garden.

Mr HALL - I presume that a bit of the landscape vegetation that has been planned will be reasonably low maintenance. Sometimes eucalypts can be fairly high maintenance.

Ms REGENT - That is right. That was part of the brief, so the landscape architects are very aware of that and are aware that there will probably be only one person on site to take care of the gardens and look after the clearing of leaves et cetera and maintain the trees. There is a list of plants on that plan if you are interested in the specifics.

Mr HALL - Okay.

Mr HALL - Scott, you mentioned that the building has a lot of glass in it.

Mr CURRAN - Yes.

Mr HALL - Is the glass something like a comfort-plus or similar? What do you use in that sort of construction for glare and heat?

Mr CURRAN - We have double glazing to the sliding glass doors and we are putting comfort glass into the corridor spaces.

Mr HALL - The windows are normal glass or safety glass?

Mr CURRAN - It would be safety glass to meet the requirements of the code.

Mrs NAPIER - Do you put a glaze on those windows?

Mr CURRAN - If you specify a comfort-plus or a special type of glass it comes with that incorporated into the glass.

Mrs NAPIER - In terms of fire access, when one considers the connection of the Anne Street medical centre and the need to get back through to the western side of the block, it seems to me there would be difficulties in getting a fire engine through there. There is also the

question of where the fire connections would be for the hoses et cetera. The other thing I was thinking about was the kitchen. The kitchen is backing onto the western fence, in effect, and that is more likely to be a place where you would get fire, yet I couldn't see that there would be so much ease of access in getting through there.

Mr CURRAN - We discussed fire fighting with Tasmanian fire services and they like to fight the building from the front. They like to arrive at the front door, check the fire indicator panel and see where the fire is. The fire indicator panel is located generally within a metre of the front door. They then plug into the fire plug, which is generally in that area, and fight the fire in the building from the front. They don't normally go around to the back of the building to fight the fire. That is all part of the strategy that will be developed with them as we work through the hospital.

As to your second point about the fire on the boundary, all the walls that are on the boundary have to have a specific fire rating, unless they are set back three metres off the boundary. All the walls on the boundary at the moment meet the minimum requirement for the BCA under fire protection. Also, with fire egress or exit out of the building, we have put the building into more compartments than we are required to under law. We probably could have got away with three compartments but we have put this back into four. If there was a fire in a ward area, that fire would be contained within that area. The doors are smoke and fire doors and they close and contain the fire in that area until the fire brigade arrives and is able to fight the fire.

Mrs NAPIER - So you are saying that those rooms that are on the north-west wing, in effect, would be accessed via the main entry to fight that fire?

Mr CURRAN - Yes, I believe so.

Mrs NAPIER - I guess your fire services people will determine that. I would have thought you would need some kind of access to get around to the back of the building, into that landscaped courtyard area.

Mr CURRAN - No. Generally they fight the fire from the front. They would go to the fire indicator panel and establish where the fire is. That is their first point when they arrive.

Mrs NAPIER - That particular element that I am asking about, has that been approved by the fire services?

Mr CURRAN - No, not yet. That is based on discussions that we have had with our building surveyor. Under the Building Code of Australia we have strict requirements on how big a fire compartment can be. We have made our fire compartments smaller so that we can have a number of different fire compartments within the building. It basically means that some of those walls that are adjacent to fire doors will have an additional fire rating on them so that if a fire comes to that area where the fire doors are, for example, it cannot burn through the wall within a specified period - I think it might be 90 minutes.

Mrs NAPIER - There appear to be three toilets for non-staff. Would that normally be the number of toilets? There are two access toilets and one unisex. I am now thinking of the community health areas. Is that normally the number of toilets that might be used by members of the public.

Mr CURRAN - I think we are one toilet above the required number of toilets under the BCA.

Mrs NAPIER - There appears to be one meeting room yet the hospital is designed also to deal with the community health component. The trend is I think not only to do one-to-one consultation but also to do, in some of the areas, small group work and sometimes larger group work. I can see that there is also the health and welfare room. I was wondering whether there was a need for at least another room that was bigger than your one-to-one consultation rooms for the range of work that might potentially be done?

Mr MOLONEY - I guess some of the rooms have the ability to be used for those purposes - for example, a physiotherapy room. Correct me if I am wrong but I believe physiotherapy at this stage is provided one day a week, so it is certainly quite a large space which is linked quite well with reception and the front-of-house area and which could be used for larger groups in addition to the meeting room.

I guess general rooms 3 and 4 would be set up more for use with small groups of two, three or maybe four people. It certainly would not be designed for larger groups. We also do not anticipate heavy usage of the family room so there is also the opportunity for that also to perform the function of a meeting room because it is likely to be set up with couch-type furniture.

Mrs NAPIER - In terms of feedback from the community, have they not indicated a need for more multipurpose rooms?

Mr MOLONEY - Certainly compared to what is currently there on site I think everyone is quite pleased with what they are seeing at this stage. I have not received any comments back, either at George Town on Show or at any of our alternative consultation sessions, that increased meeting rooms were required.

Mrs NAPIER - Some of the family/child/early parenting-type programs are becoming more prevalent, as are some of the preventive and rehabilitative programs that are available, whether you have arthritis and whatever it might be for, so if there was a need for another space, where would you build it?

Mr CURRAN - If we do need to expand the centre one of the ideas is that the SES shed would be moved from the corner and that we would flip the carpark over onto the other side, in that space between the vehicular access and the ambulance station, and extend into that area through there and readjust the front entry.

Mrs NAPIER - Okay. I think it is good for the record to know where that space would go because it seems, with the group and small-group programs that are emerging in community health, that might be an area where the design is short.

I note that you provided a useful summary of some of the issues to take into account in relation to the hydrotherapy issue. A number of members in the community were keen to see it as part of this. I think you told me that it could not fit within the projected budget of \$6.1 million. I want you to put on the record what the options are in terms of whether that might potentially be developed where that SES shed is, or basically in that

area, or whether we are going to see the kind of services that might be needed perhaps being developed elsewhere?

Mr MORRIS - When we consider what services an area like George Town needs and as we considered our perception of the future and what was required, and as we began to think about this building, the need for a hydrotherapy pool was never identified. It subsequently was and we have done more investigation of it. As you pointed out, some of the arguments are in there but I guess from our point of view we have a substantial query about the issue of the role of that service as appropriate for the community. Even if there were money available, would we invest it in that particular purpose for this community? Then we have the issue of whether we should be providing hydrotherapy pools in all our facilities around the State. If George Town has one, why not other places? Is this appropriate for the local community? Then you have to look at the logistics of actually operating a pool as part of the health facility: how do you staff it, how do you budget for it, who looks after it, how do we meet all the appropriate standards and health guidelines which we of course, par excellence, would have to meet? Looking into the future it has never really seemed to us that, for a community of this size, it is appropriate to spend that much money on a separate pool in a health facility. Should such a thing be required would it not be best to integrate it with an existing pool arrangement, of which there are one or two options in George Town? Should that sort of service be required up here those are the options that need to be explored further, rather than us as a health service, building a new district hospital and community health centre, investing that kind of money for that particular service here. That is our approach to this particular issue. I think Sophie and Ben have done more specific investigation of the requirements. You should also note that the Australian standards authority is currently revising and I suspect will increase the level of standards that apply to these kinds of pools. We don't know yet what they will be but my hunch is, based on what I know about hydrotherapy pools, that the standards are going to be even more onerous. It just seems to us that it is not really the kind of investment that is appropriate.

Mrs NAPIER - In the notes you said that it was costed at roughly \$500 000, including recurrent costs. Can you give us a breakdown as to what it would cost to build it and what are your annual projected ongoing costs?

Mr MOLONEY - With the \$500 000 estimate, that is excluding operating costs. That was as a rough ballpark estimate from projects of a similar nature and that was based on information supplied by the George Town Council.

Mrs NAPIER - Are you saying that the \$500 000 was for construction?

Mr MOLONEY - Purely for the capital cost of construction. Things that need to be included with any project of that nature would be an increase in parking requirements, facilities such as change rooms, and the actual building because if we are talking about a heated pool it is likely that we would build a building around that pool to keep it well insulated. So there are a number of areas there where there is quite significant expenditure.

Mrs NAPIER - And there current costs?

Ms LEGGE - We don't have the expertise in our rural areas to maintain these pools. They obviously need to keep the heating above what a normal pool would be but there is also

the ongoing maintenance in specimen collecting every day and cleaning out these pools if there happens to be a bug or something trapped in there. We only have a very limited budget for our rural hospitals as it is. At the moment we have one maintenance person who looks after the whole building and landscaping and that is an ongoing cost that we haven't even put into our requirements. Also, we only have a physiotherapist one day a week. If anybody was to enter that pool they would have to be supervised. It is not only a physio, they would have to have a physio assistant. If anybody became ill in that pool and was unable to get out, we would have to have people available at all times and we don't have that sort of service at the moment.

Mrs NAPIER - Are there any precedents on the mainland of similar size rural and regional hospitals with hydrotherapy pools?

Ms LEGGE - The shires over there have taken them on.

Mr MOLONEY - There was an example - Tamworth regional council had undertaken a hydrotherapy pool as part of their recreational pool complex. Looking through such things as the Victorian health guidelines plus the New South Wales guidelines, there is a little bit of literature on hydrotherapy pools. One of the comments made in one of the documents - I believe it was the Victorian health guidelines, but I may need to check that - was that they suggested a minimum usage of approximately two days per week for the hydrotherapy pool. I believe that is currently comparable to perhaps the usage that a city the size of Launceston would generate.

Mr MORRIS - Tamworth, for example, has 40 000 people.

Mrs NAPIER - One other suggestion that I have heard in the community was that there could be a bus service to Launceston to provide the service there. Is it likely to be entertained that that could be provided as part of the community health package?

Mr MORRIS - The short answer is yes. I think we want to try to improve service access for people in George Town and that might, on some occasions, be to services that we can get located here. On other occasions it may be getting them to Launceston or wherever else. In relation to hydrotherapy, I think if that is required as part of a physio program for a particular client then transporting that client to the service in Launceston would be something that we would endeavour to work out for that particular client.

Mrs NAPIER - I know a number of people in the community would like that facility and I appreciate your putting on the record some of the issues associated with that.

Mr COCHRANE - Phil actually threw that open for discussion. For a facility of the size we are building, to incorporate a hydrotherapy pool would increase the risk profile exponentially for the operation of that facility - the possibility of contamination of the pool, infection issues, public liability. One of the larger nursing home consortiums built a large hydrotherapy pool and after one year's operation they had to reduce access purely to their own clients because of the increase in their insurance profile and the exponential increase in operating costs. While it is very nice to have for the community, I do not see that it is a core service that we would want to run from a district hospital.

Mrs NAPIER - The disability access provisions, in terms of coloured pathways et cetera, would certainly increase disability access, but I thought you said that the main entrance to the hospital would also have some sloping so that there wouldn't be a step. That would reduce the potential for tripping but is that still wheelchair-access friendly?

Ms REGENT - Yes, absolutely. Wheelchairs can cross a path with a gradient so long as it doesn't exceed a certain slope, so these would not exceed that.

Mrs NAPIER - So they would be able to go along it even though they'd be going on a sideways slope?

Ms REGENT - That slope is very small. It just means that any water that might fall on that ground surface can flow away from the building instead of against the building.

Mrs NAPIER - Would it also be adapted for the visually impaired? Will there be tactile surfacing as might be required?

Mr CURRAN - It is a requirement under the code that we provide tactile indicators.

Ms REGENT - Variance to surfaces et cetera.

Mrs NAPIER - So that it will be suitable for both, to cover at least those particular areas?

Mr CURRAN - Yes.

Mrs NAPIER - There are two dental surgeries. Will they be fully equipped for a private dentist should one be attracted to the area?

Mr MORRIS - Yes, they will and we continue to be open to any option that we can cook up to provide adult dental services.

Mrs NAPIER - I read that. That was good.

Mr MORRIS - A mixture of public and private, whatever we can do, we will look at anything. We are not fixed to one particular model of how we would do it but the surgeries themselves are part of that. They will all be fully equipped, up-to-date and meet standards. That is one possibility, one brick in the wall that helps us.

Mrs NAPIER - Yes, I agree. I was interested that the north-east hospital did not include an upgrade of the dental surgery area, although the potential is still there to do so. What is the cost of building a two-surgery dental area such as you have built into here? Capital costs and separate for equipment, if you can do it.

Mr COCHRANE - With a lot of our developments we provide the building envelope and the in ground services and then Oral Health Services come along and install the equipment, chairs, compressors and the gear that they need to run the service. It is very difficult for us to state a per square metre cost to provide that facility unless we know what it actually costs Oral Health Services to fit out a surgery.

Mrs NAPIER - Within this budget are we going to equip the surgeries?

Ms LEGGE - They will be transferring some of their equipment already from existing facilities. They have new pieces of equipment that they have only had for this year, so they will come across and the rest will be specific as far as I am aware.

Mrs NAPIER - Could you provide the committee with the cost of constructing a two-surgery area? I guess there is the capital issue and what you would normally expect to be in this budget. Separate from that, what would be the cost of equipping it to the equivalent of a private dentist being able to use it?

Mr COCHRANE - We can certainly do that.

Mrs NAPIER - That would be good. We were discussing heating and you said that the heating was going to be by electricity but then there would be gas requirements and that that would be through bottles. Was there a quote from the gas people to see if it was feasible to have both heating and all other gas requirements online?

Mr CURRAN - Our gas at this stage is just to the oven and the cooktop in the kitchen. All of our other heating is electric, through radiant ceiling panels above the beds. That is a tried and true system that we have put into the other hospitals. We have not investigated the costs of putting in a gas system.

Mrs NAPIER - Presumably there would be a high recurrent cost for hot water for such a facility. I would have thought, given that George Town is one of the places that is online for gas, we would be getting a quote to keep a bit of honesty in the system, to see what Aurora can do or to see what the gas people can do to come up with best price?

Mr CURRAN - We can certainly look at the option of providing gas hot water. All of the infrastructure is there. It is matter of what type of hot water cylinder we actually put in, whether it is electric or gas. It is quite easy for us to do that so we will get our consultant to have a look at that.

Mrs NAPIER - Could you advise the committee of the result. If we are trying to encourage best price through competition between gas and electricity, given the recent recommended price increase in electricity, then the more we can make it cost effective to use gas the more options there are open for the general public, let alone for our hospitals. The works are hoped to commence in May 2006 and completed in July 2007. Is that still an appropriate time frame?

Mr CURRAN - Yes, I believe so.

Mrs NAPIER - When do we expect stage 1 would be completed?

Mr CURRAN - I think that is probably in about nine months at this stage. We are reviewing that in line with our documentation at the moment and we should know that in probably another week's time.

Mrs NAPIER - Is it likely still that the work would begin in May?

Mr CURRAN - We are hoping to. We are still aiming for our tender on 25 February.

Mr BEST - The one-stop shop concept I thought was very good and I just have some questions in relation to that matter. One concerns the siting. It is a very good site in its proximity to the CBD and other things that are there; you have the existing ambulance service and the fact that it is an existing hospital site itself. What aged care facilities are there in George Town and what other sites were considered? I know what you are aiming at here and I am thinking of other projects. They may be of no relevance at all but I just wondered whether there were any opportunities in that regard.

Mr MORRIS - There is a private residential aged care provider, Ainslie House. Around about 2001 or 2002 there was talk about whether there were alternative sites or what might be the future plan, knowing that a possible new hospital has been considered for George Town. We did investigate that scenario at the time. I think we concluded that, given the location of Ainslie, which is out more towards Low Head, as the local, private aged care provider they had a very clear role and function. We don't want to duplicate what they are doing. Their location is appropriate for their function and our location is appropriate for our function, particularly noting the use of, and hopefully the future development of, the community health model. It is much better to be accessible and near to the local precinct where buses operate and people can walk in and congregate.

Mr BEST - Right, I see what you mean.

Mr MORRIS - I think that debate has been worked through and I think everyone is happy where things sit at the moment.

Mr BEST - Because they are private operators the likelihood of any further aged care will obviously be on the existing site which you are referring to, as opposed to an annex like what we are looking at today.

Mr MORRIS - Yes.

Mr BEST - You mentioned, which I thought was quite impressive, the comprehensive integration of services, the range of services that don't, I suppose, ordinarily fit the mould. Part of that is due to some Federal involvement with the partnership of the George Town Health and Welfare Committee. Since then you would have looked at all groups that operate, ones that may be funded and ones that may be volunteer, in and around the community. Could you elaborate a little about that, perhaps?

Ms LEGGE - What are you asking, sorry?

Mr BEST - You mentioned the partnership with the Health and Welfare Committee and I am just wondering about the usage of this facility by those that receive funding and those that don't. There would have been some consultation. I know it talks about preliminary consultation in the master planning exercise. Are there many groups that you have spoken to in relation to the project?

Ms LEGGE - We have spoken to anybody that we can possibly think of that might have liked to have a bit of input into the building or access to it. Even within the welfare groups and things like that there were actually a couple identified that didn't want to move into the building; they wanted to be community-based, as in domestic violence.

They are set up with the police at the moment and they are really happy with that interaction. The relationship that they have developed with the police and things like that is a really positive one so we know to leave it as is. The other one was the youth workers. They have decided to stay where they are - I think they are in this council building - and that actually provides for young people who do not want to be going into a health facility as such and gives them access to another zone area. They come here for their dole programs or whatever else they are doing at that point.

Mr BEST - Sure, because you have CES in here already?

Ms LEGGE - Yes, so they feel that is more where they would like to be. We are certainly not saying that everyone had to come into this building but we allowed the ability for them to have input into it. They identified things such as wanting not to have clients visiting in their work space. That had to be separate and things like that. We have developed flexibility so that rooms available also had an in and an out. If somebody started to getting agitated or anything like that there was flexibility there. We are trying to make all of our rooms as multipurpose as we can so that the physiotherapist, for example, is available on Wednesday for physio. That still gives you six other days that the community groups can use that room. We need to be flexible like that in all our rooms to enable community ownership so they can use this environment. In a year's time someone will be able to rock in and say, 'Have you got a room that I can use?' Those four rooms and the centre hallway can be very flexibly booked for people from Launceston or for services. We can also work with the doctors who already have rooms. The ambulance bay also has another meeting room. We have to be really flexible in making sure we can be a really flexible block in providing any services needed for George Town.

Mr BEST - Because it is a hospital and almost a community health centre, is it not?

Ms LEGGE - Yes.

Mr BEST - Obviously there would be existing child care services in and around George Town. Was that considered as another possibility for a site that you would develop as a hospital site? I saw in the plan that you have your child health and a play area. I suppose you would see child care as a separate entity, similar to aged.

Mr MORRIS - Yes. We recognise that having access to child care can be an important part of offering a service. There is some child care available in George Town and we would not want to duplicate that. From my memory the child care area in George Town has not the room for a hospital and community health centre, so I think what we are offering here is fine.

I think that little play area is something: I do not think we pretend that it is the whole kit and caboodle of child care. In general that is commensurate with what we do in other places. I think there is one other rural area where there is a small child care facility on the whole campus site, which was a fortuitous circumstance with a private provider. We have looked at a partnership arrangement should anything develop but we have pretty well decided that we are not going to set up formal child care facilities as part of our development. We will try and make it child friendly and at least have a play area where there is a family and child health service incorporated.

Mr COCHRANE - A parent may come in with a baby to be assessed by the child health nurse. If she has another child then while she is talking to the nurse we have a secure play area where the child can play and mum can keep an eye on her without interfering with what is happening with the nurse. That seems to work very well in all our facilities.

Mr BEST - Do you feel that you have enough carparking there? I know you are limited in space and design and that sort of thing. What sort of numbers of people are you expecting with these additional services? Do you feel that you have enough parking capacity?

Mr CURRAN - It is difficult to gauge because providers will not all be there on the same day - physio might be there on a Wednesday but somebody else might be there on a Tuesday or a Thursday. The carparking numbers are dictated to us by the amount of space that we have available on site. We have discussed the carparking issue with the council and they have been happy with the numbers that we have been able to provide. That, in conjunction with the parking on the street, will give us greater numbers than we have on site at the moment and it also gives us a better ability to deliver things to the site. At the moment when things are delivered to site it basically blocks the access. What we have done now is to maintain the vehicle access so that when trucks come to deliver we can still maintain that through route, so the traffic flow is certainly going to be a lot better. We have been able to get patients and visitors a lot closer to the front door, so that is certainly an improvement on what we have at the moment. We have the capacity for overflow carparking to be on the streets in and around the area.

Mr BEST - For the purpose of the record that you do have a contingency for asbestos and also off the record we talked about security lighting and the fact that there is level entry. I just thought I would mention those three issues. I am not sure if you want to say anything in relation to that.

Mr CURRAN - The lighting will be designed so that at night if somebody approaches the facility it meets all the requirements of the codes. There is an asbestos register that is available on the building and that will be made available to the contractors when they tender for the building. Asbestos is a difficult issue and there are strict requirements on removal. An advantage for us is that we are demolishing the whole site. We are not trying to work in and around with existing materials, so with the contingencies that we have I think we are well within the normal practice that we would have for a building of this type, age and size.

Mr BEST - Of course you have designed it quite well with level entry. Inside the building, would that be synthetic carpet? I am looking at the last page.

Mr CURRAN - There has been quite a lot of discussion about areas that need to be vinyl and areas that need to be carpet. Yesterday I think the George Town staff went on a tour of the facilities to assess basically how much area they thought should be carpeted and how much they thought should be vinyl and we are still working through the actual extent at this stage. Our preference would be to keep vinyl through corridors and in ward rooms but to also incorporate carpet in areas like the patient lounge, reception areas and other areas to try to soften the effect of having large areas of vinyl. We are still working through that issue at the moment.

Mr BEST - Carpet, I think, is a nice choice but from what I have seen in health facilities in rooms where it gets stained it seems pretty hard to get the stains out. It is a nice finish and it does make it feel a bit more homely and relaxed and that sort of thing but how you are going to manage?

Mr CURRAN - There is a strict requirement on the type of carpet that we can use in a health-care facility. One of the issues that we are working through at the moment is how much carpet we can put in given that if it does get dirty it is very hard to keep clean. It is that versus how much vinyl you can actually have.

Mr BEST - Can you treat it so that it can't be permeated by stain?

Mr CURRAN - Manufacturers claim to have treatments that do all of those things but our experience is that carpet still marks and still stains and requires regular cleaning and regular treatment. Vinyl is by far the best choice of material but you have the issue of the aesthetic appeal of vinyl, having an appearance that can be cold and quite hard.

We have discussed ways of trying to soften the vinyl by putting in some patterning and borders and a few other things and they are options that we are looking at at the moment to soften the effect of the vinyl. Definitely the vinyl is the easiest for us to keep clean and maintain but that is an ongoing issue that will be resolved in the next two weeks before our final documentation.

Mr BEST - Do these windows open? Do they open for ventilation?

Mr CURRAN - Yes. That is a toilet window, is it sorry, that you pointed to?

Mr BEST - That would be, yes. There are other windows further over.

Mr CURRAN - All those windows open. They will be a combination depending on where they are. An awning window is the best in terms of security but you cannot have an awning window where small children walk past because they will clip the side of their head, so we put sliding windows where there is a walkway or an access path but where people do not walk past we would put an awning window in. On the ensuite windows, for example, they would be an awning window.

Mr BEST - How do you think the ventilation will work on hot days, because it gets stale. You notice today how stale it was in there. I suppose the location of the kitchen was another issue but it is important that you do get ventilation.

Mr CURRAN - That is right. With the sliding glass doors that we have to each of those wards there is a real opportunity to open that up to be a small opening or to open it all the way back so that we can get natural ventilation through the building, and use the corridors as well. It is really about trying to get as much natural ventilation through the building as we can.

Mr BEST - Are those sliding doors lockable?

Mr CURRAN - Yes.

Mr BEST - So they can be locked and it is just the same as a normal hospital wall, I suppose.

Mr CURRAN - They have a reed switch on them as well which goes back to the nurses station so nobody can accidentally leave the door open at night. It is always monitored back to the nurses station.

Mrs NAPIER - So are they controlled from the nurses station or are they controlled by the patient?

Mr CURRAN - By the nurses. At eight o'clock, for example, if we want to lock all the doors, then they can lock all the doors on the reed switch, or they can switch it off and that gives the patient an opportunity to open those doors. It is quite a simple system that is very effective.

Mrs NAPIER - Does that mean within each room their heating is controlled within that room?

Mr CURRAN - Yes.

Mr BEST - Where you have the community nursing room, you have some little change there to the plan I have. There is an oblong white space?

Mr CURRAN - Yes, I am not sure what happened there. That is a drawing error actually. Something has happened to the fill that goes into there.

Mr BEST - Okay.

Mr MOLONEY - Through the design stage we amended some of the drawing.

Mr BEST - I wondered if that was something different. I think the design of the building fits in quite well. Is that the actual colour?

Mr CURRAN - No.

Mr BEST - It is not? That is just the mock-up is it?

Mr CURRAN - That is right. We are looking at using a darker brick. There is a combination of red bricks and there is a brown brick next to it in the Anne Street medical centre. There is a new brick on the market. It is not brown and it is not red; it is a cross between the two. We are looking at using that style of brick, so it is a modern interpretation of a red brick. We are not backing away from the fact that this is a new modern building; we are saying we want to integrate it but we did not want to go with the brown brick. That is next door and we have the ambulance station as well that we are not competing with but have to fit in with so we felt that that brick was appropriate. It does not really represent very well in that 3D plan.

Mr BEST - No, that is all right. I was just a bit concerned when I saw that colour. Finally, I was really impressed with the layout of the landscaping and the garden. I thought that was really good and that really will make a difference. This idea of walking out to

courtyards is really quite pleasant. I notice there is seating and that sort of thing. There is some hedging here as it borders Anne Street. What sort of height will that go to? Will that go to the fence height or a bit higher? Will that provide some sort of privacy for patients?

Ms REGENT - Yes, absolutely. That is the idea along that street frontage, to provide a bit of shade but also privacy and hopefully mute the noise from the road as well.

Mr BEST - It is going to be 1.5 metres, which I think is a good height. Your main vehicle entry an entry only. Is that right?

Ms REGENT - It is one-way.

Mr BEST - That is fine, and then your exit is on the other side. There will be enough sight distance there for vehicles not to run someone over?

Mr CURRAN - No, that is just an ambulance bay. You go around the shed and then you go back out to Cimitiere Street. When we were on site there is an existing shed and a whole lot of wood piled up and a couple of old trees. The idea is to get that to go back out into Cimitiere Street so that when trucks come to deliver we can get them off to the side and then the access is not blocked.

Mr BEST - Thank you.

Mrs NAPIER - How many staff are there?

Ms LEGGE - On a given day we worked out that there would probably be 20. Not at present but in the new complex . If the physio is on board today or we have three health and welfare people we were looking at about 20 staff being there. At the moment we have three nursing staff on in the morning, two in the afternoon and two on night duty. Then we would have maintenance during the day, two community nurses - but they are out, they come and go - and then your visiting services et cetera. There are obviously a few more when we are bringing in allied health workers and things.

Mrs NAPIER - Is that hospital component staffed according to the nurse per staff ratio that is supposed to be going right through the whole system?

Mr MORRIS - The nursing outpatient model has not formally been put into rural and regional hospitals as yet; it is intended to be so.

Mrs NAPIER - What is the date that they are likely to have it in by?

Mr MORRIS - I would not want to commit to a date. I am not in control of when it happens but it is intended to happen. Our hunch is that George Town will be within the requirements with their existing staff. I cannot say for sure because we have not formally run the model as yet.

Mrs NAPIER - There are no immediate plans to run that model?

Mr MORRIS - We are aware that it would be a good thing to do. I think we would like to do it this year but we are not running that program ourselves. It is being run by strategic services and it depends on all sorts of things.

CHAIR - To each of you thank you for your presentations to this inquiry. Can I also say to Beth Smith and Sue O'Toole, who have sat through this hearing, thanks for your hospitality this morning and please pass that on to the catering staff as well. It was much appreciated at the end of a fairly long drive.

Mrs NAPIER - Especially the date scones. We have to get that on the record.

CHAIR - With that, we conclude the inquiry. Thank you.

THE WITNESSES WITHDREW.