THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN THE BOARD ROOM, WEST COAST DISTRICT HOSPITAL, QUEENSTOWN ON MONDAY 29 NOVEMBER 2004.

WEST COAST DISTRICT HOSPITAL DEVELOPMENT

Mr SCOTT CURRAN, **Ms KAREN SCHNITZERLING**, **Mr WILLIAM COCHRANE**, **Mr PETER ALEXANDER** AND **Mr PHILIP MORRIS** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Can I just indicate that we appreciate the two site tours which we have been provided with. It has given us an appreciation of the intended new site and indeed an appreciation of what is happening here. We also appreciate the input from other people who have joined us on the tour of the intended new site.

Can I also indicate to members of the committee that I appreciate the fact that we have convened this meeting at fairly short notice, I have to say, but it is important that if we are able, as a committee, to consider various applications which come before us in a reasonable time frame then it is certainly incumbent upon us to do so. I appreciate the assistance of the committee in getting this particular inquiry together.

I would also like to indicate to members of the committee that on 18 November I wrote to Minister Llewellyn and indicated to him that we were prepared this week to hold the inquiry but that there were some misgivings that I had as an individual. I was not speaking on behalf of the committee but I did write to the minister, in my role as chair of the committee, and indicated to him that I was less than happy that executive council had signed off on this project some weeks prior to the submission being forwarded to the committee. That is a matter that we will take as a committee at a later stage. Suffice to say at this juncture, I did write to the minister and expressed my dissatisfaction with that, but nonetheless we were happy to proceed to the inquiry. The minister has written back; I don't have a copy of his letter, but I will circulate it for members of the committee to read at their leisure.

Mr MORRIS - The Community, Population and Rural Health Division of the Department of Health and Human Services presents this submission to the standing committee on behalf of Aged, Rural and Community Health Services, of which I am the State manager. We are seeking approval for the redevelopment of the West Coast District Hospital as in integrated in-patient, aged-care and community health centre, providing a broad range of services to the West Coast municipality.

As you have seen, the new development is to be located on a new site. In this new facility we will provide a wide range of services - which I will outline in a moment - including in-patient residential aged care, community health, GP and allied health services. We believe that this new development will fulfil a growing need to provide an all-encompassing service that meets the needs of people in rural and remote areas based on the west coast and specifically in and around Queenstown, with more serious

treatment referred on to the major centres, such as the North West Regional Hospital, as occurs now.

We will put the project to tender with a view to completion and occupation in March 2006. We are delighted to be able to put this submission before you.

Mr BEST - You're State manager for the -

Mr MORRIS - The Aged, Rural and Community Health Services.

Mr BEST - Right, and that is a State -

Mr MORRIS - Yes, part of the State Department of Health and Human Services. We do have some services which are funded by the Commonwealth, such as the Residential Aged Care, as well as some community services.

Mr BEST - So how do you sit, then, with the Federal agency for aged care? You work beside each other, no doubt.

Mr MORRIS - Of course. As we discussed outside, we believe this hospital was first constructed in 1938. Some people say 1938 downstairs, we have it as 1939. Then a two-storey masonry building with the nurses' accommodation we believe was added around the mid-1960s, 1966, and it has had some engineering upgrades throughout the 1980s. In 1995, the lower wing, which is the residential aged care, was added. Essentially, the main building has been unaltered since its original construction.

From our point of view, the site is not ideal; it is built into the hillside which falls away steeply into town. We believe the pedestrian access is extremely difficult for disabled, frail or aged persons, as I think was evident when we were walking around the building. The site, as it is currently configured, is actually not compliant with the requirements of the Disability Discrimination Act, and as health service providers this of course is a key thing that we need to be aware of.

From our point of view, the buildings are high maintenance, they have inadequate thermal insulation. The current buildings are a bit inflexible and not easily adapted to changes required by the functions. Karen talked about that the access into rooms, the doorways being too narrow, and there are some major problems such as the accident and emergency entrance, which I think we showed to the committee members a moment ago.

Our intention is to develop an integrated, one-stop, health service site in which everything is on the one site. We want this whole building, as well as the services that are in it, to meet contemporary health care standards.

This development is not associated with a cutback in existing service. Rather, it has included every service on the one site, as well as improving patient and client amenity. We think the development of a new hospital will also enhance our ability to attract staff by provision of a higher quality environment. In the Aged, Rural and Community Health program across Tasmania, we do in some areas have challenges in recruiting nursing, medical and allied health staff. One of the things that may make it easier, or at least not

go against us, is the ability to provide a high quality built environment where everything is co-located and there is good coordination amongst the services and staff.

The list of services that we hope to be providing from this site is, we believe, quite extensive. It includes 10-inpatient beds; medical and nursing outpatient; 24-hour, on-call emergency care; general medical in-patient care; post-operative and post-natal in-patient care; rehab inpatient care; palliative inpatient care; maintaining the residential aged care; community nursing and home care; ambulance services, tele-health and visiting services. I have enclosed a list in our written submission. So in terms of our project objectives, we want to build a new hospital that will improve patient comfort and amenity, that will match services to community need, that will facilitate community access and use, that will be flexible to meet current and future community needs, and also be functional and easily maintained.

It is also imperative for us that we meet the building codes, the aged care accreditation, as well as contemporary healthcare standards. We talked about the provision of ensuite facilities, for example. That is an example of how the standard has lifted in terms of people's expectations. In the case of aged care it is one of the things that will enhance our ability to meet ongoing accreditation and to secure funding from the Australian Government. We think that by putting all the services on the one site we will achieve a lot of advantages, in that services will be better integrated and coordinated. We all know that those are issues in the contemporary healthcare system. We think if we have a really well-functioning, high-quality environment with a lot of services, then we will be able to attract additional services, because we will have a high-quality environment, both in the building as well as in the staff relationships, to attract new people.

We also see ourselves as providing a centrally located hub for community activity. One of the things with this building is that there is not really an ideal meeting space - we are in it - and we would like to have more capacity in the new facility to have community use of our services.

In terms of the design, Scott will, of course, talk a lot more about this, but in most of our facilities what we are aiming for these days is to give a non-institutionalised feel, especially for residential aged care. In their case the facility is their home, the place they actually live in and have to be comfortable in. So whilst we have to maintain the functionality of the actual site so that it works - and you heard Karen before talking about the way lights are arranged and how the views are organised - it must have aesthetic appeal. At the end of the day people have to feel very comfortable in living there. Obviously we need to have internal access to all parts of the facility, and Scott will talk to you a lot more about compliance with codes as well as maintenance and running costs.

Our desired time-line for the development is tenders in January, commencement in March, and hopefully we can get some building work done in the slightly warmer months, and hopefully finishing in March the next year.

In concluding, I would like to commend this project to you. It is one that has been circulated around in the community for some time. We believe it is an exciting project that will significantly enhance health services at the West Coast District Hospital, and I commend it to you.

Mr CURRAN - Some of the site constraints that we needed to have a look at have been service access and delivery into the building, the provision for disabled access and the ability to service the hospital and to enable people to move around in order to do the day-to-day functions that are associated with a normal hospital.

As we mentioned before, the existing Gaiety Hall is not listed as heritage building at the moment. We believe that the heritage listing is imminent. A lot of people I know have had a look at the building and said it should be pulled down. The advice that we have had from our heritage architect, Lindsay Nelson, is that even though the building is not in great condition, it has a number of redeeming historical features. Some of those are that it was a place of gathering for people who worked in Queenstown, where they socially interacted and mixed. Also, it was an example of the Mount Lyell Mining Company and their effort to provide facilities for their workers, and they shouldn't be underestimated. It is also considered to be significant because of the form of construction that it actually has. The rammed concrete formwork walls are quite unusual and relevant to Queenstown, and as such are fairly local to this area and should be preserved. With that in mind, we set about having a look at the building and the constraints that we had. There are a number of allied facilities that need to be located associated with the hospital which we felt would be best served into this hall. Given that we have a roof and we had walls, we felt that the best way to utilise this would be to put in the areas that had smaller rooms and didn't require views or sunlight.

The trees that are located over in this area here have been mentioned as being of significance as well. I've done quite a lot of research into that. As I mentioned before, there are a number of stories about these trees, that they were possibly planted to commemorate World War I. There's another story that they were planted by two school children when they moved to the school site. The best information that we have at the moment is based on some information that we received from the Tasmanian war memorial database, which is compiled by Mr Fred Thornett and which includes avenues of honour, and it does not include any reference to these trees. Mr Thornett was contacted and he said he visited the Queenstown site and recorded the names on the honour board, and suggested that he would include a reference to these trees if indeed they'd been planted as an avenue of honour.

If these trees had been planted as a war memorial they would have had a considerable historic, cultural and social significance, therefore reference was made as part of these investigations to the President of the Tasmanian Returned Serviceman's League. His advice was that, given that there were no plaques and no other evidence to suggest that the trees were planted to honour fallen servicemen, the acceptable solution would be to plant a new avenue of honour. We have indeed taken that tack, and we are proposing to plant a memorial walk that will be between the two buildings.

In trying to preserve the historic integrity of this building, what we have also set about doing is to set this building back some eight metres so that it respects this building. We have also had a look at how we could best not mimic this building or copy this building, but to honour this building and also the parts of it that have become important. You will see later on when we move to the elevation just exactly the elevational treatment that

we've taken. So you've got the Gaiety Hall, the proposed new hospital, and the service area that runs down Little Orr Street. We're proposing that Little Orr Street becomes a one-way street. We've got the maintenance shed, parking for the spare ambulance and on-site car parking. The advantage of this on-site car parking is that it gives us direct access into this part of the building, and by lowering this section of the building it gives us direct access from the footpath.

We're proposing that there will be gates at either end of this memorial walk so that at night, when this section of the hospital is not operational, it can be closed up and it can be secured to prevent vandalism and people just walking through the hospital late at night. We're also proposing to put a boom gate across this area so that the ambulance can access this area after hours, but also to stop people from speeding and taking a short cut down Little Orr Street.

With Gaiety Hall, we propose to reinstate the façade as it was before, which includes two new windows and new doors. An existing door would be used for the GPs to access this area. We imagine that this would be able to be used when the rest of this hospital is closed down to give some flexibility for the GPs. So we've got two GP consulting rooms. Each of those consulting rooms has a treatment room which is linked back through the corridor. We have toilets and a baby change area. The GP reception area and GP waiting area is actually a self-contained area within this allied health portion. This is the link with the ground floor of the hospital. As patients arrive they will park their car in this area or on Orr Street. They will access up the memorial walk. Both of these doors are fully automatic sliding doors that will open upon approaching, so the patients and visitors can enter through that area. It is basically flat through this area, linking the level with the footpath with Little Orr Street. We propose to put our disabled car parking so that there is direct and easy access into this memorial walk.

There are a number of areas that we have set up as being flexible spaces so that a number of different service providers are able to use those. If, for example, podiatry were to come they could use one of those; speech pathology could use one of those areas. They basically provide some flexibility through this area to cater for different service providers and their different requirements over a different period of time. One of those consulting rooms that we have is one of those flexible consulting rooms. We have a physiotherapy area with a gymnasium and a small office. There is pathology collection, a toilet; x-ray, dental with two surgeries and a reception area, and child health. Each of these areas will be provided with a number of toilets, disabled access toilets, mothers rooms and associated services to enable patients, visitors and staff easy access to those facilities.

This then becomes the ground floor proper, if you like, of the hospital or the lower ground floor. On arriving at the entry area, you would proceed to the reception and then be either directed over towards the allied health or over towards this lift which would take you up onto the next level. We have a number of nursing staff offices through this area here, and associated file and storage areas and photocopy rooms. This room that we have up here, the day centre, is essentially the meeting room associated with the hospital. What we have done is positioned that at the front of this area off Orr Street. We have created a recess back from this area as an area where people can collect and meet and sit, a bit like a small town square, if you like, or small town collection point. This is where meetings such as this, or information evenings, medical seminars, all of those sorts of things would occur in this area.

Back through to the back-of-house services, which is the kitchen and staff and laundry, all of the deliveries would come down Little Orr Street. All the items would be dropped off. The dry store, cool store and freezer are all located close to where the truck would be emptied. There is under-cover access so the trucks can actually back into this area and people can unload goods and provisions without getting wet. That food will then come into the kitchen, be prepared in the kitchen and taken upstairs through the back section of this two-way lift up to the next floor.

The staff dining area has direct access to the kitchen and there is also a small outside eating area off this memorial walk. The laundry for the aged care component is where all the laundry for the residents at the aged care actually have their laundry done. The laundry that is collected for the hospital is actually done off site, so that is collected and put into a car and then taken elsewhere to be laundered.

An important consideration that we have in this hospital at the moment is that staff need to go outside at night to be able to access the morgue. It is visible from the Lyell Wing as well, so what we tried to do with the morgue is to make it very discreet, to have easy access for the staff if they need to use it and also to keep it very discreet from the public areas. There is a small sitting room that is associated with the morgue, so friends and relatives are able to discreetly come back into this area and sit and be with the body for as long as they want to.

Other associated services like community store are also based in this area to give direct access through to the rest of the hospital.

On the first floor, when you arrive by lift there is a nurses station directly in front of you. You will be guided either into aged care or down into the hospital into the acute area. When we looked at designing the building there were a couple of things we tried to achieve with the rooms as we have been setting them up. One is that we wanted to have external space for all the rooms, so that it did not matter where in the hospital you were, you still had access to sunlight and also to fresh air. So what we have done is provide a series of balconies or courtyards through the facility to enable patients to pull their sliding glass door back to access those areas. We have designed the rooms to orientate them so that each of the patients receives sunlight for a fairly substantial part of the day, whether it be early in the morning, midday or later on in the afternoon.

Each of our bedrooms has been designed with care and attention to enable our patients to move around; for the beds to be moved in and around; and for wheelchairs, walking frames and lifting gear to also be easily accessed into the rooms. One of the big issues that we have with the hospital currently is that you cannot get a bed straight out of a ward without doing about five or six different shuffles to get it backwards and forward and out. That is one of the restrictions that we have with this hospital at the moment: because of the load-bearing walls, it is really difficult to demolish the walls and rebuild them to widen them about 500 millimetres. All the corridors we have through this area are 2.5 metres, which will enable easy access for these beds, if they are required, to come out into the corridor and be moved around.

A door accesses into aged care and we have a number of other doors that contain aged care within this area. At the moment we are still working through the issues of which

door should be locked and which door should be open. As you can see, these rooms are orientated to get sun; there are balconies so each of the bedrooms has access onto them. Each of the balconies has a clear-glass balustrading through it and the balustrading will be at 1 050 above the finished level of the balcony.

Associated with the aged care, we have an assisted bath. There is a emergency escape stair. The dotted lines on the plan are fire compartments that we need to set up to meet the Building Code of Australia. They will be fire walls and they will also be smoke walls. In some cases they will be a double wall so that we do not need to penetrate that wall and compromise our fire or smoke walls. All windows associated with these wards are double-glazed so that we can retain heat and so that we can also omit noise from the street. Some bedrooms look back into the courtyard spaces. They will receive morning sun and also have direct access out into the courtyards, which we see as being spaces where you can have relaxation but also privacy.

One of the other major considerations that we have here is the rain and mould. We will not be putting any pavers into the job. What we are looking at doing is having all-concrete finishes with a sprayed-on finish that enables it to be easily cleaned so that moss and mildew does not build up and form a slippery surface. Another important considerations has been how we lay the roof out. Originally we had a series of gables that went over the top of the roof. After discussions with the maintenance people here it was determined that we should not have any gables with box gutters because of the instances where hail has fallen, it has not melted and as a result has blocked up box gutters and caused those to overflow. As a result of that we went back and redesigned all of the roof. We have a series of skillion roofs now so that we do not have that problem of hail, or indeed snow, into any of these box gutters.

Going through the aged care a little bit further, there is an area for sitting in the dining room. The sun is really good down through this portion of the building. It is quite a pleasant outlook into this area here, and gives the patients an opportunity to see who is coming and going into the hospital up and down this memorial walk. This is larger than the area that they currently have at the moment. What we are examining at the moment is the layout of those spaces and how those people will sit in those rooms, and how they will actually use those rooms. We have a bifold door that folds back to enable this to become quite a large room if that is the need. It is all about trying to create flexibility of space through those areas.

With the construction techniques that we are using on the building, we are looking to maintain as much flexibility as we possibly can. We will have a series of non-load-bearing walls so that in future if any of these areas need to be reconfigured, for whatever reason, if they need to become two-bed wards or three-bed wards, or indeed if they need to be altered for anything else, then the flexibility is also there for us. This section of the slab will be sitting on the ground, but as we leave that section the slab will become suspended and that will also enable us to have flexibility with future things like plumbing installations and water, which is also another major restriction that we have in this hospital here at the moment.

We have a quiet sitting area as well with aged care. On of the things required was the need for a separate space for patients if they needed to retreat to other than their room, or indeed if they needed to have somewhere quiet where visitors could come and talk to

them then they could retreat back into this area here. Once again it is a nice sunny spot with the sun moving around the building and views into this courtyard space. We have also tried to get as much glass and light into these corridors as we possibly can, so that even in the middle of winter these spaces are still quite light and bright and cheerful.

There is an outside area that at the moment is a staff balcony. The area dotted has been identified as future expansion. We have also highlighted this purple area, which we see as potential for future expansion if the need for that ever arises. We have another emergency escape stair which goes straight out onto the street. All of the other services - clean linen, dirty linen, pan rooms, sterile rooms, sterile store, drug room - associated with running a hospital are back down through this area. We have some pan rooms and some cleaning stores that are distributed through the rest of the hospital, but the majority of those backroom areas or work areas we located back in towards the back section of the hospital away from these patient areas.

In the acute bed area, these are double-bed wards with a shared ensuite, once again with the ability to go out onto the balconies. There is a nurses station; offices; storerooms; pan rooms; a secondary bath; staff room; staff facilities; ambulance bay with direct access into A&E, and a treatment area; a consulting room, once again to aid with flexibility; storage for equipment such as humidicribs and other things associated with the A&E area; disabled access toilet; and a small waiting area. We have also designed these rooms very much for flexibility, to give an opportunity for them to be used differently in the case of a patient who is dying. There is a flexibility in these rooms that would enable a family member to stay. If a baby is born, it gives the opportunity for the mother to stay here and to have a larger room to keep the baby in the room with her, and for bathing and teaching of feeding and all the things associated with that.

With the Gaiety Theatre, as you can see, the state of the windows as they were before. The doors have been reinstated and the facade is going to be cleaned and tidied up. The roof was replaced some years ago. There is an existing bow in this roof at the moment and that was replaced and repaired leaving the bow and we intend to do that. Concrete was mentioned before in the Gaiety Theatre and we have had some experience with this type of concrete work before. There is a building, not identical to this, at Inveresk in Launceston, which had a similar construction. It was not identical composite-base concrete, but a similar construction where reinforcing - railway tracks, basically - was exposed outside. Large cracks had appeared on the side of the building; they were tooled out and formwork was stripped back and repaired. The building was patched and a Sikaflex system was used. We are two years into that building and that has been a very successful repair job. We have had the Sikaflex man come to have a look at this and he has given his opinion that we can repair the concrete work on this building in a similar manner to the work that was done on the stone building at Inveresk.

There is a memorial walk with trees. We have not decided on the trees that are to be planted there yet. We will undertake some further consultation before it is decided what they should be or who indeed should be commemorated. There is a gathering space at the front of the day centre.

With the construction of the building, we are attempting to give us as great an opportunity as we can to complete the building on time. That will involve us using a series of pre-cast concrete panels to enable us to get the first floor poured. Once the first

floor slab is poured, a series of steel columns that will go up and we will have a structural steel grid with timber trusses. The roof is the first thing we will be attempting to build, so that we can finish the inside of the building while we have the roof on. So with things like rain delays or lots of rain, in theory what we can do is proceed to build the building underneath that roof. We have picked up materials that are in Queenstown at the moment; red brick, rendered finishes and also corrugated iron. They are the three building materials we will be using.

When we were looking at how we should design this building, it was thought that the best way to pay proper respect to this building was not to mimic it with a gable, even though we did initially think that that was going to be the best way to go. It turned out that, because of other underlying factors such as hail, it was relevant for us to look at another building form. We had a closer look at it and inspected the buildings that are further down Orr Street. If you have a look at those buildings you will see a number of verandahs with single posts that support those in a shop-front situation. It was felt that that was a much more appropriate form to carry out through to Orr Street until we reached the corner. So just to recap, a series of precast panels will go in; they will be then clad in brick and the cladding in other areas will be corrugated iron.

We are looking to put in a light coloured roof to minimise the heat gain. Balconies are set back and you can see the glazed balastrading and the glass sliding doors that are double-glazed for each of those walls. We put a series of steps into the roof to break up that long elevation. We provided a series of setbacks through the verandahs and also through the toilets. We are projecting some roofs out to be sympathetic with the projections on the roof awnings that go through down in the bottom of Orr Street just around through the corner.

We have a large, glazed roof line over the top of the entry area. Little Orr Street is where you will drive down to access accident and emergency.

We have put in high-level windows to let light back into the corridor. These windows through here will have white film on them so that it lets light into that corridor but people cannot see the action or the activity from the ambulance.

The staff room is where the staff will take their meal breaks. The four windows that we have going down through here are all the service rooms - the sterile store, clean linen, dirty linen and all those other rooms are there.

In the service bay we are proposing a new generator that will provide emergency power for the hospital in the event of power failure. That new generator will go back in this area underneath this building. There is a series of louvred panels to allow ventilation into that. Our medical air and our oxygen will also be in this area here and also the services associated with the cool rooms.

A window we have at the end of the corridor allows light and distant views as you are walking along the corridors. The roof that I was talking about earlier goes over this area to allow trucks to move in and out of this zone. We have gone back to a timber structure with a gable to be sympathetic and we thought that that was appropriate. There are a number of glazed sections are on the roof as it moves down both ends, so essentially as

you get onto that memorial walk it provides protection and cover for you entering into the hospital.

With the front of the building, we're trying to create a community gathering space so that before you come into this day centre, weather permitting, it gives you a spot where you can gather. This is very much about activity through this area as well; we're getting a spot where the community can actually gather so that if you come in here and run into somebody you wanted to speak to, it will give you the opportunity to sit somewhere and talk to those people. It's very much about the people who live in the hospital, the sick people who are visiting the hospital, and visitors as well, so that everybody gets an equal opportunity.

With the balcony for the aged care component, we've projected this balcony out a little bit further to create this shop front appearance so that there is protection for people who do need to get out of the rain in this area. As it steps back up Orr Street, you can see the stepped effect we've got with the roof running back up through there.

With the view that we've got from Orr Street back down towards the hall, you can see the gathering points and the trees. The materials will be brick, render and corrugated iron.

There is a space that we would reserve for night shift staff so that they've got easy access in and out of the building. You can see the building is set back quite a long way off Little Orr. The glazed areas that we propose to use on the walkway will maintain a nice light area, covered so that if it is raining there is an amount of protection. Gables and actually two small box gutters in this area enable us to narrow the roof down to a very low point to enable us to joint the two buildings together.

With the view approaching this new entry area, the memorial trees will be on either side, with a grassed area, concrete paving with a spray pattern finish, and automatic opening doors. This is all timber framing through this area to pay some sympathy to the hall that is next door. You will be able to look right through this whole area.

CHAIR - Thanks, Mr Curran.

Mr COCHRANE - I would just like to reinforce what Scott said with some of the services, in addition to the layout and some of the other features in the building. We are also having reticulated medical oxygen and medical air to all the bedrooms and Accident and Emergency. The design of the Accident and Emergency links to the treatment room and enables that space to be opened up, and in the event of a multitrauma accident we have quite a large treatment space where we can look after people. The ambulance area is under cover, so an ambulance can back straight in there and get people out rather quickly. In the event that there was a major disaster locally, the under-cover ambulance area can also become a triage area where you can treat people initially, get them stabilised and then hopefully have them evacuated to a major centre as quickly as possible. So that is some of our thinking about that layout as well.

CHAIR - Anything else, Bill.

Mr COCHRANE - No, I don't think so.

CHAIR - Karen or Peter, is there anything that needs to be added to the submission so far?

Mr ALEXANDER - I am happy to respond to questions.

CHAIR - Okay, we will open the inquiry up for questions.

Mr BEST - Most probably the biggest issue, I guess, is the emergency aspect and how the new facility would cope in an emergency. There is a view, as I understand it, within the community about moving staff in if you needed to respond. What would the procedure be in relation to that?

Ms SCHNITZERLING - I am sorry. I don't get your question.

Mr BEST - Well, if there was an accident or something like that - maybe a mining accident - where you have multiple injuries, seriously injured people, what would be the procedure in those circumstances?

Ms SCHNITZERLING - Yes, you have disaster plans, though certainly there has not been a disaster plan designed for this new building as yet. You always assess the number of casualties that you have coming in and then decisions are made as to what different areas of the hospital are being used. The A & E area is designed to be very close to the nurses' station, and there are certainly acute care rooms very close by to that, so what you would simply do is take people out of those close rooms and put them in other rooms, or make decisions as to who could go home, and use those rooms. There would be a couple of rooms close by that you would be able to use. Does that answer your question?

Mr BEST - I think so.

Mrs NAPIER - It is my understanding that there is a west coast emergency plan. Is that a recent one, and what did it predict even in relation to this existing hospital?

Ms SCHNITZERLING - There is actually an emergency disaster plan for the hospital. There is a copy in my office, and there is a copy downstairs in the nurses' station. There is a disaster plan and it certainly states those sorts of things. You look at the numbers of people you have in and then you make decisions as to who might be required to be sent home to their family and then you make available space for those people you need to care for on site.

Mrs NAPIER - Originally this hospital had a capacity for 23 or 24, but that has been brought back to 10 in this plan, even though there are 13 beds that are currently available in this hospital. For the record, could you indicate why it is considered that 10 beds are adequate for the new facility?

Mr MORRIS - In the clinical services review this matter was looked at at some length. That report has been available to the public for some time. It is fairly evident that when the hospital was 23 beds the occupancy was in the low 20 per cents, which meant that most of those beds were not being used. When you compare that number of beds to other areas around the State with a similar population, that is not a surprise. A decision was made more than 12 months ago to reduce the bed capacity here to 10 beds, following the

clinical services review. Occupancy for the last financial year has been about 54 per cent. It shows that relatively low occupancy and it shows to us that 10 beds is probably more than adequate.

Mrs NAPIER - What percentage of those would be step-down beds, those people recuperating from major surgery at, say, Royal Hobart, Burnie or LGH?

Ms SCHNITZERLING - It can vary at any point in time. The clients we accept into our acute beds are general medical-type clients, whether they be paediatric, adult or aged-care clients who needs medical care. We certainly have post-operative care clients, post-natal care clients, rehabilitation clients and palliative care clients in our acute beds. So the mix at any one point in time is hard to judge. There could be one or two post-operative patients at any one point in time. I think most of our occupancies come from general medical clients.

Mrs NAPIER - Is there an active policy to encourage people, once they have had their operation, to come back and recuperate here on the west coast?

Ms SCHNITZERLING - We have no issues with people coming back to recuperate. We certainly inform all of our ante-natal clients that we are able to manage them post-natally should they choose to come back from Burnie or wherever.

Mrs NAPIER - And do they?

Ms SCHNITZERLING - Oh yes, we get quite a number.

Mr MORRIS - If I can just add, that's a key role for our facility, to offer that sort of step-down care. We would welcome patients in that situation.

Mr BEST - Someone made passing comment about it being a community-care centre, but has the model been designed from the needs in the community? Could we hear a bit about that? Maybe you might also talk a bit about what is transferring across. Is it going to be the same in terms of services?

Mr MORRIS - The clinical services review looked at all the services on the west coast, with a particular reference to what was required here at the West Coast District Hospital. We believed that the blend of services, all being together on the one site, is appropriate. I think the level of services - we talked about 10 acute-care beds - is more than adequate. Bringing the GPs into the site is a new approach here but it is done in some other places around the State and we believe it has a lot of merit. In an area like this, GPs and nursing staff, along with the allied health staff, it's important that they work together. I think we have endeavoured to provide a lot of consulting room access so that we can maintain the existing visiting services that we have but also have some flexibility to have more come in here. I think the family and child health and dental will have its own area within this building, as I think Scott showed, on the lower ground floor. That's again consistent with what we're trying to do in some other sites, and we believe that associates this area with all the health services on the one spot.

Mr BEST - And this has been a study that's been going over some time?

Mr MORRIS - The clinical services review was an extensive process. Originally it was initiated after the Government announced the decision that they were going to look at development of the West Coast District Hospital. We felt it was important to review the services that would be located here. As we commenced this project, with some outside members of the community and other health service providers on the committee, all those people on the committee said that rather than just looking at Queenstown we ought to be looking at the whole west coast, which we thought was an excellent idea. So it became the west coast community services review, and it endeavoured to look at the needs of the community right across the west coast.

In so doing, we put out a couple of reports and advised the community of the processes that we were going through. That demonstrated, first of all, the sorts of services and approach that we should take here in Queenstown, but also importantly identified how we might make the whole health system across the west coast work better. It was a very complicated system with lots of different providers, so one of the recommendations of that review was that there be a single auspice provider of health services.

Then there was a subsequent investigation of who that provider should be, with attention given to the west coast health and community services as well as the Department of Health and Human Services. The minister finally decided that the department would be that single auspice provider, so on 1 July this year all health services on the west coast have now come under the management of the department. The point of that is that this will also enhance our ability to coordinate across the whole west coast.

To take one little example, an Allied Health worker might have been contracted by one of those other providers, West Coast Health and Community, or Zeehan Medical Union, to visit that town, while the department was using someone else to visit Queenstown. Each was only doing a part-time role, but maybe if we put the resources together we could have generated enough resources for perhaps a full-time or almost a full-time position. That might then give us the capacity to attract someone here on a more ongoing basis. So those are the sorts of efficiencies and advantages that we think will come about through that. So this hospital development forms part of that whole picture, and in its own way here at Queenstown is an effort to coordinate all those things together on one site.

Mrs NAPIER - Before we leave the issue of the surgery, it's been put to me that where you have a major mining accident or tourist bus accident, where there are quite a number of people, rather than trying to get all the patients out, especially if it happened in winter when the roads can be closed and so on, a better option would be to bring a team of specialists in to deal with the emergency rather than trying to stabilise people and get them out. Can I have a response to that, please?

Ms SCHNITZERLING - To do that you would actually need to keep a range of equipment on site. Keeping a range of equipment is one thing, but equipment always needs checking and maintaining. To do that you need staff with the skills to do that on site, so how are you going to maintain those skills of those staff unless they are doing that type of work. From that quality point of view, it is not a good idea to have equipment on site that staff aren't going to use on a regular basis.

Mrs NAPIER - So the issue is more about the kind of equipment you would need more than it is anything else?

Ms SCHNITZERLING - It is the equipment but also the staff and the training that they need to work alongside specialist teams. You couldn't rely on a specialist team to come in and take over because they don't work here all the time. They need to know where stuff is, so you then need staff who have an understanding of what their needs might be. You are just not going to be able to maintain that type of skill level in staff that don't do that sort of work. Does that make sense?

Mrs NAPIER - It does but I think it is really important to have it for the record because there is certainly some concern that there will be a loss of a surgery, even though there are accident and emergency facilities there.

Ms SCHNITZERLING - An operating theatre you mean?

Mrs NAPIER - Yes, an operating theatre.

Ms SCHNITZERLING - We have not had an operating theatre for - how long?

Mr MORRIS - Some few years.

Ms SCHNITZERLING - So we do have the capacity now - it is about five years?

Mr MORRIS - I cannot recall the exact time but it is some few years.

Ms SCHNITZERLING - We have not had the capacity for about five years to actually conduct any sort of emergency surgery.

Mrs NAPIER - With a 10-bed acute sector, if you had a bus accident with 20 very seriously injured, how would this hospital deal with that?

Ms SCHNITZERLING - It depends on the site, it depends on the weather, there can be a whole range of options. Emergency services would be involved - ambulance services; SES; helicopter dispatch and whether they will be able to land; all those sorts of things - but there would be teams of people who would attempt to come and assist. Depending on exactly where it is, we are not necessarily going to need to bring all those people into the hospital. We may or we may not. Most of the time you deal with people on site and despatch them from there to appropriate care.

Mrs NAPIER - And while we are talking about that related issue, we have a helicopter pad here but the new site doesn't accommodate that. Where is it envisaged that the helicopter landing site would be in this proposal?

Ms SCHNITZERLING - We started looking at that a while ago, didn't we, Scott, but I don't think we have come to any conclusions.

Mr ALEXANDER - We were told at a public meeting recently that a helicopter has landed there once in 28 years. If you had someone in a helicopter from an accident site, and they were in the helicopter, you wouldn't bring them here. If they were in a helicopter you

would take them to one of the major hospitals, so you wouldn't be unloading people here. What you might need is to have someone from this hospital, who is considered too severe, taken out. There are a whole range of safety provisions around where and how helicopters can land and it depends on the capacity of the helicopters et cetera. You have problems with helicopters landing on building tops, so it would be most likely the helicopter would land on the recreation ground and there would be ambulance transfer.

Mrs NAPIER - You say the helicopter has only landed here once?

Mr ALEXANDER - My understanding was that at the last public meeting June someone said that there had only been one helicopter landing out here in recent memory.

Mr BEST - I guess that scenario of the bus accident is similar to the tragedy at Cradle Mountain, where patients were treated and then taken away and that sort of thing. Again, it is all the scenarios of what happens and the circumstances, but that is pretty much how the event would unfold.

Mr MORRIS - Our facilities in district hospitals across the State are not designed to be mass casualty centres. That is the proper role of the major base hospitals. Our role is to do what we can to stabilise patients and then get them retrieved appropriately, effectively and efficiently.

Mrs NAPIER - The contracted areas that are currently provided here that are allied to the hospital, the acute sector, are X-ray and pathology. Can we have an indication of what would be available under this new facility as compared to what is available now.

Ms SCHNITZERLING - We have a new contract with Northern Imaging that is the same as the previous contract we had which I think went for ten years. There is a level of service that they are obligated under this new contract to supply us, which at the moment is two days a week of X-ray services.

Mrs NAPIER - As I understand it, smaller equipment can only deal with full frontals but cannot do side X-rays. A question has been raised about what the capacity of the X-ray equipment that would be located here.

Ms SCHNITZERLING - There is certainly X-ray equipment here that Northern Imagining use, so we have an expectation that the same capacity will occur in the new facility.

Mrs NAPIER - Would that mean moving equipment from here, or new stuff?

Ms SCHNITZERLING - There are further discussions occurring at the moment with Northern Imaging as to what they perceive their needs are for the new facility, because the equipment here is actually fairly old.

Mrs NAPIER - What does the contract that has been around for ten years actually say, and what does it guarantee in terms of the kind of service? Two days a week?

Ms SCHNITZERLING - I actually don't know. I am sure it does not say we will be able to provide MRI scanning or CAT scanning or anything like that, but it provides for imaging

of our basic musculoskeletal system, so they will do basic skull X-rays, chest X-rays, abdominal X-rays, that sort of thing.

Mrs NAPIER - And in relation to pathology?

Ms SCHNITZERLING - There was a contract signed a while ago with North West Pathology. Their accredited pathology service is in Burnie, and so pathology was collected and taken to their pathology rooms to be tested and reported on. There certainly has been some pathology testing done here, but that is just point-of-care pathology; that is not an accredited pathology test. Those machines that are being used for that are actually old and obsolete and they will not be going to the new hospital. What North West Pathology are looking at is a point-of-care type machine, which is a much smaller machine that probably will conduct a larger range of tests than are able to be offered at the moment.

Mrs NAPIER - So the kind of tests that can be done now will still be able to be conducted, even though it might be through different equipment?

Ms SCHNITZERLING - Yes.

Mr MORRIS - Pathology is an area that we are hoping to improve through looking at some of this new technology, but I cannot commit to it today because there are more discussions to be held.

Mrs NAPIER - You would be aware of the community concern that there might be a downgrade in those areas. I am getting it on the record for that reason.

Mr MORRIS - No, no downgrade.

Mrs NAPIER - Apparently in 2001 there was a visiting paediatric physician, but that has not been available since. Is that planned?

Ms SCHNITZERLING - I understand that there has certainly been a statewide shortage of specialists. From the re-look at the Mersey situation there has been a review of obstetric services for the north-west and the recommendations in that are certainly for improved specialist services in relation to obstetrics and paediatrics throughout the entire north-west, and visiting services to areas such as Queenstown and Smithton. Hopefully through that review there will be services around the State once again.

Mrs NAPIER - In relation to the obstetrics, as I understand it birthing normally isn't done down here, although it can be. The design of the new facility, does that accommodate a birthing centre?

Ms SCHNITZERLING - We are certainly maintaining the equipment that we will need if a birth is imminent. That can potentially happen in the accident and emergency department or we simply can transform one of the acute care rooms. I think the one opposite A and E probably could be fairly easily transformed with the type of bed that one would use for a birth plus the equipment that is required. That is the aim with all of those rooms in acute care, for those rooms to be flexible so that we can shift a bed out if we require a

special sort of bed, or take one bed out and put in a sofa bed for a family who is staying with a palliative care client, so the aim is for those rooms to be very flexible.

Mrs NAPIER - When I was looking at the plan, whether it is in relation to a birthing centre or the palliative care issue, quite often you need a large enough space so that the family and others who are visiting can be part of it. You are saying that that one on the Dixon Street side is the one that you would consider using?

Ms SCHNITZERLING - No. Where the courtyard is, that one there.

Mr BEST - You have a big bath area over on the other side there, haven't you?

Ms SCHNITZERLING - Yes.

Mrs NAPIER - Aqua births?

Ms SCHNITZERLING - No.

Mr BEST - Sometimes women like to get in the bath.

Mrs NAPIER - It is the trend; I wouldn't like the idea, but that's true.

Ms SCHNITZERLING - It depends on the presentation.

Mr BEST - Sometimes the mothers, when they are in labour, like to have a bath.

Ms SCHNITZERLING - It can be in the car park, unfortunately.

Mrs NAPIER - With physio, I am told that the west coast mines are now using the Mersey rather here. Is it envisaged that you are going to try to increase physio services to encourage local usage? What is the plan on that?

Ms SCHNITZERLING - We actually have a physiotherapy service based from the North West Regional Hospital. We used to have, I think, one physio for two days a week. We now actually have two physios for one day a week. As far as the mines accessing private physio, I am unaware of that. Certainly with our regional health services there is new funding, and we are hoping to have access to it very soon, for other allied health services and there is the potential to top up physio through that for the whole of the west coast.

Mrs NAPIER - Dental: I note there is a new facility built into this design. Is that for children only or is that for a full dental service? What sort of visits will you be providing?

Mr CURRAN - The discussions I have been having with dental are to provide them with a surgery or dental facility the same as the one that we put in the Deloraine Hospital, which is two surgeries and a sterilising area and reception.

Mrs NAPIER - That is in the other building, isn't it, the old hall?

Ms SCHNITZERLING - Yes.

Mrs NAPIER - Which ultimately will be knocked down. Where does dentistry currently occur?

Mr CURRAN - There is a facility in central Queenstown at the bottom of Little Orr Street. There is a two-surgery facility there.

Mrs NAPIER - And that gets closed down?

Mr CURRAN - Yes. The service gets relocated to the hospital.

Mrs NAPIER - Is that provided by a private dentist or just public?

Mr CURRAN - My understanding is that it is part of the public system but -

Ms SCHNITZERLING - It is part of the public system. I know Oral Health Services are certainly very keen to recruit dentists for the area on some sort of regular basis but certainly DHHS has the capability of working with private dental providers if people are wanting to come to the area.

Mrs NAPIER - So it could be contracted to use that facility, like they do on King Island.

Mr CURRAN - Yes.

Mr MORRIS - A mix of private/public is something that we are quite willing to look at.

Mrs NAPIER - And with all the equipment you need already set up, because that is the only way you will get them.

Ms SCHNITZERLING - With the current small building in the centre of town, if we have dental allocated in the Gaiety Theatre, if dentists do start practice, when they need the assistance of other health professionals they are close to other health professionals if they require that assistance. That has been our experience in the past, that they have often needed them.

Mr ALEXANDER - Oral health and child care are quite discretionary services; people can bring their children or not. If you have a good, single entity where people can come in and receive a range of services in a nice atmosphere, it encourages them to bring their families in and gives a much better preventive model.

Mrs NAPIER - I have lots more questions but I am conscious of the time.

CHAIR - It is important on this services area to keep that thread going.

Mrs NAPIER - The other question was probably on pharmacy. There was some question raised about the new services being online. That was what was put to me so I thought I would ask the question: what impact would it have on local pharmacies?

Ms SCHNITZERLING - There is a private Queenstown Medical Union pharmacy that is run in Queenstown and we encourage them to conduct their private business. I know

there has been some work done in Queensland on a remote pharmacy service through videoconferencing. I know that was looked at for this area, but there has been no further advancement on that. That certainly doesn't replace the pharmacy service; all it does is support remote practitioners in the delivery of medications in the middle of the night. Say, for example, nurses at Strahan potentially could assist there, but it certainly doesn't replace a pharmacy service.

Mrs NAPIER - Good.

Mr BEST - Just on back-up from other hospitals, is there going to be any conferencing available, including online? If someone comes in with chest pains, for example, would you be able to contact a cardiologist at the Royal or Launceston or something like that? Are you going to have those facilities?

Ms SCHNITZERLING - Yes. We have videoconferencing here at the moment - it can only be set up in this room. In the new facility we will have videoconferencing capacity within the treatment room, also in the day centre and upstairs in the staff room for educational purposes. It provides not just consulting for clients with specialists away, but also communication with the staff for educational purposes.

Mr BEST - Just on that service aspect, I envisage that there would be fair amount of work pulling all this together, getting all the networks and coordinations and so forth. Is that you? What is going to happen? It can't be something that is just going to happen itself; it needs management, doesn't it? You obviously have a fair amount of research, so who is going to pull that together?

Mr MORRIS - As a result of the Government's decision to appoint the department as the single auspice on 1 July, a new position of HealthWest manager - we have called this new entity HealthWest - was advertised publicly and a recruitment process taken and, luckily, Karen Schnitzerling was the successful applicant. Karen is the new manager of HealthWest so, under her vast-flung empire over the whole of the west coast, she manages all of those health services. Under her, there is a team of various people with particular roles, a nursing team and professional staff, as well as admin and clerical support. So their job is to, I suppose, pick up the beginning of this process on 1 July, and develop it over the next few years into that fully integrated and coordinated model that we want. You're right, it's not going to happen overnight, but it will happen.

Mr BEST - So you've got these key people that you've used, as well as other people who have come in. Are you going to continue; is that how it will be brought about? You've probably said, 'We've researched this whole thing, we know what we really need to do', but are you going to continue that consultative process in some way or some format?

Mr MORRIS - Yes. There will continue to be consultation with the community, and of course with the health service providers. This could be an opportunity for me to plug the new HealthWest Services Advisory Council which we have been promoting down on the west coast for the last couple of months, though we haven't yet been killed in the rush for people who would like to join that council. That council, when it is formed, will be an ongoing group that will formally hear our plans and development ideas, and formally get the opportunity to comment on that. Along with that formal process, there will be informal consultations as required, and in terms of the health providers we will need to

link them into meetings and to sharing what they're doing right across the municipality. That will be Karen and her staff's job to make that happen.

Mr BEST - Thank you.

Mr HALL - Mr Chairman, I would like to just change the tack a bit with the line of questioning, and refer to Mr Curran, the architect, and talk about the old theatre. I have to say there appears to be quite a bit of controversy in regard to that, and there is some feeling in some of the submissions we've received that it ought to be demolished. You explained, I think, that it's not heritage listed yet but it's imminent. So in view of that, obviously, as an architect, it would have been much easier for you to have had that demolished and probably develop the whole thing on a greenfield site. What additional costs do you think will be incurred by having to keep that old building there and redevelop that? Has an estimate been done on that at all?

Mr CURRAN - I think in terms of redevelopment costs, even though we have to spend money to renovate the hall, the cost to actually produce a space within that hall would be markedly cheaper than if we were to build it as a new space. What it has done is impact on the design that we have, and it has forced us to re-look at how we would design that building to enable us to fit it onto the site. I must say that our initial reaction when we saw the site was to get rid of the hall and utilise the whole of the site. When our heritage architect started doing her assessment, it became apparent to us that we would need to keep that building. Even thought it wasn't listed at this stage, as we progressed forward it became clear that we should be including that hall as part of our plans, because if we didn't we would become unstuck at the other end because we would be forced to keep it.

Mr HALL - You say you'd be forced to keep it -

Mr CURRAN - Yes.

Mr HALL - So the advice has come from -

Mr CURRAN - Our heritage architect has prepared a report here, which I only received on Friday. There are a number of pages here that talk about maintaining the character and quality of the building, and the significant impact that it has had on the town, not just in the way that the building actually looks, but as a social space and about how people gathered and about how people were entertained. The history of that building over a period of time is significant enough for it to be retained as a building.

Mr HALL - Just setting that aside at the moment, there would probably be some more questions -

Mrs NAPIER - It was a matter we discussed outside, but for the record I've got some concerns in terms of the amenity for the persons who are looking over that little

Mr CURRAN - The memorial walk.

Mrs NAPIER - Yes, those people who are in those aged persons beds. I cannot see that they would be able to see anything beyond that roof. It would seem that if it was possible to take that building out - it is not a particularly attractive area - that would give much

better amenity, I would have thought, for the older persons who are living their final days there.

Mr CURRAN - It is a constraint of a site that we have. When we looked at other alternatives of where to place those aged care beds, it was thought there was a possibility to place them along Little Orr Street, which is back in the area where that service zone is at the moment, with a view back over towards the school. However, given that that side of the building does not get any sun and is a very cold place, when you consider all the constraints that you have on the site it would be better to have sunlight into those rooms. The beds are all orientated against walls, so the views are sideways so that you would be looking along memorial walk. If you rolled straight over in bed and viewed straight out, as we saw on site, you would look straight into the back of that red roof. What we have tried to do is to soften the impact of that building by placing that eight-metre walkway down through the middle and softening that with trees.

Mrs NAPIER - Compared to the perspective that Lyell House is in - and I accept that a number of those beds are facing blank walls as well, so it is not exactly best use of the view - there are some beautiful views that are accessible and viewable. There would be at least four beds in that area that would not get a view other than the roof. Is there not some other way to lift the height of that? I suppose you would have to lift the whole floor, and what would that cost? Is there some other way of giving them a view of something other than a roof? I have to tell you, I wouldn't want to spend days looking at a roof.

Mr CURRAN - It is going to be recoated, though.

Mrs NAPIER - You do admit, though, that they will not be able to see anything other than the roof?

Mr CURRAN - No, they will see the roof, but they will have an opportunity to see in either direction other than the roof. The roof is directly in front of them, I acknowledge that, and when they look out at their balcony and they look straight ahead they will see the roof, but there is an opportunity for them to view in either direction and also to view down into the memorial walk.

Mrs NAPIER - But if I am in bed six, five, or four, or even three and two, I am not going to see much, am I, except being able to look down at the balcony.

Mr CURRAN - If you are in three or two -

Member of Public - You are looking at the morgue down here.

Mr CURRAN - That is a constraint that we have on the site. If you go for sunlight to create a warm and inviting room for them, we cannot do that if we locate them down the other side.

Mrs NAPIER - As I understand it, it is actually listed on the West Coast Council's development plan as a heritage site. Have discussions been had with the West Coast Council as to whether they would see the retention of that building as being important, or

whether they would allow that to be demolished and a new facility built to accommodate the perspective for the older persons?

Mr CURRAN - It will go back to the Tasmanian Heritage Council, who will have the final say over whether that building is allowed to be demolished.

Mrs NAPIER - My understanding is that it is not with the Tasmanian Heritage Council.

Mr CURRAN - No, but the advice that we have been given is that as soon as we put in an application to demolish that building there will be a listing placed on that building.

Mrs NAPIER - Because it's listed on the West Coast Council development plan?

Mr CURRAN - Yes, and because of all of those other reasons that I have outlined previously, about the social context and all those other things.

Mr BEST - Given that it is not going to be a hall, it is actually going to be a series of facilities - and just looking at the map, you have physio, a gym, X-ray, pathology et cetera - why would you not be able, to just rebuild? Okay, keep the façade and those things that you are talking about. Maybe, though, just drop the roof so that people are not looking at that red. It seems a bit harsh, even the colour.

Mr HALL - It is a change of use, isn't it.

Mr CURRAN - These are the issue that we have to deal with with in heritage every day.

Mr BEST - But sometimes you can modify.

Mr CURRAN - You can, but the advice that was given to us is that the construction technique is very important because it is particular to this area.

Mr BEST - Is that the roof?

Mr CURRAN - The whole of the hall - the hall, the construction, the pieces that were added on. It even talks in here about the floor, even though that has been replaced over a period of time. It was identified in 1995, as part of the Godden McKay report, as being a building that had some significance. All the things at the moment are stacking up against that building being demolished.

Mr BEST - Well, it is going to fall down, isn't it, if this redevelopment did not happen?

Mr CURRAN - In all likelihood it would over a period of time.

Mr BEST - Wait another two years and you probably wouldn't have to.

Mr CURRAN - It would probably take longer than that. Some developers take that tack.

Mr HALL - When I asked the question regarding any additional cost, do you have any figures that you might like to put on the record?

Mr CURRAN - Yes. Work that we have to do to turn that building into the allied health services building is $587 149.44

Mrs NAPIER - Where would the bulk of that expenditure be directed? If you have to redo some of the floor, underneath floor section or fix up the cement, can you give us a breakdown of that. Maybe they might be able to table a breakdown of where the expenditure would be made in redeveloping that building, including restoring heritage components of it.

Mr CURRAN - In very rough figures - just pulling some pieces out of this breakdown at the moment - there is probably about $100 000 worth of rectification work that needs to be done to the hall.

Mr BEST - You will have a suspended ceiling, won't you?

Mr CURRAN - Yes. We are lowering the ceiling down to the top of the windows so that it makes the building a lot easier to heat and a lot more practical for the uses that we need.

Mr BEST - You will have just a cavity within the gable?

Mr CURRAN - It will be flat - a new plasterboard drop-in ceiling goes through there. We will be relying on some roof lights to let natural light into the interior of the building, and also some natural ventilation.

Mrs NAPIER - What are you going to do with the wooden ceiling that is currently there?

Mr CURRAN - That will remain intact.

Mr HALL - Is there any remediation that is needed to be done? I noticed that when we were looking at it from Dixon Street, the profile appears to be dipping and falling away on the southern side.

Mr CURRAN - There's water damage that needs to be rectified and also I think there are some structural elements that need to be strengthened in there as well. The roof was, I think, replaced in the 1950s when the school took over the hall. The drawings that were done of the roof at that stage showed quite a significant sag in the roof.

Mr HALL - Could I just look at this existing facility at the moment. There was quite a bit of rationale behind the reasons why this hospital couldn't be redeveloped to a satisfactory standard. I noticed on page 8 it gave an estimate of additional costs with redeveloping this existing site. If you take away the staged demolition of the existing building to bring it up to probably some OH&S standards for removing asbestos - which I understand is not contained in this main hospital building but is in a couple of smaller buildings - the site works to get level access and also site stabilisation, you are looking at a bit over $500 000 to do that. I acknowledge that there are some structural difficulties here within the building, but was an estimate ever done of that to redevelop this building to a satisfactory standard? We're looking at over $7 million to do the new project, which is quite a significant amount of money, so it behoves this Public Works Committee to look at all aspects.

Mr COCHRANE - The history of the development I suppose goes back to when the original funding submission was put into Treasury. At that time we went through a project initiation process and our submissions actually listed a series of options. Part of that report was an assessment of this existing facility by a professional consultant and an architect. It was their recommendation, based on the costs at that time, that it would not be cost effective to redo the hospital for the various reasons that were indicated in that report. I don't know whether it actually came up with a specific cost at that time, but all the options were costed and the most cost effective and the optimal way to provide the services was to redo it on a greenfield site.

In addition to the cost of redoing the hospital, with what we're planning, these smaller rooms with individual en suites, some of the internal walls are structural and where they sit on the slab there are strengthening beams underneath. Those strengthening beams will in every likelihood be in the wrong areas. So it's not just a matter of knocking walls out. If we wanted to build a facility that gives us the same flexibility, it really means in most cases that we would be back to the bare earth. That would include also taking out the current services, because we have old cast iron risers going up the side of the building for plumbing and we have vitreous enamel pipes under the slab. It gets to a point where if you didn't do that you'd be spending money on a building that had some very significant compromises on the longevity of some of the services. We've had two or three professional assessments done and everyone has come up with the same conclusion.

One of the major problems with this building - and one of the major strengths, if you like - is that it is very sturdily built. It's a very solid building and if you tried to take out walls or widen doorways or widen passageways, because it's so robust a construction it would become a very difficult process.

Mr HALL - But there wasn't any quantum of money put on that? You didn't get that far through the process, is that what you're saying? It was dismissed for other operational reasons?

Mr COCHRANE - Without having the initial PIP under my hand, I'd be reluctant to say that. I know part of that to get through the Treasury gateway there does have to be a value management study done on what is the most cost-effective way. Obviously that was proved at that time that a new facility was the most cost effective method.

Mr HALL - I'm not saying you're incorrect in what you propose; I'm just asking those questions because obviously there has been money spent. I think in 1995 there was a new age care part; the wing was added to it, so that's relatively recent history. The question would then flow on from that, I suppose, that if this committee approved the development of the new hospital, what would happen to this existing facility? Has any thought been given to that? You've got quite a large building sitting here in the town; would it be tendered for sale?

Mr ALEXANDER - It would. In the initial concept for the new hospital there was an amount set aside, though because of the escalation of building costs that may or may not be available. We'd be reluctant in the current environment to demolish it in the first instance simply because there has been enhanced economic activity. Certainly people have approached us informally. So we would intend to sell it if there were a use; we'd

retain responsibility for it in the meantime. If, in the foreseeable future, we couldn't find a use for it then we would either secure it or demolish it.

Mr HALL - Obviously it would have to go through a change-of-use process under the West Coast Council's planning scheme. Are you aware that there are other possible uses for the site at the moment?

Mr ALEXANDER - Yes, it is very difficult for exactly the same reasons as it is difficult to reconfigure as a hospital; it's very hard to predict. If you draw the analogy with the old Launceston General Hospital, for a number of years that was seen as a millstone around our necks, to be honest. There was no foreseeable redevelopment. The increase in the residential market in the last two or three years has made it a saleable prospect to redevelop. The same thing could happen on the west coast.

Mr HALL - The nurses home, that is still in adequate condition, or not? I saw somebody shudder there, so is there any proposal for work to be done there at this stage?

Mr ALEXANDER - Not out of this project budget. Again, Karen knows better than most that again it comes to the amenity and therefore being able to attract and retain staff in the area. We are asking government independently for maintenance funding for our existing buildings because maintaining the infrastructure we have is pretty crucial to us.

Mr HALL - In the new development site, is there room to establish new quarters for nurses there? No.

Ms SCHNITZERLING - Just an aside from that, there has been some development of some of our property at the moment because there can be funding through the Australian Government working with universities to provide accommodation, firstly for students in rural and remote areas, and then other health professionals - nurses, doctors et cetera. So we are working our away along that track at the moment.

Mr HALL - So in a logistical and strategic sense, if the nurses home here had to be redeveloped, is that an issue - being separated by some distance from the new hospital?

Ms SCHNITZERLING - In all honesty, I think it is always beneficial to have accommodation for staff that is away from the facility because it helps give you your own identity, so to speak, and to get you away from the job. However, if that is left up here on the hill without the hospital functioning, potentially it is isolated in this township. That certainly needs to be looked at, but we have already started looking at working with the university department for help in relation to accommodation for staff.

Mrs NAPIER - Although the Government have sold the old school, you bought back some of the land on which we are building the new facility, so it would seem to me a good idea to buy back the school. That can be part of the university teaching centre and provide accommodation and allow for any expansion that might be needed into the future. It would also give you space for a helipad. It makes sense to me.

Mr ALEXANDER - I hate to disagree with a member of the committee, but the school was built and configured for a totally separate purpose. Big, high-ceiling classrooms with lots of glass are not easily convertible to the sorts of uses that we would want.

Mrs NAPIER - They did a good job at Glen Dhu.

Mr ALEXANDER - It is a two-storey building with no lift and it is not appropriate for disability access. The Health department is really trying to reduce the money we are pouring into old assets, to keep our service delivery as good as it can be. We really don't see that there is a good use of that building for health-related things. As far as expansion goes, certainly we have had lots of approaches including demolition of that site. Again, there are heritage issues around that site which, if you reuse it, it wouldn't be a problem. There are murals and so on of heritage interest. Without demolition we haven't got a helipad. As I say, essentially the configuration of it would not suit anything that we do.

Mrs NAPIER - In terms of expansion, this seems to take up the site. The only way that you could come up with expansion is to fill in your courtyards and the balconies, which would reduce the amenity of the facility.

Mr CURRAN - There is an opportunity across the back side of the site down Little Orr Street to consider for expansion, and we have set the building off Little Orr Street as well in the event that expansion would be required through some of those areas. So we have not used all of the total site that is available to us. There are still some areas that are available for us to expand the hospital into.

Mr ALEXANDER - What is known as Little Orr Street is not a street on the title. It stopped short of our property although there is a walkway through there, so that is not a public street.

Mrs NAPIER - So you own Little Orr Street?

Mr ALEXANDER - The title goes straight through, past the trees and on another seven metres, and there is no constraint on that title.

Mr CURRAN - The only right-of-way that we have -

Mrs NAPIER - So you could build over it if you wanted to, couldn't you.

Mr ALEXANDER - If it were necessary, I don't see why we couldn't.

Member of public - It's a drainage reserve.

Mrs NAPIER - Do you know of any constraints that would prevent you from building over it?

Mr ALEXANDER - The gentleman over here has just said it is a drainage reserve, and certainly drainage is an issue that we are resolving with the hospital, but it is not a street.

Mr BEST - I was actually going to ask a question about the drainage. I refer to the site elevation plan, particularly the southern elevation, no doubt the drainage issues will be removed with the construction of the building on that existing asphalted area, but what will happen with the drains down that street, because you also have a mechanical plant room, haven't you - a power room?

Mr CURRAN - Yes, that is right.

Mr BEST - So you will have that; there will be adequate drainage, I guess. You will have kerb and channels or something, will you, and that will be picked up down the bottom end into this other street, Bow Street?

Mr CURRAN - Yes, we have to upgrade the stormwater and sewerage line that runs down Little Orr Street to be able to take the new capacity of the stormwater and the sewerage that we are putting into it.

Mr BEST - Right. So that joins into Bow Street?

Mr CURRAN - Yes.

Mr BEST - I have a couple of questions in relation to the ground floor level. Starting with the outside, I just noticed with your three-dimensional picture there seemed to be two versions. We talked about the importance of the community having areas there to sit and talk or whatever. One three-dimensional picture I looked at had a raised bed around the trees and the other one did not. Do you really want people congregating in this courtyard? What is the strategy there, because you have offices there too, haven't you?

Mr CURRAN - We see that as being an ideal place for people to meet. People will be coming and going through this area all the time. Given that you have people who are sick coming to see the doctor, people who are coming to visit patients and staff who actually work there, it is a really good opportunity, I think, for the people to mix and meet. This memorial walk that we have here is a great spot for that to occur.

Mr BEST - So you won't have seating in that area? That will be outside.

Mr CURRAN - I would like to see some seating down through that area there.

Mr BEST - So that is yet to be configured?

Mr CURRAN - Yes.

Mr BEST - Okay. The other question is: obviously you want one reception. I wouldn't suggest that you would have two. But just looking at that site plan, on the ground floor you have your main reception area heading into the main part of the facility, and then of course people go to the Gaiety Hall area for treatment for other things. I guess they will be encouraged to present at the reception and then be referred from there. They will not just turn right unless they have a specific appointment?

Mr CURRAN - The reception areas actually open into that link-way, so as soon as people present in that area there they will be able to see the reception basically right in front of them. It is envisaged that they would ask for directions there and -

Mr BEST - Yes, it is pretty obvious; there is not going to be any confusion with people wandering around. The day centre, which also doubles as a public meeting area, what is the capacity of that, roughly?

Mr CURRAN - I think it is about 50 square metres, from memory.

Mr BEST - So you would be thinking of what, 20 or 30 people, perhaps?

Mrs NAPIER - Fifty square metres is a fairly big area.

Mr BEST - It is a big area, isn't it, but then it is squared.

Ms SCHNITZERLING - It depends on whether you are looking at tables with chairs around them or whether -

Mr BEST - Sure. I just wondered what -

Mr CURRAN - It is about 50 square metres, so we're talking probably about 30 to 35 people in that room comfortably.

Mr BEST - That's what I thought.

Mrs NAPIER - Can I ask a question on the day centre? Is it envisaged that you would run a day activity service, whether it was for older persons from within the community or for mums and children?

Ms SCHNITZERLING - It certainly could be used for that. No decisions have been made on that at this point in time, but certainly child and family health are looking at it for parenting classes. Our regional health services arm is looking at using it for helping promotional activities et cetera.

Mrs NAPIER - Do you have a day program for older persons?

Ms SCHNITZERLING - There is one run at the moment from Zeehan; there have been clients in the community transported from Queenstown to Zeehan. But certainly that will be looked at as to what the needs of this community are.

Mrs NAPIER - In looking at the design - and I think facing onto the street is a great idea - my question relates to storage. It is a flexible centre, as I understand it, but whether you are running a mum-and-kids session or a day service for older persons, there doesn't seem to be anywhere you can store things.

Ms SCHNITZERLING - We haven't got to the detail on that yet.

Mr ALEXANDER - What we have tried to do, and we have done in other places, is to develop a flexible space which would have capacity to maintain tables and chairs and maybe even a cupboard with a television and audio-visual things. It is designed to be as multi-use as possible. That is why it has its own street entrance, a tea-making area and toilets; you can close off the rest of the facility. In a lot of our facilities around the State there are all sorts of private groups and other groups that we are encouraging which are unrelated to the Health department as such, but we would expect them to bring and take specialist equipment with them because it could vary from time to time with any group.

Mrs NAPIER - I was looking at that and I was thinking that it has great potential as a day centre for multipurpose activity, but potentially that spare office could be so, but you have the doorways on either side of the WCs. I wondered whether the doorways would be better back one to the south so that the spare office could at least be used as a storeroom.

Ms SCHNITZERLING - I don't think that will be a spare office; I think it will be a used office.

Mrs NAPIER - Storage is a real issue for community groups and services.

Ms SCHNITZERLING - It certainly is.

Mrs NAPIER - You wouldn't want to be carrying stuff backwards and forwards; you'd want a storage area.

Mr COCHRANE - At the Westbury Community Health Centre we had a space where a shutter went across and they could put their tables and chairs in there when they weren't using them. When you opened it up and moved the tables and chair out, it didn't restrict the physical size of the space because it became space that you could use.

Ms SCHNITZERLING - Also on the ground floor is a community health store, so that is a storage space. Community equipment, in essence, comes down from the community health centre in Burnie and goes straight out to the clients in the community.

Mrs NAPIER - I wouldn't have thought you'd want people running other programs necessarily accessing that space. I just raise it as an issue because 50 square metres isn't very big if you start putting cupboards and storage areas in it. It is functional without taking away, but there is nowhere if you wanted to increase the space. Presumably there could be physical recreation occurring in there for older persons and things such as that and it would seem to me that you would need to -

CHAIR - There is an easy solution, if I can truncate the discussion, because there is a huge amount of sub-floor space in behind there heading back up towards Dixon Street. The only intrusion is the fire services, so there is heaps of space if you wanted it.

Mrs NAPIER - We could gently suggest in our report that consideration be given to storage adjacent to the room.

Mr ALEXANDER - The trouble is that storage needs expand to fit the storage that you provide.

CHAIR - Okay, I think the point has been made.

Mrs NAPIER - On that same building, the gymnasium that is shown isn't even as big as your X-ray room and I would have thought that whilst you are presumably looking at a treadmill or an area where you can develop flexibility, you usually need a table that the person can lie on and you might need exercise bikes and a few other things like that that physios use -

Ms SCHNITZERLING - The physios have actually reviewed that and commented on the size of that, haven't they, Scott?

Mr CURRAN - Yes, and they thought that was appropriate for the activities.

Ms SCHNITZERLING -Yes, they thought that that was appropriate for the activities. They have certainly spoken about things like strengthening classes and they would take that down into the day centre to do that sort of activity.

Mrs NAPIER - Physios I have been to involve you in using bicycles and goodness knows what else, and it just seems a tiny little area for doing physio.

Ms SCHNITZERLING - That recommendation came from those health professionals themselves and certainly that area will be shared by podiatrists as well when they visit, and they have looked at that area as well, haven't they?

Mr CURRAN - They have, yes.

CHAIR - Again, this reduced plan may give the impression of that being a tiny area; I suspect that it is not such a tiny area, it could well be in the order of 15 to 20 square metres, probably more.

Mr CURRAN - It is 20 x 4.

Mrs NAPIER - Whilst we are looking at this plan, the width of the walkway - the memorial walk - you said 8 metres?

Mr CURRAN - Sorry, it is 7 metres.

Mr BEST - Just a couple of issues while we are still on the ground floor: you have the morgue area, you have a staff dining room and you have the base entry for the lift. I can see two double doors on what is termed the morgue viewing area which could be a very quiet place for people to go. However, do you think there ought to be a door between the corner of the lift and that hallway on the western side? You have a staff dining room, with people coming out and entering, so I am just wondering whether you lose a bit of privacy there. Do you know what I am referring to?

Mr CURRAN - Yes, I do.

Ms SCHNITZERLING - Privacy for the staff or the people viewing -

Mr BEST - Well, you are going to have people coming and going into the staff dining room area and then you have the morgue viewing room. I do appreciate you have a double door there and it is set back in a way behind the lift recess -

Ms SCHNITZERLING - For that privacy.

Mr BEST - I just thought maybe you might have had a door in there but I just raise that as a question in relation to to discreetness.

Mr CURRAN - I think we could consider that.

Mr BEST - I think you should. The other issue I had was in relation to the ground floor. You have a plant generator, oxygen medical gas and a freezer cool store. Would that be the noisest part of the hospital - you have trucks coming and going in there as well, haven't you?

Mr CURRAN - If the generator wasn't operating the only noise that would be coming out of that area would be the plant for the freezer and the cool store.

Mr BEST - You haven't bought the gear obviously, but you would have some idea of the sort of thing you are looking at. What sort of sound will there be? You have those units up the top, those aged facilities, just up above that. You have bedroom 1 -

Mrs NAPIER - That is to compensate for the view.

Mr BEST - The noise, the activity and the trucks.

Mr CURRAN - We have an acoustic consultant who gives us advice on areas such as that. He will give us advice on whether we need to put padding underneath the slab or whatever so that the noise is mitigated in that area.

Mr BEST - It depends on which way the noise is generated. One would assume that it would come from the western side. With the southern elevation I would assume it would come from the southern side and not generate down through that memorial walk. I just thought you needed to think about that one. I have a couple of questions on the courtyards. What do you envisage with the courtyards? From the picture, it appears your roofs are all sloping outwards towards the streets, but you're still going to have -

Mr CURRAN - Those two courtyards that we have there are open to the sky. They'll be treated with waterproof compounds so that the water doesn't penetrate down to the area below. Then they'll have a surface over the top of that basically with some pits in the middle to take the water, so we're looking at running the water -

Mr BEST - So you'll have drainage from there.

Mr CURRAN - Yes. We've been looking at whether or not we should provide two square pits through there or whether we'd be better off to just provide one long grated pit. We're just having a look at how the water's going to drain in that area.

Mr BEST - I was thinking when you were talking about your boxed guttering that in fact you'll have to have something like that in there, won't you? But it will be separate in the sense that it's not actually drainage, it's not that everything's going into it, but where it's exposed it will -

Mr CURRAN - It will be a boxed drain.

Mrs NAPIER - On the courtyards, are they to be glassed in all the way around?

Mr CURRAN - Yes.

Mrs NAPIER - Like on the LGH.

Mr CURRAN - We're looking to try to use those to create a means of lighting corridors.

Mrs NAPIER - It'll bring light into all the other rooms, too.

Mr CURRAN - Yes

Mr BEST - Just moving along, then. Your nurses' station: you have one near the southwestern corner.

Mr CURRAN - That's the aged care one.

Mr BEST - That's your aged care nursing station. How does that go, then, in relation to supervision of that wing? You've got through to beds seven and six, and then you've got this blind slotted line. Is that a firewall or something?

Mr CURRAN - All those dotted lines are smoke and firewalls, yes.

Mr BEST - I suppose you would have dementia beds further down near the nurses' station, would you? And those needing less care would be further along?

Ms SCHNITZERLING - Yes, it depends on your client type as to where you place clients in any facility, but certainly we've been doing work on the communication system, the call bell system and how there are a motion sensors set up within certain rooms for clients with dementia. We're also looking at wrist band-type situations for clients who may wander and you'd like to know when they've reached certain points in the building, so there'd be some sort of alarm on the call bell system. We've been working on all of that, and that certainly has been considered.

Mr BEST - I'm assuming those with high need would be from bedroom one to perhaps five, that's probably what you'd be thinking. Would that be right?

Ms SCHNITZERLING - It depends. Sometimes a resident may deteriorate in bed nine and it can be very disruptive to move them, so you consider what their nursing needs are at the time and adjust your staffing to meet those needs.

Mr BEST - It seems a shame you don't have a design where you can see everybody almost -

Ms SCHNITZERLING - But that's a residential aged care home as well, and their privacy needs to be respected.

Mr BEST - But it's not all acute, is it - yes, that's fair enough. Then you've got the acute beds further along with your other nurses' station, and then beds nine and ten are part of your surgical.

Mrs NAPIER - Can I ask a question about that area of supervision? What kind of traffic would be using the lift to access the acute sector?

Ms SCHNITZERLING - Potentially that could be used by people who don't know the facility, and they would come into the main entrance of the hospital during normal working hours and then be redirected, 'We're visiting so-and-so who was dropped off here last night'. 'Yes, they're in acute section'. But when the lifts open - we have discussed having decent signage but we also discussed having nurse calls at each of those nurses' station. If they can't work out where to go, if they can't read the sign, there will be a call bell where they can press the bell and the nurses be alerted that someone is at the desk who needs assistance and they would go to their assistance. The same applies to the other nurses' station down the other end.

Mrs NAPIER - The reason I was raising the question is that you have a number of health services that are going to be in the hall - doctors, physios and so on - but then I would think that at various stages those same persons would need to access the acute sector, which is at the other extreme. The lift is perfectly placed for the aged-care section, but I wondered how much disruption there would be to the peace and quiet of that other sitting room by people using the thoroughfare through to the hospital section.

Ms SCHNITZERLING - The actual doorways to the residential aged care are at the end and that defines aged care. The other doorway is between the courtyard leading off the acute sector; there is a corridor there. That is a doorway defining residential aged care and also another doorway defining residential aged care. This resident quiet room sitting room, certainly there can be some visitors who come up via the lift - and we have looked at this - who might want to see a resident privately and the resident may be willing to see them. We simply usher them straight into there, they wait and we get the resident for them.

Mrs NAPIER - Okay. So that's not actually an aged-care -

Ms SCHNITZERLING - It is aged care but it also comes off the courtyard. It is set away from the bulk of it so that it can be separate from aged care.

Mrs NAPIER - I just wonder what use might be made of that because it seems to me that in the lounge area of the balcony, dining and sitting area, where there is a bit of a view, that looks to be relatively small for 16 beds.

Mr CURRAN - It's actually 45 square metres for the dining area; the sitting room is another 48 square metres. They are quite large rooms for the numbers we have in them, remembering that not everybody is going to be sitting in there at the one time.

Mrs NAPIER - No, that's true. It's just that I counted up 13 chairs and I thought, 'If you have a visitor, that's some more bodies you have in the area'.

Mr CURRAN - We'd like to set that up so that we have flexibility with what that space can be used for.

Mrs NAPIER - Related to that, the balcony space is quite small, especially when I compare it to the staff balcony. That seems like a ballroom out there, but the one for the aged persons is pretty small.

Mr CURRAN - Our experience is that not a lot of people actually go outside unless they want to go out and smoke or for any other reasons. What we have tried to do is to make that area so that when the doors slide back it helps to bring outside inside a little bit, rather than having a huge balcony that doesn't get utilised. That was the thinking behind that: that each of the residents has a chance to have their own balcony space. The staff really don't have anywhere else to go to an external area; all of their spaces are inside. It was felt that that would be a good space where they could get away from the day-to-day and have access to the sun and fresh air.

Mrs NAPIER - What square metreage is the balcony?

Mr CURRAN - On the aged-care balcony?

Mrs NAPIER - Yes.

Mr CURRAN - It is two and a half metres wide by five and a half metres through the middle section.

Mrs NAPIER - So it is probably bigger than it actually looks on the plan. Just for interest, what is the width of the balconies that each of the aged persons have?

Mr CURRAN - Those balconies are around about a metre wide through the narrowest point, and where the doors are they go back out to about 1100 mm.

CHAIR - Committee members, we have been going for about two-and-a-half hours. I guess we need to focus fairly solidly. I do appreciate that it is important, given the nature of this extensive expenditure, that we satisfy ourselves that it is good expenditure, if indeed we are to approve this project. So it is certainly not my position, nor my right, to truncate any questions at all but, as I say, it has been a fairly extensive discussion in terms of the fit-out, the lay-out and all that goes with it. Are there any more questions on that?

Mr HALL - Not quite on that thread, but I have three questions here, if you wouldn't mind, Mr Chairman, to Mr Curran. We had a bit of evidence this morning that on the proposed new site was an old service station or garage there. Are you aware of that and what the implications of that might be?

Mr CURRAN - Yes, I have been made aware of that, and we have certainly made our consultants aware of that, and that will be the subject of their site investigation when they get down on site to do some geotechnical -

Mr HALL - So there may be some additional costs if that turns out to be a polluted area?

Mr CURRAN - If they do find some pollution, yes.

Mr HALL - Okay. I noted on page five it mentioned that the Government had allocated *x* amount of money. The quantity surveyor says that the cost of the project may be well in excess of what a similar project in Launceston or Hobart might be because of perhaps

isolation and the difficulty in attracting builders. Do you have any idea of what percentage it might be over and above what is estimated at this stage?

Mr CURRAN - I couldn't tell you right now, but I could provide that information to you if that was a request.

Mr HALL - If you would, please.

Mr ALEXANDER - There was a preliminary site investigation done before the architects were commissioned and before we entered into any negotiations to purchase the land, and that covered a range of things: provision of services, possible contamination, heritage issues et cetera, so we do have some information. That did not show evidence of contamination, but it just took some samples. We will be doing more extensive work there. On the second question, prices are very volatile, and I won't read it unless you are interested, but we did bring a paragraph by a quantity surveyor which is not related to this project, but which explains very much what is happening: the bulk of work that is available in the urban centres, making it unattractive for people to travel, because that is a cost to them, and the availability of some subcontractors, and the quantity surveyors themselves are very reluctant to quantify what that cost might be. Two years ago they essentially had a table. Town X was plus 6 per cent, Town Y was plus 10 per cent. They are very reluctant to provide any definitive information because it depends what other tenders are in the market at the same time.

Mrs NAPIER - So why has it blown out to $7 million, because in the 2004-05 Budget it was $3.9 million? This documentation actually says it is $7 million.

CHAIR - The submission addresses that - it is for those very reasons.

Mr ALEXANDER - Yes, the funding was actually determined back in 2001, and then Cabinet and Treasury determine when that funding becomes available. But until now, again those building costs have been relatively predictable over the last decade. In the last two years that has ceased to be the case because of the volume of work.

Mrs NAPIER - And the Chairman has drawn to my attention that it is a couple of years away. It is just that it is always interesting to find out why.

Mr HALL - Just a final question, Mr Chairman. This current structure sits in relative isolation from a residential area. The new hospital will be almost right in the middle of town and there is obviously going to be an impact in terms of when the construction starts, and then the ongoing running of the hospital. Has consultation occurred with the residents who are close by in regard to this development?

Mr ALEXANDER - Not specifically with individual residents other than through the planning processes. There have been two public meetings this year and as a result of one of those public meetings Bill and myself came back to talk to the people locally, so we made that opportunity available from our point of view. Plans have been on display since January and we have been available to respond to people.

Mrs NAPIER - In relation to plans, the point was made that people said they hadn't seen these particular plans. What variation is there from the plans that I remember seeing

back here at the hospital, probably five months ago or thereabouts? What variation is there from those conceptual plans to these more detailed plans and how have they been made available for the community?

Mr COCHRANE - More recently we have had a look at some of the issues that Scott has talked about, and the major difference has been the change to the roof line. There have been some minor changes to the floor plan - a move of the cleaners room to here or the nurses station from that side of the corridor to this side - so basically they have stayed true to that original concept. It was only on 15 November that we lodged our development application and the biggest change has been the roof line. Now that we have got to development application stage and a more finite level of planning, one of our next steps will be to update the drawings that we currently have on display publicly.

Mrs NAPIER - Are these updated plans available within the community?

Mr COCHRANE - Not as yet.

Mrs NAPIER - In the light of concerns that I think a number of us have received in relation to the consultation process, do you agree that it might well assuage concerns to have that kind of documentation out as early as you can get it so people are informed?

Mr ALEXANDER - Certainly, but as Bill said, there have not been substantial changes. We have understood that there are certainly community concerns about some of the elements of the design and those relate to the absence of an operating theatre and those sorts of things which have been well and quite openly discussed. The major physical changes have been to the roof line, which has been really from an engineering point of view to ensure that we don't retain hail or snow in internal guttering where it can't get away. Internally, there has been a refinement of the design with the service providers. For instance, you asked about the gymnasium and those sorts of things, so it would be minor realignments of one room to another but not to a scale where we have thought it would adversely impact on anyone.

Mrs NAPIER - For those who would argue that the consultation has not been with the broader community, how would you respond to the criticisms that have been brought forward that the consultation hasn't been more generally made available to the wider community?

Mr ALEXANDER - There are always things you can do better. I think Phil spoke earlier at length about the consultation concerning the service need. Our job is to respond to that service need in developing a design. A gentleman this morning said, 'It would have been nice if we put a billboard on the site with a picture'. We thought, 'Yes, that would have been nice', but we didn't do it. So certainly there are things you can do. As I say, we have been here twice for public meetings this calendar year. As a result of one of those public meetings and conversations with some of the gentlemen here in the audience today we came back and talked to them, we certainly made the invitation that we are available and I think we have responded whenever that has been the case.

Ms SCHNITZERLING - We have had plans posted both at the hospital and at the council offices in Queenstown, from the concept plans earlier year and then, as plans have progressed, they have been upgraded. With the way we are working on the plans, at the

moment, I am meeting with Scott on a weekly basis so there are lots of minor changes that are occurring the whole time. But really, as Peter said, the actual concept hasn't changed. We invited comments from the community to be either passed onto the council offices or to myself here at West Coast District Hospital. We have said that on a number of occasions and have been very open to receiving comments.

Mrs NAPIER - Just for the record, because there has been a lot of representation about this too, is it likely that this will continue to be a hospital or, given the range of services that are to be provided on the one site, is it likely to be seen as a multipurpose centre?

Mr MORRIS - I will comment on that one.

Mrs NAPIER - I must admit, even in the budget papers there was 'multipurpose centre' in one paragraph and 'hospital' in the next paragraph. The two, as you are aware, have different requirements in terms of consultation and potential management.

Mr MORRIS - We are talking about the redevelopment of the West Coast District Hospital; it is not an MPS. The idea of an MPS, if applied to the west coast, would apply to all health services. I think there appears to be a belief that an MPS equals a single facility; that is not the case. The concept of an MPS can apply right across an area. In the case of the west coast, the only thing that would ever make sense is an MPS incorporating all the health facilities and services. The idea of an MPS in simple terms is that all the funding that comes into an area is put, metaphorically, in the one bucket. Then the money is doled out from the bucket by the provider in consultation with the community. In this case here, we have at the moment shelved the idea of an MPS; it may have merit across the west coast, but it may not. We have some of the building blocks in place, including the HealthWest Services Advisory Council, which we would like to get off the ground. If an MPS was ever contemplated, that group would obviously be a key community consultation point. Where there are MPSs around Australia, there does have to be a formal community input structure. In a way, we have already achieved the concept of an MPS, namely the single bucket of money, central management with a view to services across the whole area, with formal community input. We already have all health services under a single management; we already have the funding coming in, admittedly from all sorts of different sources but it is all reported in a global way as well as in the respective cost centres. We intend to have a formal community advisory committee. The other objectives of an MPS concept are to have service integration and coordination. We are endeavouring to embody those concepts in all we do throughout the west coast, including in this particular development. That is how I think we would view that.

Mrs NAPIER - So you're unlikely to hand it back to the council

Mr MORRIS - Yes.

Mrs NAPIER - I just wanted to get it on the record that it has been raised.

Mr MORRIS - An MPS can be run by a department, local government, community entities - there are all sorts of different forms around Australia. In Tasmania, three MPSs currently exist: two are run by the department and one by local government.

CHAIR - On page 16 of your submission you mention that airconditioning will be provided only to dental treatment rooms and so on. I take it from that that there will be no airconditioning to anything outside - mainly aged care - so the rest of the accommodation will not be airconditioned. You would be aware of studies in the past into the health, as tracked here on the west coast. If a person is in hospital going through a recovery process from whatever illness, what do you then say to the suggestion that on the new location there could well be some problems with regard wood smoke and the like, given the inversion layer nature of this valley. Wouldn't it be appropriate to provide a fully airconditioned facility if indeed my suggestion to you about the wood smoke problem and its contribution to health is in fact reality?

Mr ALEXANDER - There are really two parts to that question: the effect on health and the response of the building.

Mr MORRIS - I am aware of the inversion layer in some locations but I am personally not aware of studies done on Queenstown, so I would need to seek further advice on that matter. But I know, in view of a conversation with one of the members here today, there are some issues there.

Mr CURRAN - I was just going to say that we've produced a fairly simplistic diagram here that shows how the building will be heated and cooled and how the exhaust system will work. Heating and cooling will be provided in the day centre - this is on the lower ground floor - in the physiotherapy area, the dental surgeries and also in the kitchen. In addition to that, tempered air - which is heated, make-up air because those rooms don't get enough air - will be provided in the kitchen and also into the laundry. Tempered fresh air and a heat pump will also be provided in the morgue viewing room to enable that room to be kept at a reasonable temperature.

On the ground floor, the dining room and the sitting room for aged care will have a heat pump which will heat the air from within. The resident's sitting room will also have a heat pump, heating and cooling the air from within, the same as the lounge room for acute care. Near the nurses' station, the office next to that will have a heat pump with tempered fresh air. Treatment and Accident and Emergency will have a heat pump with tempered fresh air, and the nurses' station and the two offices that are associated with the nurses' station will have a heat pump with tempered fresh air.

The big problem is that if we aircondition a building, the minute the door is opened or a window is opened basically the system is compromised. What we're trying to do is give people flexibility to control the situation in their room. If they're cold they can turn their heater up; if they're hot they can open the window and try to get natural ventilation. I think everybody's aware of staying in a hotel when you've got the heat pump going and you don't have access to open a window. That's very much along the line of our thinking at the moment. We need to give each of the residents or the patients that are in acute care an opportunity to control the environment that they're in. As soon as we do open a window or a door, then that system is compromised.

We do have medical oxygen and we also have medical air. Karen is probably best to speak about how breathing is treated by that, but that is also available in rooms.

Ms SCHNITZERLING - It's certainly for medical reasons that they require that.

Mr COCHRANE - In receiving this plan from our mechanical consultant, the red or pink colour indicates cassette-type heat pumps that will circulate the air and push it back through a filter back into the room. In the other areas, where we have the tempered air, they'll also be treated with a heat pump but we will be drawing a percentage of fresh air in from outside, and that fresh air will be run through filters. I imagine we're talking standard filters at this time. If we wanted to take out wood smoke or other gaseous contaminants we would have to go to some sort of electrostatic filter that would scrub that air and do it properly. For a facility of this size I hate to think what the cost would be and the ongoing maintenance. During the day when people are coming -

Mrs NAPIER - Are you saying it couldn't be done?

Mr COCHRANE - Oh no, it could be done. Anything can be done if you throw enough money at it. We haven't really been aware that there has been a problem in this area. Even through our health assessments and the clinical needs that have been done this has not been raised as an issue, so it is something where we are going to have to go back to the drawing board and do a bit more research. During the day, when people are in and out of the hospital, there would be an ingress of unfiltered air into the building and it would be the same as anyone walking up the street. Of an evening, when the hospital is actually closed down and you would not expect the residents to have too many of their rooms open, particularly in the winter period, we will have air being removed from the building through all the areas that have exhausts, but we will have make-up air coming in through all those tempered areas. That will actually be filtered. Over the period of an hour we might have four air changes within the building. We get rid of the old air through the exhaust systems and the new air will come through and diffuse through the building. That air will be run through filters, and particle filters may be down to one micron. It certainly will make the internal environment a better environment than what is outside. But during the normal day, when people are in and out of the hospital, I would not suggest that the internal air environment would be markedly different from external, apart from it being hotter or colder as the situation requires.

CHAIR - Can I then just draw to your attention a Federal Government study released in 1992 which showed that the Lyell District, which incorporates Queenstown, of course, had a substantially higher premature death rate than anywhere else in the nation. If that is the case, if it has either worsened or certainly not improved, if we have a major air quality problem here in this town and if we are not addressing that in some significant way, then we may be contributing to a further deterioration of people's health rather than a rehabilitation. I make that comment and ask you to take that into consideration as you further consider this project.

I just have one final question. I note from documentation that the project received approval of the executive council on 11 October but was not forwarded to our committee secretary until 8 November, which was exactly four weeks. Can you indicate to the committee the reason for that?

Mr ALEXANDER - It was our understanding, and this has happened in the past, that this has happened through the administrative processes, in this case through various changes of staff, so it did not happen. From our point of view I can only apologise for

that. We are looking at it now to ensure that the pathway of documentation back from executive council to the department and to your committee is seamless in the future.

CHAIR - I appreciate that. I think it is appropriate for the committee to communicate that to you, because we have convened as quickly as we possibly could, given the submission of the document to our secretary and indeed the submission itself arriving only on Thursday last week. We have experienced this in the past, not with your department but with other departments, with major capital expenditure, and for us to give due consideration it is really is important for lead times to be appropriate.

Okay. We thank you very much for extensive presentation, and indeed your open and frank responses to our questions.

Mrs NAPIER - Can I just ask one more?

CHAIR - Okay, very finally and very briefly.

Mrs NAPIER - Has there been any consideration of how the services provided by the new building are going to be linked in with transport to Burnie? It seems to come up as an issue that can potentially be a fundamental flaw in the delivery of good health services to the west coast.

Ms SCHNITZERLING - We certainly have not been looking at that in relation to the building project. We have an ambulance service which we had considered in these plans, but we do not have a transport service as such, so we haven't considered them in this context. However, it is being looked at as an issue for the west coast.

THE WITNESSES WITHDREW

Mr PETER SCHULZE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Harriss) - Welcome, Peter, not only in your capacity to make this presentation but certainly as a formerly, highly-regarded member of parliament. We appreciate that you have travelled to be here and we welcome you to this part of our committee hearing. Peter, you are more than familiar with processes of committees. WE have received your submission and have had the opportunity to go through that, so would you like to speak to that.

Mr SCHULZE - Mr Chairman, I would like to thank the committee for coming here to Queenstown to inform those people who are aware this is happening, which might not be too many.

Since sending in my submission I have become aware of other matters on which I will make a few comments, but they will not be too extensive. It appears the committee has only very recently become aware of the proposal - in fact, I received an e-mail from Parliament last week indicating that you were only just getting the plans and that you were only just aware that it was a new hospital and not the redevelopment of the old one. In light of that, it is pretty important that you be brought up to speed on quite a few issues. As has been indicated, there has been a lot of public concern about this development. I would like to go through a few points as to why that public concern has developed. It is important you understand those concerns for a development that wasn't requested by the community. The first point is that the first announcement proposed a cost that could not possibly provide an adequate facility and I think that was quickly picked up and recognised by the community, so that immediately raised areas of concern in their mind. That matter of cost has been addressed by the previous witness, so I won't go any further on that.

Secondly, the new building - and that has also been mentioned - has at different times been called both a hospital and health centre. People see health centres as a lesser service, and indeed in some cases they have been and they are. Even in the local council a motion of support was proposed by the local doctor for this new development and the motion called it a 'health centre', so that didn't really help minds to focus on what we were going to get. In fact, there was also concern because that motion that was supported by the West Coast Council, which of course is not the Queenstown Council any more, was not even qualified in terms of saying, 'We support the new development, providing it has the same services as the old one'. Immediately those sorts of things do not help the public perception.

The third point is that there has been a downgrading of services here over the years, as I guess is the case in a lot of regional centres with health. In terms of surgery and operating theatres, some of that is often inevitable for reasons explained here today. In other cases we don't see the downgradings as appropriate. There is a continuing suspicion that, if we have a changeover from a hospital from one area to another, in that process we may lose further services and there is a constant consciousness about that. I think in the last few weeks the psychiatric service that was coming here regularly has been relocated to another west coast centre - through transport difficulties, I understand, that should be able to be overcome. When those sorts of things happen again, it

undoubtedly raises concerns in people's minds. There was some talk also about pathology, that they might be enhancing the service of pathology. But the enhancement might not be necessarily by having a local service; it might be by having better facilities in a remote location and sending more away than they have been and reducing the element of service here. Because people here think about jobs in the district, not only other services that are provided, that also means there is a constant concern in people's minds all the time, 'Is something else going to be relocated or taken away?' A point made by one of the members of your committee earlier - and what I believe - was that over the years, as services have been diminished, the transport facility has not been appropriately increased. In fact, there is lesser use of the aerodrome. I could tell you many sad stories of people having to find transport to get to and from health services that are only available remotely. I think there was an indication by previous witnesses that that might be addressed. When people say it might be addressed, it means that it is not there at the moment.

The other area of concern that has been raised in people's minds is that the mining industry has expressed concerns about the level of health services on the west coast. There are some public letters in circulation, that I could perhaps leave with the committee, in terms of the mining industry's concerns.

Some years ago Mr Llewellyn, when he was shadow minister for health I think, vigorously opposed the closure of the old St Marys Hospital and a replacement with a health centre on the basis that it was going to be diminished service. A new building here doesn't necessarily mean a diminished service but people remember that situation, the argument for not closing the St Marys Hospital if Labor got into power - which they did and they didn't close it - because Mr Llewellyn felt and said that the health centre replacing the hospital would result in a lesser service. These things of course impact on the public mind and the concerns that are raised.

Because of some of these concerns, I visited the minister's office and talked to Ross Brown and the minister some time ago and I left a letter there proposing that a local consultative committee be formed, which would have on its membership mining industry, local government, hospital and community, to try to resolve some of these issues that had come up because, I will tell you, public meeting don't resolve these things at all. They can become slanging matches and arguments between people and it is not a healthy forum to resolve concerns. So that was the proposition I put forward in a letter to the minister some time ago to which I have not ever received a response. I felt I was trying to be constructive in that way to bring elements together to resolve some of these problems.

The other thing at the moment, I believe, which hasn't really helped the process is that it is currently seen to be rushed. The time for submissions that people have been given from your notice in the paper recently was very short, shorter than I believe should be. I was interested in making a submission of course - I am still a Queenstown ratepayer - and I sought extra information on that. It seems to me that the latest information, while it has come to your committee, hasn't been always immediately or publicly available in terms of being able to look at things more closely.

Sure, we have had the concept plans and plans have been put up. In a brochure that was circulated recently I think it said plans have been sent to the council but they were

received by council but not to be passed onto the community - that is for their own processes and planning processes, I understand. Again, the public feel that they have been a little bit shortchanged in that regard on information and I will touch on just a few points in relation to that a little later.

The other question, Mr Chairman, is about is a new building necessary and I accept that there are features of the current hospital are not conducive to meeting today's standards in modern health practice, as I said in the submission. The current building has been satisfactory and the community hasn't generally called for anything better. I believe that whether you have a new building or use the old building is just really a matter of economics and cost to a large degree and I don't know what documents are around. I haven't seen any that have been extensively costed to say, 'To redevelop this is going to cost $10 million; to build a new one is going to be $7 million'. I think it should be taken a stage further than it has been and from your committee's questions that would seem to be appropriate from your points of view as well.

In respect to that, I believe that within the costing of a new one you have to include the costing of the demolition of this one. I think you are playing with yourselves if you are talking about this being a value for other things and around the State we see a plethora of old buildings left behind - the Devonport hospital, the Burnie hospital and so on. For sure, there was evidence given earlier about the building market and the property market picking up and how they have been able to do something in Launceston, but I think you would have to be a super-optimist to believe that here in Queenstown, with our population stability - we are worried about it going down and we don't have that much hope of it going up - that this building would have any significant commercial value. You will always get nutters who will tender and take on a building like this, as you often see around the place, and then they find it hasn't worked out and at the end of the day the responsibility falls back on the community or someone else. We have two empty schools in town, two empty hotels - a lot of empty buildings. We have a surplus of old buildings in the town. I was very concerned years ago when the Government closed the Central State School and moved that to the high school that they did not pull that building down and turn it into a park instead of just off-loading it onto somebody who more than likely further down the track finds its really not viable at all, it is purpose built and we have a surplus of buildings here anyway. So I think the pulling of this down and turning it into parklands should be budgeted into the cost.

Maybe the nursing home would have some commercial value because it has been built as accommodation premises, and that may be continued. As far as this building is concerned, I wouldn't see much value in it at all. It could be a burden on the community or other people further down the track, and it shouldn't be.

The existing hospital here is on two levels, obviously, and there has always been criticism from health professionals over the years that such layout with lifts, and so on, is not satisfactory and should be avoided if possible. So I was a little bit surprised when I saw the first plans for the new hospital that that was going to be on two levels. There had been a feeling that it shouldn't be. There is plenty of land around in Queenstown; the old school should be just pulled down and the land used, so that we have a full flat site for the whole hospital - the same style of hospital on the flat generally as they were promoting at one stage as in Burnie. That is just a comment.

To continue and try to keep some sequence, I had always understood from earlier studies that there were various categories of hospitals and various categories of health centres, and each of these having different service levels, not just the provision of service but the provision of a service at a given level. I have never been able to identify this clearly, and maybe that's something your committee could look at. The Government has given us an assurance that we won't lose any services, and that any services that are here at the moment will be in the new facility, but there is some concern that the level might change.

The Government might say, 'We'll guarantee Queenstown always has a bus service', but if there's only going to be once a year instead of once a week, the service is still there but the level of it has changed. That's the point I am trying to make. I understand that with some health centres some of those criteria are stipulated - the time the doctor has to be available and so on, but I haven't been able to get any evidence on that. Maybe that is something the committee could look at.

In the submission I made, Mr Chairman, one of my main concerns is the health status of Queenstown people. I will table a document for you in relation to that and I'll just make a couple of comments from it. The health status here is very bad and it was identified by a Federal government health study quite some years ago. Those figures have been confirmed by more recent studies and I think they've been somewhat submerged in saying the north-west coast has a bad health outcome compared to other parts of the State. That's largely influenced by the figures of the west coast, which is included in the north-west.

I have been concerned about this issue for many years, as you would be aware. For instance, infant mortality is 258 per cent above the national average; cancer is 313 per cent higher; lung cancer is 648 per cent higher; circulatory diseases are 257 per cent higher, and in all twice as many Queenstown residents die before the age of 65 than the national average. The health bureaucrats have been most unhelpful in these statistics, and some have said it is only lifestyle. But other towns, such as Rosebery, Zeehan and mining communities throughout Australia with the same lifestyle, don't have the same statistics. Then they said it is simply a work-related thing; but the statistics show the incidence in male and females is the same, so I don't believe that is the case either.

You keep talking to different officials and then they say the figures in that first study were too low a number, and it was probably just a statistical glitch, but it was across a lot of diseases and it has been confirmed since. There seems to be this inclination not to want to deal with it. I've written to the Federal Government about it, but they say it is a State matter. I wrote to the health people at the university, but they didn't answer my correspondence, and I have brought this matter forward in a number of other arenas.

Dr David Crean is very concerned about it and believes that there should be further investigations of it. I have been pushing and spoke to the minister recently about trying to get monitoring of the smoke levels in the town, because, in my view, since these earlier studies, the study in terms of health, smoke and people has been advanced and has clearly shown that that is a major problem in a lot of areas. In Queenstown we get a lot of it at certain times of the year with inversion and the number of woodheaters here, and the levels of wood-smoke pollution here are consistent in my studies with our higher

incidence of mortality levels. It is generally regarded now that the cancer risk from wood smoke is 12 times greater than that from equal amounts of tobacco smoke, and I only hope it does not take as long to address that problem as it has the former.

So there are two issues in regard to this that I would allude to. One is, as you perhaps were concerned about, Mr Chairman, whether the health status of this community is being taken into account in the planning of the new hospital in terms of simply the quantum of support that is needed in these situations with an ageing population. There are still a lot of retired people in Queenstown who may have difficulties.

The other area which I have been more specific about is the need for the most sophisticated and advanced technological level of air-conditioning in the new hospital. In fact, the new hospital is in a far worse site than this hospital in terms of wood-smoke pollution. It is a bad area where the new hospital is proposed. If you go round there on some evenings and look at all the woodheaters and the way the smoke comes down there and in the town generally, it is worse than this site. In fact, there has been a general awareness of the health problems here by doctors over many years, and by anecdotal evidence for dozens of years. Indeed, when I was a child in the late 30s my father built a house up here on the sand hill, because we were living on the flat and he did it to get away from the smoke pollution. That long ago it was recognised and acknowledged. So it is disappointing that people are not prepared to take these things on board and continue to make excuses in respect of that.

When I went to get further information on the air-conditioning just this last week, I was advised that the service drawings had not been completed, and so that concerns me about the general information availability for your committee and for the community in general. I understand they are hopefully getting those drawings finished in time for this committee hearing, but of course that does not get them disseminated through the community.

I have been seeking some information on this matter for quite some time: I understand the hospital staff were told at some earlier stage that there would not be heat pumps. Then when I spoke to the department about it they said there would be heat pumps, and they have told the hospital there would be some radiant heaters too. I do not have enough information to be able to do a proper submission on the relevance of those things or not. I do not believe radiant heaters are of much value. I thought they went out with lace-up boots, but maybe not. I think heat pumps had been discounted - or so people had been told - because they wear out and get noisy and so on. I am neither for nor against heat pumps, but when there is conflicting information and I cannot get the details I want to make an assessment of the air-conditioning system, there is something vitally flawed about this process. I believe it should be placed on hold until those design and service drawings have been completed and are available for public scrutiny, and also to enable your committee to seek other professional advice on such matters. I believe that would be the appropriate way to proceed - to seek the advice of an air-conditioning specialist or whatever, to obtain the best cost outcome in terms of rehabilitation or otherwise.

Earlier I had some concerns that the sound-proofing may have been inadequate but, after discussions, most of those concerns have been dispelled. I thought I was advised that the building would be double-glazed throughout, and there was certainly soundproofing between certain sections. I am not quite sure whether that sound-proofing was going to

be throughout. At the hearing here earlier it was mentioned that it would be in certain areas, but I did not know whether that meant all areas. But I believe that high-quality air-conditioning is required. It is done in a lot of modern buildings these days, buildings that people are coming into going from all the time. If you filter the air and pressurise it properly and have good clean air and if somebody opens a window or door you get an outflow of air anyway so you don't get pollutants coming in. Even though it might diminish the heating or cooling capability of the system, at least you are giving it particular protection.

I just would like the opportunity to receive all that information, assess it and be able to come before your committee again, Mr Chairman, when that comes forward because, without it, it is not satisfactory. It does seem that this is being done with undue haste and, in talking to people in town today, I found that a lot weren't aware that this hearing was on here at this place at this time. While there was a notice in the paper about hearings being in Queenstown on this date, I don't know whether the details were posted in that respect.

That is the main part of my submission. I would like to table a couple of things for the committee: one is an article on the mortality levels in Queenstown. The studies that have been done and more recent figures in 1995-2000 show that the west coast still has the highest rate of fatal cancers. So much for their saying it was 'a statistical glitch'. I have had correspondence from the State Government in regard to these things, giving me all these with the throwaway lines. That worries me. I have said in here that the prime and first responsibility of any government is to protect its people from harm and so this is an element in that arena. With cigarette smoking, people do it voluntarily; but with wood smoke pollution, that is imposed on the unsuspecting by the ill-informed and allowed by authorities who do know better. In fact other authorities around the world - and Auckland is an example - they are totally banning woodheaters because of an awareness of what they do. But, as I say, if it takes as long to address properly as cigarette smoking it will be another 40 years away, but let us hope not.

Anyway, I will submit those as evidence and I submit also letters expressing concern from the mining industry in respect of health services here. I would also like to submit as evidence that the committee look at some time - I don't think you would have time now - is a video I have made up showing smoke pollution in Queenstown at various times, how it develops, the inversion layer and tables of matters in respect to it. The minister has that and hopefully from that they will support a monitoring program here as they have done in Devonport, which is a joke when you look at the sea breeze up there.

CHAIR - Thank you for that, Peter, and thanks for tabling those other documents plus the video. I can assure you the committee will take them into account as well as having a look at the video.

Mrs NAPIER - Could I ask you to elucidate what your understanding is of the mining industry's concerns about health services on the west coast?

Mr SCHULZE - I think from the letters that you can read later there is an indication that they feel with the mining industry here there is always a fear that there will be a major accident and they wonder whether the facilities are good enough to support that. There has been other discussion on that today and I think that was one of the initial concerns. I

don't know whether the department has addressed these things since the industry made their concerns known, but they were certainly aware of them. I don't know how they have been dealt with but it might be something that the committee could follow up on. I think there was a general concern about the health services generally being adequate without even regard to dealing with emergency services.

I talked to the department about dealing with emergency services - if, say, there was a sudden emergency with a bus over a bank - and the department gave similar answers to me as they gave your committee which, I felt, were quite reasonable.

Mr HALL - Peter, you talked about Federal government reports or studies into health on the west coast, and then you mentioned other studies since. Are they anecdotal, or have they been -

Mr SCHULZE - No, there were other studies on statistics more recently announced, and I've got details of them.

Mr HALL - Right. Were done by the State or by -

Mr SCHULZE - I think they were followed up by the State, but they are only broad brush ones in terms of districts. The earlier study done by the Federal Government actually was fairly rigorous all over Australia. This district I'm talking about with the high incidence of these ailments was just the Lyell district, which didn't cover the other towns of the west coast; it was primarily Queenstown. I think it had the worst outcomes of anywhere in Australia, which concerned me and there was some media cover at the time.

It has concerned other health professionals. It has concerned at least three other doctors who have worked here in the past and other health workers, and there's been a lot of local anecdotal evidence about it, even down to the point that some streets are particularly bad. There are higher levels of mortality in some streets, and sometimes you can almost tie these to the way the smoke builds up in some areas, and the video shows a lot of that. On the video there is a picture from the aerodrome up here on the hill and you can see the smoke just rising up to the level of the hills in Queenstown. Many people have photos and would be familiar with, particularly in April-May when there are frosts, and so on, looking down into Queenstown from the Gormy Hill, it's like looking at a lake - because of the inversion theirs is a blanket of fog which of course is full of smoke.

I think a lot of people probably think the west coast is pretty wild and woolly, but Queenstown doesn't get that much wind a lot of the time, not like Strahan or the north-west coast. We're wet but we're not windy, so you do get a lot more fog than a lot of people would suspect - the way the valley runs you don't get a lot of prevailing wind.

CHAIR - Peter, you made the comment early in your presentation that no new facility had been particularly requested by the community.

Mr SCHULZE - That I was aware of.

CHAIR - Yes, but you'd be aware that it is incumbent upon health deliverers to make a judgment of a current facility, whether this can be upgraded or whether there needs to be

another facility. So whilst in your evidence you suggest that, to your knowledge, there's been no request, nonetheless it is incumbent, isn't it, upon the health deliverers?

Mr SCHULZE - Yes. I was sort of making that point to indicate why people get concerned. When they are doing something that we didn't ask for, we get a bit suspicious. I'd also accept that often in communities like this we mightn't be broadly aware of the latest techniques, modern technologies and health services available, and they need to be imposed on us. We're used to what we've got and we are comfortable with that. I have said, it is quite appropriate at times for the department to come along and say, 'You need a better service than you have and we'll give it to you', even though we might not have seen it ourselves.

A lot of the aspects of the new proposal are obviously good; it is only a few of the things that I'm concerned about - in part, the way it's been dealt with, and in part the lack of dealing with the issues and concerns that people have had in a more appropriate way.

CHAIR - Thank you. You also then touched on the matter of the downgrading in facilities and services on the west coast over a period of time, and the fact that there hasn't been an upgrading of any great proportion in transport to and from. When you say a 'downgrading of facilities and services', do you mean across the board? You're not specifically focusing on health care in that comment?

Mr SCHULZE - I guess it is across the board a little bit. I think the biggest thing that people focused on was the loss of the operating theatre here and a surgeon being permanently posted in the town to operate. That was a big loss and there would still be some advantages in having it. But I personally accept the explanations given, that surgery is now all specialists doing it and you can't have every specialist here and you can't continue to maintain the experience levels and operating theatre staff to do it. When you talk to people in detail about it, a lot of them would admit, 'If I am going to be operated on in a serious way, I wouldn't want it to be here. I'd want to be in a more specialist area with experienced staff'. But nevertheless there was some facility lost here and some of the smaller operations that could have been done here would have been beneficial to the community.

As I said earlier, when that sort of service was taken away, there was no upping of the transport facility for patients and people going away. This is right across the board, from people who have to casually go away for some small ailment to people who go away for a serious ailment. For example, some years ago a friend of mine who was being treated for cancer had to go to Hobart for further treatment. He endeavoured to get support transport from the Health department and was told he wasn't ill enough to get it so he went on the service bus and died in Hobart the next day. There are lots of stories you could tell on these sorts of issues, and I suppose if you live in outlying area these things are going to happen from time to time. I believe there has not been an adequate upgrading of support in terms of air transport. The aerodrome here hasn't been closed but it is not used a lot. I think the psychiatry service that has been relocated in the last few weeks, I understand, to Strahan, it may be a matter of cost to the department. I don't think the guy concerned likes travelling by road from Strahan to here and maybe he should be flown to Queenstown, instead of flown to Strahan.

Over the years we have had a lot of visiting specialists come and go and it is a bit hard for me to assess if they are still coming at the same level as they used to. I guess that is a matter of demand and facility supply. Again, as I said earlier about pathology, I worry that they might give a better service but it might take longer to get the information back than if they do it locally. It is also a job in the town for someone locally, too. It is certainly within the department's ability when they are hiring North West Pathology to say, 'We want a contract with you, but in the contract it will state that you have to have a pathologist in Queenstown for a certain amount of time doing these tests'. So while the employee isn't on the government books, there can still be control exercised as to where the service is done.

Mrs NAPIER - Peter, can I ask you a question in relation to the facility, whether we need airconditioning or not. How would you balance that against what might be the preference of some of the older persons living there who want to breathe fresh air, even though we might say it is killing them?

Mr SCHULZE - Well, you can still go out on balconies in airconditioned buildings, and that happens at a lot of other places - hospitals, hotels and the like. You can still have a very good airconditioning and let them go outside if they want to breathe the foul air. It is nice to have the balconies on the hospital but I don't believe the utilisation will be particularly high in the climate that prevails here and in the circumstances of a nice, warm hospital. It happens a bit and it is nice to have the balconies because it gives an outlook - if you can make them lower that roof.

CHAIR - I think the designers are as frustrated as we are about the heritage process.

Mr SCHULZE - I fail to understand that. I don't believe that hall is particularly highly valued as a historical item in the town by the community. It was not that old when I was young and I remember it as a theatre and then as a rollerskating place. I don't recall any association with the Mount Lyell Company or employees being associated with it.

The company's association for their employees and helping them was a little further down the street at the Recreation Club, where they had very sophisticated facilities, billiard tables, boxing rings and all sorts of things there for the employees. I do not ever recall, nor anyone that I have spoken to in the short time that we have had, recall that as having that immanent value. I am surprised that that would be the case, about it being imminently listed. We cannot get other things listed here. We have been knocked back on getting other things listed which are of far more value to the community and of cultural interest and artistic merit, including Miner's Siding which was knocked back.

Mrs NAPIER - You haven't got the hospital listed yet.

CHAIR - Peter, anything you wish to say in summation?

Mr SCHULZE - No, not at this stage, Mr Chairman. I would like the opportunity to get more detailed information than we have had, the latest drawings and the latest service drawings, so we can give further analysis to soundproofing and the general services, particularly airconditioning, and have an opportunity to come back to the committee on that. I do not know whether that is possible or not, but I do make that request. Others also who might feel they have not been given enough information to make submissions

on at this stage might want to avail themselves of such opportunity also. I am not necessarily suggesting you come back; we can always go down there.

CHAIR - Okay. We cannot give you a commitment one way or the other on that, Peter, until we deliberate in camera as a committee. But I have made a note of that as a condition of yours and clearly we will give it some consideration. I do appreciate it. Thank you very much. Thank you for your patience, for being here throughout a fairly long day.

THE WITNESS WITHDREW

CHAIR - Could I just indicate to people who are here and who have a real interest in this, we have received a number of submissions. Gordon's is one of those, and all of those written submissions we are certainly obliged to take into consideration, and clearly we will. Members have had a chance to digest the content of those, so in Gordon's absence we then need to move into the next phase of our deliberation, which means that we consider our evidence so far and take it in camera, so if we could ask you all -

Mr SHEA - Mr Chairman, is there any way of submitting anything to you. I am one of those who did not realise you were sitting until the weekend. I am doing an e-learn computer course and I am a bit scared of missing time and I did not have time to present anything. But I am very concerned at the way the committee -

CHAIR - Come forward, because we have indicated to the minister, when I have written to him, that we would not deny anybody an opportunity given that there was only one day of notification.

MR RAYMOND THOMAS SHEA WAS CALLED**,** MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Mr SHEA - Thank you, Mr Chairman, for the opportunity. I am a long-term resident of Queenstown, and in particular I have been a long-term servant of the Health department. In that sphere I have been a member of the Queenstown Hospital Board, West Coast District Hospital Board, Sick and Accident Fund, and also a member of the North West Regional Hospital Board from 1991 to 1997.

I am very concerned with the comments being raised within the community without full consultation. I can go back to 1960 and 1970 when this hospital was being looked at to be replaced. I was surprised when I heard people sit here and say that they have not heard about this hospital being relocated. The late Mr Hudspeth, I think he was chairman of the board, he wanted to put it down over a hill opposite the cemetery, which wasn't a suitable place. Then I go back into the 1970s when we were looking at somewhere for the elderly people. They were looking at the area below this hospital, in the areas of Knox Street through McNamara Street, taking over that whole block. During those periods the Government of the day didn't see fit to spend that money - and I speak of your Government in those days. They were willing to build a new hospital but because of financial restraints we had it built here.

The board in those days thought, 'At least let's spend some money to upgrade the hospital', which they did in various stages throughout there. This was a 64-bed hospital. We had the women down this end and the men up the other end, and that was changed in the mid 1970s. When we were running out of money they were going to move the servery section, the catering section, so we asked for that area there to be bulldozed away at some cost and that is where you see the carpark at the moment. Then when they wanted to build the elderly health area the only alternative was to take over the men's area and change that and that was done with hospital staff at the time. Brian Gardner was the carpenter and he did a lot of that work. That was the start when we saw the elderly people come here and stay. It was said then by the community that it wasn't a fit place for them to be. As I said to you, I am very concerned that there has been a group of people who have put a lot of doubt in the minds of a lot of the people in Queenstown.

First of all they came out and they wanted the money not to be spent on health but to be spent on water and other things. Well, if they knew anything about government money they know damn well that is the only place it can be spent. But I do thank you for the opportunity of saying that there are a lot of people in this town who want to see this hospital proceed and proceed, on the site that has been identified, and removed from here.

CHAIR - Thanks, Mr Shea. Any questions by the committee?

Mrs NAPIER - I think it is good to have the background of the whole procedure on the record. You are quite right about funding; if you didn't use it for a hospital you would have lost it.

Mr SHEA - Yes, that is right, and I can't understand the senators who supported the first move. For sure, people have the right to argue the pros and cons and I don't begrudge them of that. I think you have to take people on trust and when they say, 'There's been no

downgrading and that's been advertised'. I am doubtful whether it is going to be. Really, it is up to a lot of the people whether they use the facility. Peter spoke about the surgeon. Well, the people of the town didn't use the surgeon. He was one of the best surgeons we could have had but people wanted rather to go and stay with their relations up the coast or down in Hobart. That is why he didn't have enough work. For him to continue with his accreditation we had to send him to Burnie to do weekend work. Then afterwards he wasn't prepared to put up with the hassle and bustle and he is now still stationed at Strahan as a GP. It is up to the people, and nowadays if you don't use it you lose it. Whether that is right or wrong, there are a lot of things that you do need to have to make you survive.

I do thank you anyway for the opportunity.

CHAIR - We thank you.

Mr SHEA - It worries me that we might lose this facility that we most certainly want.

THE WITNESS WITHDREW.

Mr DARRYL GERRITY, MAYOR, WEST COAST COUNCIL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Mr GERRITY - I would just like to thank you for this ad hoc opportunity and I would just like to put council's position. Council twice has supported unanimously the relocation of the hospital into a new hospital in the town. We analysed all the information we had at the time and we did a lot of consulting and, as I said, twice we have reiterated our position that we support it. There have also been two public meetings. As you are aware, there has been a lot of information going out. This hospital issue has been around for 15 years or so at least, probably longer according to Ray Shea, who would be more of an authority on it than me. The information has come out all through the community, through two surveys carried out by Di Hollister: health needs assessment programs for the northern part of the west coast and for the southern part of the west coast. The professional officers have also put out a report and supported the hospital.

I would like to put on record that council fully supports the relocation and the rebuilding of the new hospital. There will be some issues discussed. Mr Schulze brought up airconditioning, sunlight et cetera. These will go through normal council procedures such as planning, building, plumbing inspectors et cetera and we will ensure that the best possible conditions are available to the residents who use that facility. Rest assured, we will be very diligent in our examination of the planning and building permission when it is sought.

There are another couple of small issues I might make the committee aware of. There is a disaster plan for the west coast; it is now being reworked. On the helicopter issue, there was an accident 10 kilometres south of Strahan. A chap injured his ankle and was taken directly to Hobart - not to Strahan or Queenstown but directly to Hobart. Most of these search and rescue helicopters issues now can land anywhere that the pilot decrees safe. It can be on the road, on the water or on the recreation grounds. They do not normally bring them here to the west coast, unless it is for necessary patient stability. Everything goes to Hobart, Burnie or Launceston.

I have received a letter from Placer Dome and have spoken to the manager there. After he received the full information on what is going to happen, his fears apparently were allayed. They are quite confident that what we can do on the west coast for the mining industry is the best we could do anywhere. This disaster plan that is being worked out acknowledges that if there is a major disaster - and it may be a mine, a tourist vessel going down, or a boat or a plane; God forbid that these happen - the best we can do is stabilise those injured and ship them out. We recognise that we cannot accommodate a multitude of injured people in a medical facility that would treat them. The best we can do is stabilise them. We have had many desktop exercises; bodies go into coolstores and so on and we do the best we can. We fly in what medical experts we can to triage or stabilise them and get them out. It is now well recognised throughout much of Australia that small, isolated regional communities cannot cater fully for injured people.

Mrs NAPIER - I would like to take the opportunity to look at the status of the hall. I accept the evidence we have heard today. Do you see it as needing to be a heritage-listed hall?

Mr GERRITY - No, I don't. It was actually a picture theatre that became a roller rink and a basketball stadium. We all like to preserve our heritage. It would have to go through a community process but my gut reaction is that they would rather see it go for the benefit of the asset that is going to be built there, rather than keep it. Maybe the facade can stay there and the roof flattened. I can't predict what council would say, but I feel they would agree that it is not true heritage. As long as the hospital didn't intrude into the streetscape or demolish the streetscape that was there but in fact complemented it, which they are intending to do, I don't think the building would stand up. However, heritage councils are funny to deal with.

Mrs NAPIER - But you have it listed in your plan and -

Mr GERRITY - It was listed in the plan; it went through a process. Godden Mackay did the heritage study in Queenstown, and it is listed through that study. I think a case ought to be put up for its removal. I don't know how severely that case would be fought by residents; I don't think it would be fought too much if it's going to bring a benefit. And one of the other issues is that it doesn't stuff up the streetscape, because it is an historic main street, and we want keep that historic streetscape.

CHAIR - I think the challenge there, Mr Mayor, is that because your planning scheme recognises the architectural significance, as I understood the architects to have told us earlier today, that then, of itself, will introduce Heritage Council consideration of the building. Their advice, based on experience, is that the Heritage Council then would likely say it has to stay.

Mr GERRITY - Yes.

CHAIR - I personally feel that it's an argument worth running, if in the best interests of this total development and if this committee was to sign off on the development, and it ought to be pursued to the end.

Mr GERRITY - I agree, Mr Chairman; I think it's worthwhile asking the question of the Heritage Council, from a council point of view, whether it is possible that this could be de-listed. I think it's worth running.

CHAIR - Well, it's not even listed at the moment.

Mr GERRITY - No, no, but we expect it to be.

Mr BEST - Are there are other monuments of historical value that you've had trouble with getting a listing for?

Mr GERRITY - Yes, it's interesting that anybody could list them. You could list that building tomorrow without the owner knowing who it is; you're aware of how that works. But there's other stuff we have had difficulty getting listed for their protection, and one is probably Lake Margaret.

CHAIR - Mr Schulze mentioned Miner's Siding.

Mr GERRITY - Miner's Siding - two important icons for Queenstown, yet there wasn't anything there. I think this hall should go the same way as the hedge.

Laughter.

Mr GERRITY - The trees. They were noted as being historic; in actual fact they were not. I went to the school and I know the hedge did have other uses besides scenic.

Laughter.

Mr GERRITY - But I don't know of any historic value attached to the hedge or the building. I think, as you said, Mr Chairman, it is worth running the argument.

CHAIR - Can I then just come back to your comment that the council has provided its support on two occasions. You heard Mr Schulze say that the council hasn't qualified its support in terms of the level of facility and service which it might expect to be provided in the new facility.

Mr GERRITY - The second qualification was to say that we wanted no downgrading of services for the west coast. I think, Mr Chairman, you'd be aware that the West Coast Council does fight to retain its services. The community, without it being said, would fight for the services.

CHAIR - So is council satisfied that there is no downgrading of service with this proposal?

Mr GERRITY - On the evidence that we've received, and the briefings that we've received, yes, we're satisfied that there won't be any downgrading of services. It happens; we've got downgrading of bus services and things at the moment, but as far as we see, on the surface, we're satisfied. If they're going to turn around and deny those services that they said they're going to give us, well I think there's some games to be played.

Mrs NAPIER - What guarantees have you been provided, or indications, that patient travel and travel assistance might be looked at, so where people are going to the Royal Hobart or Burnie, or whatever, they've got basic support.

Mr GERRITY - It is difficult. I think they get a cent a kilometre at the moment and are dumped out of hospitals and facilities in Devonport, Hobart, Burnie and Launceston with no reasonable way to get back and no bus service to get back. As a consequence, the people from the west coast have to go and pick them up. They are talking about medical services and not the bus services. I might add that before the amalgamation of the west coast services, which was fragmented with the Government, council, West Coast Health, Zeehan Medical Union et cetera, if you broke your wrist on a Tuesday and you came to Queenstown you couldn't get it X-rayed. You were sent to Burnie but you passed an X-ray machine at Zeehan and Rosebery in going to Burnie. Now that there is no radiologist here, we can go to Zeehan or Rosebery to get it X-rayed. Although there is still an urgent requirement to upgrade transport services, they are not as serious as they were because of the amalgamation of health services within the west coast.

CHAIR - You made comment that the council would ensure the best possible conditions will be delivered when you consider the building plans et cetera, addressing some of the

points that Peter Schulze made with regard to airconditioning and so on, but isn't it true that if the building plans presented to you comply with the building code of Australia then you won't have too much say about the airconditioning or plumbing?

Mr GERRITY - Correct, yes, that would appear so but we can put conditions on that development or building application. If there is a major issue with smoke on the west coast, particularly in Queenstown, we could put on a condition on that that be catered for in the airconditioning. I don't think any tenderer or any department, if that was proved, would reject that condition. It may not always be wood smoke in Queenstown. There has been a lot of problems with the river, as you are probably aware, the Queen River running through town. You have wood smoke but you have a few minor things like cyanide in the river.

CHAIR - It may not be so minor.

Mr GERRITY - It is not only the wood smoke, I would say, that contributed to those deaths. However, wood smoke is an issue but not as major, I believe, as Mr Schulze pointed out. However, it is an issue that we will have to consider as a council.

Mrs NAPIER - A quick question, what consultation has there been between the designers of the new facility and council in relation to parking?

Mr GERRITY - They have assured us that there is plenty of parking there for people who want to go to hospital. One of the advantages of being in the town is that people can walk to it now, whereas up here they just couldn't walk to it. So obviously there would be less demand for car spaces at the new hospital than there would with this one.

Mrs NAPIER - Okay.

CHAIR - Thanks very much, Mr Mayor, we do appreciate that. With that folks we will have to ask you to leave us to deliberate.

Mrs NAPIER - We have the cost of the refurnishment, haven't we, of the old hall that is there, but I don't think we actually got on the record as to what it would cost to build the equivalent space.

Mr HALL - No, we didn't. It was $580 000 odd to do that, but we did not. I did ask a question but we did not get the answer.

Mr COCHRANE - Mr Curran said that he would supply you with that information.

Mrs NAPIER - Okay, good.

Mr HALL - Yes, he did.

Mrs NAPIER - Looking at the issue of the historic hall, there is the question of what it would cost to build the equivalent but having disposed of the hall.

Mr COCHRANE - Even working on the schedule of rates that we have, if we were to knock the hall down and start from a greenfield site, it would bring it under the same basic cost

structure as the rest of the facility, which was about $1 850 per square metre. That would probably add about 40 per cent to the cost. It is 566 square metres, just off the top of my head - I do not have my folder with me. So I imagine it would add probably an additional 40 per cent. We would also probably have some additional redesign costs, but whether or not the benefit to the project would make that worthwhile, I cannot say.

Mrs NAPIER - What would happen - and you may not be able to answer this question - if we just got rid of the roof and just put the same kind of slant of roof that you have on the rest of the facility and made it consistent? That would overcome the view problem, and might well be part of the solution.

Mr ALEXANDER - If I can answer some of that, it all depends on the heritage issue. Even though we are going to close that roof off and people won't be able to see it, the intent of the heritage legislation is that that structure remains intact even though it is behind the screen, if you like, and that is an issue we deal with in lots of places. There are heritage items which are actually built inside another building, but they are retained. So it is the same issue, but we understand that the Heritage Council would object to our demolishing it and taking the roof off would be the same. When we first looked at the site we recognised that building and we were not sure whether we would be allowed to take it down or not, but we knew we could develop a hospital in either case, so we pursued that as far as we could within the bounds of what we could do as public servants, if you like.

CHAIR - But, Peter, that presupposes that the Heritage Council will say it has to remain. The best research you can provide so far, or which you have undertaken so far, is to have a heritage consultant architect to say that is the likely outcome as a result of the council having identified the building.

Mr ALEXANDER - That is correct.

CHAIR - And they have heard what the other evidence is that has been tendered later, where we are suggesting as a committee that it may be worthwhile pursuing that to the end to find out whether it can in fact be demolished. The Heritage Council may be convinced by submissions from the council here that it is not a significant building.

Mr ALEXANDER - I take that on board. With the weight of that as a recommendation, I think we could quite comfortably do that. Apart from the cost, is we would certainly get a more flexible outcome. A point that maybe did not come across in looking at that - and the comment was made there is still a lift in the building - we have Acute Care and Aged Care all on one level and separated, and all the allied health separately so that the day patients and the movement of people are separate. There is not the same movement through that, but we could certainly design a more flexible facility without the constraints of that also.

Mr BEST - In some ways that split-level site I think is actually quite a good site, having looked at your plans. You can come in and you are on the one level, then you have those other services below. To my way of thinking it is actually quite a good site. It is just that building with that roof. Even the building is not so bad, it is just the roof really.

Mrs NAPIER - But you could come up with a nicer perspective, even retaining those walls. I accept the bit about the front façade, but I agree with what the Chairman says on that -

if you could push the issue through the council in terms of whether it has to be listed or not. It sounds like there are many other more important heritage items in town t than this one to be preserved. And it would accede to the real problem and I think we all agree exists for older persons - great potential, but it would be nice if you had a view of other than a roof in the middle of a rural setting.

Mr ALEXANDER - There is another side of that though: we have found, particularly in Campbell Town, that a lot of people who make the rules about aged care have a different view from the elderly people themselves. At Campbell Town the elderly people love being in a combined facility; they spend their time in the waiting rooms because of the families, friends and news of the town that they get through those other people coming into the facility. They really love that interaction with the other patients and their visitors, more than just a straight view.

Mrs NAPIER - That's true, but I think we could have both, couldn't we?

Mr ALEXANDER - That would be lovely.

Mr COCHRANE - Mr Best was talking about that split-level. One other important aspect of that for our aged care clients is that they have level access out into the street from that level. From a fire evacuation perspective that is very important.

Mrs NAPIER - I take it there are no steps or anything that they have to get wheelchairs down?

Mr COCHRANE - No.

Mr ALEXANDER - We are quite serious in that, apart from the disability code, there is a concept called 'universal access'. We think, as a health department, we should really be a flag bearer of making sure everyone has the same ability to access the facility.

Mrs NAPIER - On the airconditioning, just to get that onto the record, perhaps we could ask what the costs would be for at least that component of the aged-care section to be airconditioned, if not the whole building. It sounds as if the argument was very much for people who lived there all the time, that it is more of an issue for them than it might necessarily be to ensure that the whole of the building is airconditioned. I don't know what my colleagues think - if cost is a factor.

Mr BEST - I am not an expert on this; I have just listened all day to conflicting points of view. One part of my brain says it should be airconditioned and the other part says, 'What the heck is the difference?'. I don't know if in saying that I am being ignorant. I don't know. We have heard that you can have heat pumps and other things. I must admit, I thought Mr Schulze comments were probably almost spot-on that most people wouldn't go on the balcony, knowing Queenstown weather. On days like this it would fantastic, but mostly it is going to be too cold to go outside.

Mr COCHRANE - The microclimate here in Queenstown is quite warm in summer because they don't get the afternoon sea breezes; they get the full effect of the sun.

Mr BEST - The only benefit of your balconies is you might be able to put some plants in there that might screen the roof.

Laughter.

Mr BEST - That is the only positive I can think of.

Mr COCHRANE - Just a point of clarification from Mr Schulze's evidence, at this stage of the project it is not normal for us to have to provide full service drawings.

CHAIR - That's a fair comment.

Mr COCHRANE - There was no intent to not make information available. As a matter of fact, the drawings that we subsequently provided we had them drafted up in response to Mr Schulze's concerns so we would have something to table for the committee to show them what our intentions were.

CHAIR - To confirm that, Bill, we have made comment in the past with regard to major projects like the TAFE college that we don't expect the full architectural plans, for instance. If we expected full architectural plans from you, with dimensions and everything, we would be requiring too much at this stage.

Mr COCHRANE - We also have another issue about commercial-in-confidence, about how much of that design we put in the public domain when we want to go to a public tender.

Mrs NAPIER - How do we progress this issue of whether it is airconditioned or the combination of heat pumps et cetera that were talking about? How do we best progress that?

Mr ALEXANDER - From our point of view, I think we need to go back and look at the information that is available and see what it says. I haven't been aware of it, to be honest.

Mr COCHRANE - That's about the Queenstown environment.

Mr ALEXANDER - Yes, I think it is, but I don't what the source of those health outcomes is. What we are trying to do is provide preventative health that fixes that into the future. We can certainly have a costing done of providing airconditioning, particularly to the residential area. Generally we don't aircondition those facilities because there is an ongoing recurrent cost in running it - a high energy cost, and also it is not universally well received by the clients.

CHAIR - Are you saying you don't aircondition the residential?

Mr ALEXANDER - We don't put ducted airconditioning through -

CHAIR - But your submission on page 16 suggests that airconditioning is to be provided only to dental treatment rooms, accident and emergency, kitchen and aged care living and dining areas.

Mr ALEXANDER - The living and dining areas, but not to the residential rooms.

CHAIR - I took that as their own living area -

Mrs NAPIER - That is why I suggested that maybe we could just do it for the aged care component even though -

Mr BEST - I can actually understand it. I know this is probably something you want don't want us to discuss in committee perhaps. I know airconditioning is supposed to be the right humidity and so on but especially with older people it could be detrimental with people coughing and all sorts of things.

Mr MORRIS - The issue with residential care is that the key concept is to provide a home-like environment. That is why we are hesitant about showing you the building because you don't normally have people you don't know coming through your home. So you should think of this issue in this way: as someone who is going to compulsorily establish the environment in which you live. We have decided that we are going to aircondition it, and if the resident doesn't want their compulsory airconditioned and they like to open the windows and all the rest of it, then, as the provider, we have to allow them that because it is their home.

Mr COCHRANE - And one of the key Commonwealth outcomes of the certification process is for the clients to have control of their own environment in their own room, to be able to vary the temperature as they require.

Mrs NAPIER - So it might be incompatible.

Mr COCHRANE - You could put a cassette unit in everyone's room, a reverse-cycle airconditioner, and it wouldn't be hugely expensive. But it just draws on a percentage of fresh air and recirculates internal air and they are not really set up to undertake that air scrubbing facility.

Mrs NAPIER - Perhaps, given the problem, we could ask you to have a look at what might be the best solution for that.

Mr ALEXANDER - What we have is heating and ventilation. The green areas in here, which are essentially all the ensuites, have exhaust air so what they do is they take air out and the air is replaced essentially from the corridors where it is pumped into these areas - and these are different types of our handling systems. So there is an air movement and the air is being partially recycled, topped up with fresh air, with something like four turnovers of the whole air volume every hour. So what they do is they recycle some which makes the heating much more efficient because you are not dragging in cold air and having to heat it all the time. There is cooling potential in some of these areas and the air that is brought in from outside does go through a filter but it is not a sophisticated filter in this environment.

Mr COCHRANE - It is a particulate filter that would take out pollen and other such substances down to one micron, but it doesn't remove gas.

Mr BEST - You will have pretty good insulation, too. It is all new building materials with insulated -

Mr HALL - And double glazing.

Mr BEST - Yes. You would think that whatever heating you use, and you have air flow, which is what you are saying, it should work. It is not like you have some weatherboard thing without insulation. You will have insulated -

Mr ALEXANDER - They are insulated from the point of view of both thermal insulation and sound insulation. There are standards to be met for the purpose of dignity issues in the extent of sound insulation and it really does the same thing.

Mrs NAPIER - The problem with wood particle, isn't it the particulate that really does the damage out of wood smoke?

Ms COCHRANE - I am not sure, Mrs Napier.

Mrs NAPIER - Perhaps the washing system you have anyhow will pick up the wood particle issue.

Mr COCHRANE - I am sure there would be some gaseous contaminant that the normal filter wouldn't pick up. We will leave here today and get on our bike and then start to review this issue about the air quality.

CHAIR - Okay. No further questions? Thanks for giving further evidence.

THE WITNESSES WITHDREW.