**THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT HENTY HOUSE, LAUNCESTON, ON FRIDAY 30 OCTOBER 2009**.

**LAUNCESTON HEALTH PRECINCT CAPITAL IMPROVEMENT PROGRAM**

**Mr JOHN KIRWAN**, CHIEF EXECUTIVE OFFICER, NORTHERN AREA HEALTH SERVICE, **Dr ALASDAIR MacDONALD**, DIRECTOR OF MEDICINE, LAUNCESTON GENERAL HOSPITAL, **Mr JOHN SLORE**, DIRECTOR, CAPITAL WORKS UNIT, LAUNCESTON GENERAL HOSPITAL, **Mr BILL COCHRANE,** MANAGER, MAJOR PROJECTS, FACILITIES MANAGEMENT, DEPARTMENT OF HEALTH AND HUMAN SERVICES, **Mr ANDREW SHURMAN**, **Mr IAN BENNETT** AND **Mr ANDREW FLOYD**, CONSULTANTS, ARCHITECTS IN ASSOCIATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

**CHAIR** (Mr Harriss) - Welcome. We have received your submission. We have had the opportunity to familiarise ourselves with the detail in there and the site inspection this morning built on that for us. John, are you going to make the initial opening remarks?

**Mr KIRWAN** - Thank you, Mr Chairman. If I could also introduce Ms Sonia Purse who is our Director of Finance who is here in attendance in case we have to answer any questions about dollars.

We have here a mixture of our architects who are our advisers, Mr Cochrane from the department who is helping us through this exercise, Mr John Slore who is in a newly created position as our Director of Capital Works, Dr Alasdair MacDonald who is our Director of Medicine and is leading a number of our major clinical reform initiatives and myself as the Chief Executive Officer of the Northern Area Health Service and at the Launceston General Hospital.

You have the submission so I will not go through it. We have the outline of a presentation which I will leave with you which we basically walked our way through as we walked around the hospital today so I do not think we need to talk to it.

I would like to repeat where we are coming from. This is not only from the advice we have received from the council the largest capital works program that Launceston City has seen probably since the last refurbishment or the building of the current hospital, what it is for us is not only a building of new services, a refurbishment and extension of existing services but hand in hand is a redesign of how we do business. At any given time 30 per cent to 35 per cent our patients come from outside of Launceston so we are servicing people, some from the south but the majority from the north, north-east and north-west and obviously some visitors from interstate at various stages. So it is a very busy hospital, its occupancy levels are always high and in fact on contemporary standards probably too high. Across a range of areas it is on capacity and so some of the initiatives are about giving us some capacity and an amount of future proofing.

I will finish off by saying that the model is very much based on contemporary practice to help us redesign our patient flow and quality of care for our patients, our staff and our

visitors. It is a coalition of a range of programs that have come together as one program which gives us certain synergies, some of which have been a long time in the waiting, such as the parking, and probably overdue; some which allows us to go forward. It is also a rare opportunity on a 30-year-old site to get some of the service models right and redesign them so what we will be doing here often cannot be done in more established hospitals simply because of physical restrictions but because of the flexibility and some negotiation skills, a lot of our staff are now being prepared to move to change and to move from where they have traditionally been. So you will see a new model of care emerge over the two to three years as we build as well and Dr MacDonald is the best placed to explain that as he is taking that leadership both within the hospital and to some extent also at a national and international level.

Just to say that the hospital is not without its faults. We do not hide behind that. It is a very busy hospital, however, and it provides a comprehensive range of services. When you go back to the Tasmanian Health Plan and others, we service over 90 per cent of the needs of the local community so there is a limited number of people who have to move outside of the area and the refurbishment and the changes will reinforce that as the primacy of our role. If I had 350 to 400 beds, which is where we are heading towards, it is still a large regional hospital rather than necessarily a comprehensive teaching hospital with the 600, 700 or 800 beds that you would see in a mainland situation.

It is also relatively self-contained. We do not have the option for hospital bypass or other areas like that. We have to deal with what comes through the front door, which adds a degree of complexity.

I think other than that, it is probably best, Mr Chairman, to answer questions directly either from our building and architect adviser people or from Dr MacDonald in respect to the clinical pathways.

**CHAIR** - Can I make one observation. I am just reflecting on a comment you made when we were on the site visit this morning, John, and I think this is relevant to the record in terms of getting this into some sort of context. Did I recall right when you suggested that the current levels of health demand at the LGH were not forecast - sorry, the forecasts suggested you would not be to this level until 2015-16?

**Mr KIRWAN** - Specifically in respect to the emergency department, Mr Chairman, the planning work that sits behind the clinical service plan, Tasmania's Health Plan, done by Greg Hayes, predicted we would be at the activity, which is around 42 000 episodes, in 2016-17. We are at that level now, we are already there, and as you will see in the submission, and as you would have seen this morning, although today when you were there was a relatively quiet day for the emergency department, which was good and the way we would prefer it, the current configuration is both inefficient and also is not big enough to deal with existing demand, let alone the future demand. It just reinforces the need to build and also to change our models of care. We are currently growing at 18 to 19 per cent this year in the emergency department presentations across all of the five categories we admit. That is unsustainable. That sort of growth is getting into exponential growth not linear growth and that is not sustainable in any health system. Some of the initiatives that sit behind the acute medical unit, that sit behind the integrated care centre, that sit behind the technology we will be introducing as well, will end up with a model that does not necessarily mean come to the LGH, become admitted and then

go out. We will change that model, which will take some time because that is the existing referral model and that takes time to change within a system such as this.

**Mr GREEN** - Dr MacDonald, regarding the changes and the way that you propose to run admissions and the hospital in the future, where does that leave us at a national and international level?

**Dr MacDONALD** - What we are aiming to do is part of the contemporary move both in Australia and in a number of areas around the world and that is to look at a much more efficient health system. I can give you a little bit of historical detail.

The current organ-based, specialty-based, relatively siloed system has developed over probably approaching 100 years and what it necessitates is each silo fully assessing a patient from a medical perspective. Those silos are multidisciplinary teams often, so they are discipline based. To give you the most topical analogy, when you present to an emergency department here you are seen by a series of doctors who are working in the field of emergency medicine. They are led by a specialist in emergency medicine who has a specialist qualification in that area and there are training doctors underneath them. Most of these training schemes have a component of apprenticeships so what you will find is that the training doctors are given the opportunity to do initial assessments and those assessments occur in a serial fashion in the emergency department. Because the emergency department specialists feel that they have reached a point to hand that process on to the next team within the hospital, and in my case that would be to a physician, what happens is another series of assessments occurs, usually still in the emergency department, by the medical speciality, be it general medicine, cardiology, neurology, oncology or otherwise. What that leads to is a significant number of redundant assessments and at both a national and at a State level there is a clear recognition that the work force, the time and the amount of effort that goes into such a series of serial sequential assessments is not sustainable and in that context we are working towards a much more integrated and blended medical workforce where you will see specialist physicians, cardiologists and neurologists working side by side with specialist emergency doctors rather than handing from one to the other for a series of time-exhausting assessments. So they are working together and then the junior medical staff are learning much more of a mentoring model where they are part of a team learning at the same time as that process is undertaken.

Within our hospital we have the opportunity to take some leadership in this area. We have a workforce that is ready to take on some of those changes. We have a building program that will help facilitate those changes and we are fortunate to have a number of people who are integrally involved in that change process at a national level, so to speak. The dominos all come together at the same time and that is an enormous opportunity. So with the acute medicine unit, which I will use as an illustration that I will then allude to things like the integrated care centre and how the other end of the hospital has to have all the same sort of synergies at the discharge end. The acute medicine unit provides an opportunity adjacent to the emergency department for patients who are not deemed to be emergency but require acute care within the hospital, so they can come either through the emergency department or bypass the emergency department into that environment - an environment which will have senior specialists upfront and extended hours of practice with an ambition eventually to have senior staff there for the full 24/7 hours of practice, and by that I mean consultant type staff at that time, but certainly extended practice of

consultant physicians at this stage on a seven-day-a-week model, then working hand in hand with the emergency specialists. That way they can reach into the emergency department and assist in the assessment of patients with complex medical needs, which at the moment is done by initial assessment by the emergency staff at various levels and then a handover process. So that there are no redundancies in the process, we can do these things at the same time.

The emergency department works with a sort of blurred boundary with the acute medicine unit and then the acute medicine unit occupies an area that is adjacent to the diagnostic services - X-ray, all the other things that you need to be close to while you are still running what we call diagnostic algorithms, trying to work out what the problem is, so to speak, and stabilising the patient so they are ready for a program of care. Once the diagnosis is made, one is stable, then they may need a course of treatment and that course of treatment might be required at home or it might be required in hospital. If it is required in hospital, the acuity is less because the course of treatment, the decisions are made and there is the different of acuity So patients who are requiring that level of acuity then move on to an inpatient ward environment, if that is required, with a different type of staffing mix that is focused on planned care and planned discharge and then they integrate with community services at the discharge end. Trying to produce again a removal of the redundancies that tend to occur. Everybody does an assessment of when somebody is ready to go home. Physio, OT, medical, nursing assessments are all done. That can be done in a built-up fashion, underpinned by the changes in IT that we will see rolling with this program of building and care innovation.

Also, the integration of the ICC will allow us to look at more admission avoidance strategies. So it is looking at a wellness model in the community. Patients referred by their general practitioners to that facility to have inputs in maintenance of good health, thus there is not a need to present to hospital to have that sort of care commenced. It can be commenced and the hospital can stay out of the equation.

So at each step, before the hospital in admission avoidance, at the transition between emergency to acute care to program management to discharge back into the community and support in the community, we are trying to remove the redundancies and get everybody supported by appropriate IT working together. As I say, it is an opportunity to do that; a new building and building changes are a great facilitator of change and, as I say, we are lucky at this stage, to have a number of people on the staff who are involved in this sort of innovation at a national level and in some cases are getting reputations internationally in that area.

**Mr GREEN** - Just to put that into context, with the 26 I think it was -

**Dr MacDONALD** - Twenty-eight beds.

**Mr GREEN** - Twenty-eight beds - where does that leave us in context with Mr Harriss's question, particularly with respect to the number of people that are the sustainable health model, I suppose?

**Dr MacDONALD** - The 28 beds is modelled on the average number of inpatient admissions that occur and so some of those patients were bypassed in the emergency department, so they will no longer be emergency presentations. Many of them will have their time in

the emergency department shortened because they will be identified early as requiring the services of the acute medicine unit either for the running of diagnostic tests or for acute treatments that might see them discharged immediately from the acute medicine unit and not in the former sense of the word, fully admitted to hospital. But many of them will spend a much more limited time in hospital because they have access to the right person up front the first time, as opposed to the sort of siloed sequential assessments that occur at the moment.

**Mr BEST** - I know we are talking about the LGH, but I have an interest for the north-west; all this integrates, though, doesn't it, with what's happening between Burnie and Mersey and the patients that are coming through from there to the LGH and so forth?

**Dr MacDONALD** - Certainly from the point of view of the patients coming from the north-west coast to the Launceston General Hospital there will be significant streamlining of that process because initial assessments will mean that those patients who have been appropriately assessed and investigated at either of those campuses will then be able to be admitted directly to the acute medicine unit and their journey of care through the hospital will commence there rather than with a long wait on a trolley in the emergency department. It produces an access point for patients are transfers and, hence, not emergencies; they are in need of acute care but they are not emergencies. At the moment, I think everybody who is in need of acute care ends up in an emergency department, whereas an emergency department should be for emergencies.

**Mr BEST** - Right, thank you.

**Mr GREEN** - How do you plan on looking at this, Mr Chairman? Are you going to look at it from projects within the project or -

**CHAIR** - I guess it doesn't really matter. If anybody's got any questions across the whole, unless you think it would be productive to look at the linear accelerator, car park and -

**Mrs NAPIER** - We can raise that as we go through.

**CHAIR** - I think so. Then they will provide whatever interaction we need.

**Mrs NAPIER** - I want to follow up a question from the model that you just explained. One of the phenomena you said that was starting to happen was that a lot of people were increasingly willing, now, to come to a hospital and wait for as long as they might need to because there was a better chance of being able to get to a specialist and get an outcome, as compared to the model that previously existed where you'd go to your GP and then you'd wait to be able to get an appointment to see a specialist. I wonder whether you could, for the record, explain how the model will deal with that as either a transition of people accessing specialist care or a model operating to ensure that both models are still viable.

**Dr MacDONALD** - I think there is a risk that you can become a victim of success in that context and I think we need to be careful about that. There is, however, no doubt that, with the changing generation of the medical workforce particularly, the traditional 24/7 general practitioner and the traditional 24/7 private specialist is not as prevalent as it was. So, in that context, setting out a facility where appropriate assessment can occur and on-

referral to a suitable specialist, be that within the public sector or out into the private sector, can in fact improve access. With respect to the specific comments made this morning that led to that question, from a patient perspective there are two drivers. There is some degree of limitation in access to general practitioners in Launceston and it is likely that that is going to go on for some time, hence there is a driver for patients to present to the emergency department. But there is also a generational change in our public who see the investment in time in the emergency department being an opportunity to receive broader assessment, a one-stop shop of medical assessment, pathology testing, X-ray investigation and specialist assessment, which in the private sector might well have them, on sequential days or sequential weeks, visiting at least five other venues other than their general practitioner. So I think there is a recognition amongst the current generation that, yes, they might wait a while but compared with a process that might take several weeks, even in the most well-honed private sector system, it can all be done in one day by investing some time in the waiting room - whether that is an ideal model. However, what the Acute Medicine Unit will do at the front door of that is that it will identify patients who have acute needs and deal with them immediately - and some of those patients might have waited in the community for a referral process to occur over a number of days - and select the other patients that in fact can and reasonably should wait and be on-referred to outpatient clinics or to private interventions, either allied health, medical or specialist other interventions in the community sector.

**Mrs NAPIER** - So you actually anticipated, as part of that model, that there would be a further increase in throughput; the argument seems to be that there would be greater efficiency if you avoid delays for acute conditions.

**Dr MacDONALD** - I am anticipating that the current trends will continue, that the number of specialists, for instance, working outside the staff specialist jobs will continue to drop because we have a generation of specialists coming through who want to collect a wage, have their time off and their time on. They don't necessarily want to stay at work in the same model that the previous generation did. So the trend in the medical work force that will service that will continue as well. We just want to make sure that we are set up with an effective flow system to meet both the trends in the public and the trends in the medical work force.

**Mr KIRWAN** - We are talking about acute medicine here. One of the difficulties we have is our crossover with general practice and private health. The models we are developing in a whole range of areas are based on supporting and maintaining a general practice area. That is important for us; it is not in competition with. Some other systems we come in competition with, we are quite fair about that. We, as LGH, do not employ any general practitioners and we do not provide general practice clinics. We do employ the staff of qualified general practitioners but they work as career medical officers or hospital medical officers for us, and I think that trend will continue as well.

It is important, if you look at the whole health continuum, and that part of primary health obviously sits in the Commonwealth's domain, that that area remains strong, and in fact this model is a reinforcing of helping that.

**Dr MacDONALD** - To allude to that, to use the acute medicine service as an example, the access points will be similar for other areas, such as surgery. It values the assessment of the general practitioner in the process. The general practitioner would perform an

assessment in their practice and refer the patient directly to the Acute Medicine Unit, and they wouldn't then need to present to the emergency department.

Currently, if your general practitioner deems you need hospital care, you go from an experienced general practitioner to a junior member of resident staff in the emergency department. We are going to take that step out of the equation and unless you need emergency care, you will actually present via the general practitioner to the Acute Medicine Unit where you will get the assessment of a physician or a senior medical registrar as the next person in the line. So we are actually taking some links out and giving general practice a much better interface with the hospital system, valuing their assessments in the community and plugging them in at the level that they should be plugged into in the hospital. It is certainly not, in our model, meant to take over in any way from them, it is recognising that some population groups are going to always access the hospital for general practice in some respects for some of their problems. But we also want to facilitate the seamless transition from care in general practice to care in an acute hospital setting.

**Mrs NAPIER** - In your notes that you provided there is a fairly stark indication of the age standardised mortality rates for all causes and in the north they are fairly high. I must admit, I always thought as the north-west having higher rates because of the angio- or the heart-related issues. Is that particularly loaded by age or is it loaded by some of the lifestyle disorders such as diabetes, cancer, et cetera?

**Dr MacDONALD** - The second is true. The figures are standardised by age so it's not to do with our aging population.

**Mrs NAPIER** - Okay.

**Dr MacDONALD** - What you are seeing in those figures is the fact that the health of this community and in some ways reflecting the socioeconomic distribution of this region is linked to their health outcomes.

**Mr GREEN** - What is the difference from the Australian - can you put that in context for me?

**Dr MacDONALD** - Why we are so different from the rest of Australia?

**Mr GREEN** - Yes.

**Dr MacDONALD** - Well, partly because we have the most decentralised population in Australia, so there is an issue of accessibility and with that, preventative health strategies are limited in this population. There are some engendered cardiovascular and other risks that come with the genetic makeup of Tasmanians, largely meaning northern European, northern UK, Irish; high levels of cardiovascular risk factors is also another issue, but preventative strategies that might have occurred in urban Sydney, Melbourne or Adelaide are not rolled out quite as extensively in a much more decentralised population.

**Mr GREEN** - So much for the clean air.

*Laughter*.

**Mr KIRWAN** - It could be worse.

**Mr GREEN** - That's right.

**Mrs NAPIER** - I noticed in the notes on page 14 associated with the linear accelerator there was a reference to establishing six self-contained, family-style accommodation units. Are they actually on campus or are they the ones that the Cancer Council is thinking about or are they the ones that the LGH is going to establish and where and how does it fit within this project?

**Mr KIRWAN** - They are ones that are separately funded by the Commonwealth. They may be co-located with the cancer foundation but they may not be - sorry Cancer Council. That's still in the process of negotiation. These are the ones that the Commonwealth specifically did fund in the last announcements, so we are in a process of identifying the best place for those. They will be close to LGH; they probably won't be on the LGH city block as such, but we have some land in various other places around us and close to us, and one of the options would be, as we mentioned this morning, should we be successful in getting Drysdale House back that could be one of the options. It could well be on the existing Cancer Council's land in Howick Street; we could go into that with them or it could actually be in other models and in that exercise we obviously need to work with the north-west community and with the Spurr Wing to make sure that it fits within all of those models.

**Mrs NAPIER** - Okay. It's just that we haven't discussed that position.

**Mr KIRWAN** - The actual location for that hasn't been - because there is a range of options. If, for example, Drysdale House is ruled out - I have to say, it's also now complicated - not that extra money should be seen as a complication but - the Commonwealth has regional cancer money on the table. They have 10 areas they are looking at; Tasmania is seen as one area in toto and there is potentially, if you simply do the division, about $56 million to come to this island. At the moment we are in negotiation across the island with various bodies to see how best that could do and, of course, this again fits within a model of where best and how best that model could evolve.

**Mrs NAPIER** - So we are not now able to be informed as to what proportion of that $56 million might be applicable to the north or the north-west?

**Mr KIRWAN** - That hasn't been allocated yet.

**Dr MacDONALD** - We don't even know whether we'll get the $56 million. We are still at the stage of putting in a bid so the State might miss out altogether.

**Mr KIRWAN** - As with other Commonwealth programs they will use all capital and no recurrent. So obviously that is an issue. If you are putting in a bid that had recurrent with it as well, you would put in a very different bid to what you put in for just buildings. That does go to transport and other issues, but as you saw this morning we have been quite successful over the years in maintaining the quality of our equipment and capital in the Holman Clinic. The other two areas are different for totally different reasons.

**Mrs NAPIER** - The Public Works Committee is always interested in the picture and the context of where this significant and important redevelopment goes relative to the next step and one of the issues we did talk about was Drysdale and the issue of step-down accommodation and - what do you call them? -semi-acute or non-acute beds.

**Dr MacDONALD**- Sub-acute.

**Mrs NAPIER** - Sub-acute beds, yes. I wondered in the context of that development it would be worth explaining to the committee how that could operate or what the options might be at least.

**Mr KIRWAN** - When I started here last year around Easter time, in respect to our access block the issues that mean that we have a push system not a pull system, following Dr MacDonald's comments. So in process terms that means that the system actually is pushing people through, which inevitably is frustrating and annoys the staff and particularly they then blame the next areas because they are not helping them. That was fundamentally the problem through the system. We originally identified that as probably not enough aged-care beds. I am not even sure that that is the case now. It may well a maldistribution of aged-care beds in some of the ages and others not being quite right. What we did identify, however, is that as a hospital where you either went from an acute setting to basically then a nursing home, there was nothing in the middle. There was no transitional, step-down, slow-stream or other provisions like that. There did used to be, which was the John L Grove Centre, but under the previous regional model it was then used as a regional office for regions that are lost in history. So there is already a purpose-built, transitional care facility as there is a purpose-built dementia centre, which is also used for offices at the moment. We actually have a deficiency in our model in both dementia care and finding out places. It is the aged-care type patients left in the hospital we have the most difficulty placing within that category. We have been successful in most of the other areas and had some significant success in the last six months, and that is good, but there is still an issue of transitional slow-stream, which is really in a true sub-acute model. If you are in an acute setting it is probably not the best place. It would be our intention if we can return both those of those assets to their original purpose, which also would avoid the taxpayers having to fund new services or avoid us having to purchase them in other ways, which is what we are doing at the moment.

**Mrs NAPIER** - So you would do that instead of your current arrangement which you have with the private sector?

**Mr KIRWAN** - We will probably do that and a range of other things, yes. And this should not be taken as a north–south issue, the south has some 50, 60 or 70 off-site beds; again, historical because of the old Repat Hospital and others. So they actually have a step in that model, albeit again they are suffering the same as us - that is, there is not enough in that area, particularly as we see the acuity of our aged-care patients and there probably would not be a nursing home on this island any different to the rest of Australia - basically saying the type of patients that we are dealing with now is fundamentally different to what it was 10 or 15 years ago. The acuity is going up as the age goes up as the co-morbidities go up, which means that we actually do need some of these other services, which for us is missing in the Launceston area. To some extent our own hospitals outside of that cover some of that responsibility. So that is good having a

number of hospitals with in-patient beds around us, but it does not service the Launceston area very well at all.

**Mrs NAPIER** - I am not to know whether the Drysdale building is to become free or not, but I note we have a new hospitality arrangement that is being developed by the Feds down in town. One would assume that if the Drysdale campus is likely to become available then that may well be part of that decanting process.

**Mr KIRWAN** - Yes.

**Mrs NAPIER** - In terms of the decanting that will be required in the context of this building development or the series of building developments, is it useful to access that kind of building to enable that to happen more easily with the projects that you have or can you do it within what you already have?

**Mr SLORE** - We've arranged to decant the supply department off site. That's the biggest area we could find that we can redevelop into a temporary access to free up the wards that we are going to start working on. The first one will be the day procedures unit, which is across the corridor from the acute medical unit, so that will be a temporary day procedures unit. Everyone that's in that floor is going down into the supply department. The supply department is going up to Holbrook Street; we've leased a building out there so they will operate off site. That basically frees up enough space for us to keep decanting from one to the other. There will be a step program from day procedures unit, acute medical unit; at the same time we can start outside on parts of the DEM without breaking into the building and we'll just stage it through from there. Once we get the DPU and the acute medical unit up and running, then we can start basically the rest of the DEM plus the tower above levels 4 and 5.

**Mrs NAPIER** - So the tower comes in last. Where does the ICC fit in this sequence?

**Mr SLORE** - The ICC goes fairly early with the Holman Clinic. We are going to do bolt excavation on both sides of the road. We'll use the ICC site for part of our building site for the Holman bunker for basic storage of supplies for a period of time and then once we've got the bulk of the Holman in, then the ICC will start. Early next year we will start so it's pretty much midway through next year the whole of Frankland Street will be just about a building site. Also, we are displacing so many car spaces as well, so we are negotiating with the council to do a park-and-ride scheme. They're offering up some land at Hobblers Bridge out near the netball courts. We are in negotiation at the moment trying to sort out the actual bus times and how many circuits we need; they're going to be quarter-of-an-hour turnaround transport to and from the hospital.

There's going to be a bit of pain for the staff but we've had public forums, we're making them well aware that there'll be a certain amount of pain as far as parking and that goes while the building is going on. I think everyone's being fairly cooperative at the moment. They understand that we can't do it without moving people around.

**Dr MacDONALD** - Another part in answer, though, the Drysdale complex time lines aren't right. That won't become available in the time lines - they're just far too tight.

**CHAIR** - Can I interrupt for a couple of moments; there is an urgent telephone call which I need to attend to, so if we could suspend proceedings because we won't have a quorum when I leave the room.

***Short suspension***

**Mr GREEN** - With respect to the layout of the site how you propose to, even though there has been some preliminary discussions about that, manage the project when it is such a significant project on the site, and where does that leaves the site for possible future development? I know we discussed that in our tour earlier today. How you are coordinating the whole process given the intricacies of adapting each of the new sections into the existing sections?

**Mr SHURMAN** - Mr Chairman, before I answer that, for other members of the committee's benefit as well, if we want to talk about programming and staging it is appropriate to direct that question to myself. If it relates to the Holman Clinic and the car park perhaps Andrew Floyd could answer those, and specifically on health planning matters we have Ian Bennett, who is an export from Tasmania but is also bringing back international Skills - it is good to see that coming back to Tasmania.

**Mr GREEN** - So is this the team effectively?

**Mr SHURMAN** - This is the team, a combined team of three practices and one based in Melbourne with Ian's firm and one in Launceston and one in Hobart.

To answer Mr Green's question, certainly we have put a lot of effort into - we will not refer to that as master planning because in this sense that is another issue about service delivery, which the hospital is looking at again with Mr Ian Bennett - but in terms of this program, which is essentially that mixture of Commonwealth and State funding, particularly the DEM which we, I guess, started working on as a State program earlier in 2008, which is then caught up with this Commonwealth program and a combined effort by both State and Federal governments to improve service delivery in Launceston.

The site issues are not insignificant, and as you got a window of that from John Slore we are working very closely with the hospital, but the Commonwealth had put some pretty tight funding targets to us, so we are going to have to work around the site almost simultaneously with these projects. We have prepared a procurement model, which we have submitted to DHHS and to the hospital about how we would deal with that issue and what we will have to do in terms of the constructor to try to encourage the constructor to work empathically, if you like, with the hospital.

**Mr GREEN** - Are we talking of tower cranes?

**Mr SHURMAN** - Again that is something we will leave up to the constructor, but we may be able to do it from the connector roads, but that has a traffic impact so we have to be mindful of the way we go about this. Not all these things we can answer today because some of those are actually construction issues which will come from having a good constructor, and that is our intent in the next little while to go out to tender for the first package for what we call the preferred contractor.

**Mr GREEN** - I suppose the distances are a bit too far away to cover from the central point, really, aren't they?

**Mr SHURMAN** - They will be separate areas which will be dealt with in a quarantined way. A preferred contractor still enables us to use one or more contractors to achieve that staging. We do have some very detailed staging plans available and we are happy to show you them if you wish to have a look at those. We are working our way through that. They will at one point, certainly from the life and history of this project be happening concurrently. So that is a significant impact and I am glad to say that the hospital has been working very closely in this to try to mitigate any of the other options.

**Mr COCHRANE** - I suppose it would be fair to say in the program that we have that package of work happening on the Frankland/Charles streets corner. Then there is a separate package of work happening down at the back of the hospital site on the Frankland Street entry for the carpark and then further up to the LCC. They are separate construction sites for the methodology of contractual management.

**Mr SLORE** - Through you, Mr Chairman - each project is divvied up into sections, like Bill Cochrane is the project manager for the ]DEM AMU DPU, which is the biggest project. He has a project officer working with him and I've also got two other project officers working on the others, so they've all got their individual projects to look after. They will look after all the documentation and communication between the architects so that we will be running a fairly tight ship. I oversee the whole project.

**Mr GREEN** - Yes, that's all. I was really just trying to get a feel for how you are all working together on this, given the various aspects of it and as you pointed out, the State and Federal funding. Mrs Napier asked lots of questions with respect to car parking and the changes that will occur -

**Mrs NAPIER** - That's just because it affected me most.

**Mr GREEN** - Yes, that's right.

*Laughter*.

**Mrs NAPIER** - I was getting hammered by lots of other people.

**Mr GREEN** - It nearly doubles the spaces as they exist at the moment.

**Mr SLORE** - Yes, it's 405 extra spaces.

**Mr GREEN** - And you'll be able to make your way between -

**Mr FLOYD** - Correct; you'll be able to go from Frankland Street to Cleveland Street.

**Mrs NAPIER** - Looking at the construction costs that you've got on pages 20 and 21, it is almost a $100 million budget and the construction costs seem to take $76 [million and loose furniture and CPI cost escalation; does the loose furniture involve specialist equipment or what does that consist of?

**Mr GREEN** - Where are you reading from, Sue?

**Mrs NAPIER** - Page 20, down the bottom.

**Mr COCHRANE** - Within that we've got cost escalation which could be significant rather than just - it says CPI but we are quite sure, in the current environment, that construction costs will increase over and above what the CPI will. Loose furniture - some medical equipment will be in that but it will be that we will have all these new areas of the hospital and so we will have to furnish all those. There will be new waiting rooms, there'll be the ICC that will go - all of this is sort of going to support all of those components of the project. It may seem a significant amount there, but that amount of money is going to have to spread a fair way.

As I talked briefly this morning in the little walk around, at this point of time the construction industry does not seem to have ramped up excessively, even with the amount of work that's out there at the moment but by the time we get to tender we will test that and see how we go. We know that there is a lot of interest in the project because of the scope of it. We'll just have to watch this space with our escalation in costs to see how we are able to manage it.

**Mrs NAPIER** - I notice you've got a construction contingency of 5 per cent and I presume that's in anticipation. Is that in anticipation of any unforeseen factor or does it take into account that, for example, in the relation to school projects that we've been looking at they're saying that there is a building cost inflation factor of about 10 per cent in the north and north-west, but it's probably a bit higher down south. So what is that construction contingency there?

**Mr COCHRANE** - In any construction program we will have our full set of drawn plans and specifications, but there may be some issues that we weren't able to perceive during that design process. We may find some issues on site, some latent conditions when we are excavating. That just gives us a contingency to account for any unknowns in the project. We might have some minor changes to the service planning that requires a minor change to the design and the layout, which is obviously going to add costs to the project so that money is held back to cover those sorts of items. In a perfect world we may not have to use it but practice has proven that it is always prudent to go in with a reserve.

**Mrs NAPIER** - If the reserve isn't required, is there a project that it's going to be redirected towards? Is there an area where you're pretty tight on?

**Mr SLORE** - Yes, ward upgrades; we could certainly put it into that because we do not have enough money to upgrade all the wards.

**Mrs NAPIER** - So that was the issue you were talking about when we were there as part of the briefing, that there is some ward reconfiguration that would probably be advantageous.

**Dr MacDONALD** - And it's part of the project, recognising that with a number of wards we won't be able to do them all but the more money is left over the more of the wards we are going to do.

**Mrs NAPIER** - Would $6 million in the context of a $100 million - I cannot get used to saying that kind of figure for a construction project - I have not sat down and compared that to some of the other design fees and professional fees. What is the normal -

**Mr SHURMAN** - In terms of professional fees, that is probably a reasonably, normal percentage. Obviously it is done in a competitive sense In terms of when fees are put in they are not done as a given, if you like. Certainly percentage-wise it would be of this type of building in particular.

**Mr COCHRANE** - Industry benchmarks show professional fees from about 8 per cent to 12 per cent of the construction budget.

**Mrs NAPIER** - So that would be on the low side ?

**Mr COCHRANE** - Yes, clearly a hospital project is a more complex type of project - I should say it is on the upper end of the scale - but at this point it is in the middle end of the scale, what we have been able to negotiate with our consultant. We thought that we had got a very competitive outcome that suited both parties.

**Mr SHURMAN** - It is inclusive of all the engineering consultants, architectural, cost consultants.

**Mr KIRWAN** - Traffic planning.

**Mrs NAPIER** - I noticed that there is a precinct committee that is going to be established that you have referred to on page 3, the Launceston Health Precinct Advisory Group. I would have thought that had already been established in the way in which you have got a fairly highly integrated construction plan for the whole site. So have you already got an advisory committee and that is just to formalise it? How have you made sure that the input of staff from nurses and attendants though might be able to feed through into the final decision making process?

**Mr KIRWAN** - It is probably best if I respond to that one because it was basically my idea, I suppose. For the building site the project control groups - and there is a diagram in there about how to manage the governance of it - the actual building of the projects, particularly the large parts of the projects, have gone through the project controls process and those project control groups are as per you would see in most other Government agencies and they are structured and all the stakeholders are involved, albeit the emergency department one has grown in its scope and has therefore caused us to actually include more people, including a rebasing recently in respect of risk management. So we have got all those issues, because that project control group is looking at what was originally only the emergency department. It has now got the acute medical unit, the ambulatory area and levels four and five, which is a large part of it. The ICC will have its own as well. The other areas are quite distinct projects. They will be run just as projects through Mr Slore's area.

The precinct advisory group is a different concept. It comes hand in hand with the creation of the Area Health Service, which happened in July. If you look at our precinct rather than the LGH city block, when you look at what we have across the road in the direction towards the city, up the hill towards our nurses' home and potentially Drysdale

House, up Howick Street in respect to the areas we have been talking about and all of those areas, what we have is quite a disparate site that is not particularly well managed as a coordinated site and what has traditionally been the case is that LGH is actually running its bit and the other bits have managed their bits, sometimes with the department and sometimes in isolation. An integrated area health model which is what we have under an area model allows us to bring those areas together and it also allows us to bring together what is happening in the greater Launceston area. The Kings Meadows example in respect to the satellite unit is a good example, including now looking at where we actually have needs for the population of the Launceston area and the Northern Area Health Service. When you look at the area and the assets we have that go to the conglomeration around Launceston General Hospital, they are not particularly well-designed or planned as a collective. What we would like to do is establish a health precinct committee involving particularly the council chamber, UTAS and others, so we can get a handle on managing the whole site. To be frank, there are some buildings that should be bulldozed. There are probably some that should be disposed of.

**Mrs NAPIER** - The old nurses building needs bulldozing.

**Mr KIRWAN** - No, no, no. We need to fix it.

**Dr MacDONALD -** That's heritage-listed probably.

**Mr KIRWAN** - We need to fix it.

**Mr GREEN** - What was that?

**Mrs NAPIER** - The old nurses building.

**Mr KIRWAN** - The old nurses home up near the old hospital.

The Kings Meadows area, for example, caused some reaction because it was not understood what we wanted. If we actually could get the planning right around these areas then people can actually understand what a Kings Meadows health centre should be, what the Ravenswood - and, in fact, we are not well positioned, for example, at the moment to deal with the West Tamar Council in respect to some of their developments in the Riverside and other areas because, again, in a concept of care closer to home, particularly with the new technologies, areas like renal satellite units should be in some of these areas that are developing because it's within the normal lifestyle and we want to normalise a lot of these areas.

So the Launceston Health Precinct Advisory Group is based on bringing people to the table so we can actually plan the whole site in a more cohesive way with the community, with the council, in particular, which has actually been very generous to us and very patient with us, particularly over parking. However, we are on an industrial site; we are at the, what I would describe as, the Paris end of Charles Street; for example, until relatively recently, we ran a great big smoke stack next door - a big diesel generator sitting next to what is now a four or five star hotel. The fact that we've gone to gas means there is no longer a great big chimney there but it is still sitting next to an industrial laundry, for example. So, there are a whole range of issues that we need to get our head around because if you don't think about it now, and start thinking about it when

you get complaints in 20 years' time, that will be too late because we will either have vested or divested and not done it in the appropriate way. Some of that is also a case of where we consolidate. Do we actually keep consolidating ourselves further down Frankland Street, for example, or down to Wellington Street? These are questions that haven't been asked and, as someone who is still relatively new to the job, the question I asked originally was, was there ever a discussion, for example, about not re-building and moving it somewhere else? Given what's happened to the Royal Hobart Hospital, I'm glad they never did that.

**Mrs NAPIER** - So am I.

*Laughter*.

**Mr KIRWAN** - So, I am not arguing but, for example, there should have been a discussion like that. From a health planning perspective there should have at least been that discussion. What I'd like to do is encourage that, but we do also need to re-engage in some ways with our local community, particularly the council, and we have a strong relationship with the Launceston Council and the other seven councils in the northern area, we do need to do that, particularly if you look at where we are going in the future, which will be more services out there than necessarily in a building in Charles or Frankland streets.

**Mr SLORE** - Mr Chairman, adding on to what Mr Kirwan said, probably part of your question that you asked was 'Do we get out to all the staff?' Under the project control group there is a project user group; they are the people that go out and they are representatives from all over the area that we are developing, so they are the ones that have all the input into it that report back to the project control group. So, in answer to your question, yes, we do talk to all the staff and they have a fairly big input into it over a period of time.

**Mr BENNETT** - I can expand that a little. In the emergency department, yes, we met on a fortnightly basis with quite a large user group with the objective to bring them along to give them ownership of the project and we believe that that's happened quite successfully and we've had a very positive response from them. On the AMU, it's been a similar process, although, the group has been less large. There are three - that's the ideal.

**Dr MacDONALD** - That's not an established unit, because it doesn't already have staff.

**Mr BENNETT** - With the day procedure unit, again, we had clinicians and the unit manager and nurses involved with that project and we went through a very detailed consultation process. They eventually signed off the project at the completion of the design.

**Mrs NAPIER** - Given the significant additional space and the efficiencies, hopefully, that the new model might provide but acknowledging there will still be the demand for the expanded number of beds, are you confident that you are also going to get the staff to be able to run this expanded space? There is a reference, of course, to the training money that was available associated with the Federal funding and the Holman Clinic, as I understand it, but if we get this new space, are we fairly confident that we're going to get the staff to be able to do that?

**Mr KIRWAN** - Through you, Mr Chairman - I think the space fits into a couple of different categories: one is some of the space is growing existing services, and the emergency department would fall into that category and the Holman Clinic would fall into that category. With areas like the Holman Clinic because the funding that comes with the patients because the Commonwealth is in some way self-funded, although not fully self-funded -

**Mrs NAPIER** - That is a per service thing?

**Mr KIRWAN** - Yes, and it is built into the payments. In some areas it varies. In some areas we are still dependent on successful businesses cases before the department and obviously now is not the best economic time to be asking for more money, but again a lot of these services will not come on stream for another 12 or 18 months. That is there and we remind the department all the time about that. Some of it will require some reconfiguration and some movement of services, but generally a lot of it is also about given our current levels of occupancy and activity it is providing just growing room which we probably ran out of about three or four years ago, so it is a mixed bag in those areas. There are a number of efficiencies that are driving this and we are seeing some new technologies that are coming so that helps as well and the advantage of being able to design it the way we are now is different to how we would have done it three or four years ago, even probably a year ago.

**Mrs NAPIER** - One of the discussions we had was about access to a patient database that can not only be shared within the hospital but also with the GP and other sites. What proportion of this investment or what cost are we looking at for that IT service?

**Mr KIRWAN** - It is unclear exactly what that will cost. We are talking about a unified intelligence system or a unified model that joins up. We would run 30 or 40 different IT systems across the hospital and that is just us so there is almost all of the areas. To some extent all of the major functional areas and all of the major medical and surgical areas would be running their own systems. Pathology runs a separate system, pharmacy, radiology, let alone our accounting and other areas. We have common platforms. The new patient administration system we are just implementing is one of those, but they are disparate. What we are looking at doing is having one system that sits above that and trawls out of all of those systems so that we can have the one unified shared medical record which will be a mixture of digital and scanned paper and other areas so that we will have the one record. The department is just in the process of going to tender on that and we are just in the process of negotiating with PricewaterhouseCoopers to advise us on that tender. So exactly what it will cost and what our share of that cost will be is unknown, however it is factored into the budget because particularly, as we discussed this morning, for the integrated care centre to work you need an integrated care model of care and for the model of care to work you cannot maintain our current paper-based or separate ICT-based models because you do not get the economies of scale and you do not get the clarity of the purpose so that when the one test has been done and you can see the test whether it done in our pathology laboratory or a private pathology laboratory, the ability for a practitioner to see that and therefore know that that is only a week old so they do not have to order another one, is simple but is actually very hard to achieve at the moment.

**Mrs NAPIER** - That kind of thing has been talked about in Tasmania now for about 15 years, I think - 12 years.

**Mr KIRWAN** - It has been talked about across Australia.

**Mrs NAPIER** - That is probably right. Have we got some off-the-shelf systems now that you can adopt from other places?

**Mr KIRWAN** - Yes.

**Mrs NAPIER** - Do we have to devise our own? I get worried when we try to devise our own sometimes.

**Mr KIRWAN** - No. What we have seen coming onto the market now -

**Mr GREEN** - Road transport.

**Mrs NAPIER** - I remember when we came into government there was one they ended up tearing up. That was a human resource management system.

**Mr KIRWAN** - I don't thing we should go down that path.

*Laughter.*

**Mr KIRWAN** - Under oath I would say something that I would live to regret, coming from originally an HR background.

There are now models in these intelligence systems that allow that. The department has already rolled out a limited version of that in Tripview, which is called FII now, which allows us to extract activity data at a monthly download. It has some application, but for the clinical need we are looking for so that we can run the shared medical records so the person who is on Flinders Island under a HACC program who requires then some respite care so is admitted into the Flinders Island MPC who then may be requiring some acute care that comes into the acute care beds there and then may have to come here for an acute episode, each one of those at the moment is a separate transaction. If we could, by having a unified record, say, for example, if what it does is upload and transfer everything along the way and that has huge quality time saving and efficiency advantages and so they are the one patient in the system all the way through and albeit they're different funding streams, some are all Commonwealth, some are shared Commonwealth, some are all State, some may well be private, those are issues we can resolve in a different approach so it's not the patient's or the punter's problem to work out where they come from. We will do that and, in part, that's the challenge for the integrated care centre. So if the patient is being provided with coordinated care, managed care, integrated care, which is the model we're talking about, we need a system to support that. We are seeing systems around the world where that is the case. Again, we look to the models like America and others where they actually have managed care models already and they are ahead of us in some of that.

**Mrs NAPIER** - Because you hear about it, don't you; other places using it.

**Dr MacDONALD** - Yes, and we've been looking at them.

**Mr KIRWAN** - There are some Australian models in areas like chronic disease and others that are very interesting and very exciting.

**Mrs NAPIER** - When we approved the DEM for the Royal Hobart Hospital, they put the conduit through but they didn't actually put the system in there because they hadn't quite worked out what they wanted. Are we going to be just putting a conduit through or are we actually going to be putting a system into the new building, to the new configuration of buildings?

**Mr GREEN** - You must be; you're going to tender.

*Laughter*.

**Mr COCHRANE** - We are. We have been working very closely with our ICT department about the level of data transfer systems that they require. Yes, with the DEM, they actually put the conduits through that and at some time in the future they might actually have fibre optic to the desktop. But with category 6 that we put into the Royal Hobart Hospital DEM, certainly that was capable of transporting digital images and everything that was required and they're operating now quite fine with that even though they've got that capacity, if required, to upgrade directly to fibre optic to the desktop. A section within our ICT department are very, very strong on the standards that we are required to put in and nothing is substandard, that is not going to support the intended models of care.

**Mrs NAPIER** - But, within the budget, we have actually funded buying the system and setting the system up; to actually have it up and running in the new building.

**Mr KIRWAN** - Probably our share of it in that it would have to be a statewide system so we don't want a different system working at Burnie as it is here because, again, the inter-operability, using that nice word, is quite critical. An integrated model is integrated across the whole island, not just within the northern area of health services, and preferably also with the private system, which is going to be an interesting challenge. Again, this is not new, unfortunately. This has been discussed at the national level and State level for quite some time.

What I think is quite exciting is that we are now seeing some products that don't just have promise, they actually have track records in other countries. We don't have a good track record in health in Australia - and I'm not talking about Tasmania - in implementing these areas. It has not traditionally been. One of the weaknesses is that we have always had technology chasing solutions. What we actually have is a solution we want; we can explain what we're looking for, we can visualise it, we can actually point to Mrs Smith from Beaconsfield and give the example of her three visits over 10 days when really that should have been on one day and we should have been managing that. So three uses of the community car, three uses of her having to put the husband into respite or make some other arrangements. Those are the models that we know that we can actually improve on. Whether we get it quite in sync is going to be interesting. If we could sign up tomorrow, we would sign up tomorrow. It is really quite exciting what potential it gives for us.

**Mrs NAPIER** - I think it's very logical. It's the way to go.

**Mr KIRWAN** - But it reinforces those changed models of care. When we've got someone in someone's house providing home health or transitional care packages, for example, if they're dealing with Mrs Smith and Mr Smith is there and there is a problem then the ability in real time to dial in and raise the issues rather than, 'Sorry, you're not on my list, what are you doing?' and then going through the system, we really can improve our quality significantly and that will be the intention.

**Mrs NAPIER** - The other question I have is in relation to what the financial model is that applies to the operation of your car park once the multistorey car parks are going to operate. Are you going to have a care park operation, are you going to run it yourselves? It is fairly big - it is a good investment, absolutely. I am interested in knowing what the financial model will be.

**Mr KIRWAN** - The current financial model, in that we've been told nothing other than that, is that we will operate it and that is what we are proceeding on at the moment. The focus is on building it. However, there had been some discussions last year with Treasury about, for example, going to the private sector and then building and operating it. For a range of reasons, that didn't come to pass, which we are relatively happy about. What the future model is I think is unclear and, from discussion the department had with Treasury, our preferred model is that we own it and operate it, albeit we might contract out the operation and, for example, the council has expressed an interest in operating it. So the various models of what it ends up as are still unclear and there is an expectation from Treasury that they would get some return on the investment in this area and so that's yet to be finalised as well.

**Mrs NAPIER** - In the design did I see that there's a tunnel or there are some covered connection ways into the heart of the hospital?

**Mr KIRWAN** - Yes.

**Mrs NAPIER** - Okay.

**Mr GREEN** - I have only one more question, Mr Chairman. Before asking that question, I want to thank everybody for their presentations today. I think it's been very good. It gives me great heart. Thanks to Leanne for helping us at the start today and her team. It was really very good.

This is obviously a very significant project and, as we were talking to the Chairman about, normally with a $100 million project there would be lights, whistles, the whole lot. For some reason it just seems to be going under the radar, but it is just fantastic. It's going to make a huge difference obviously, particularly for those people working at the hospital, for their wellbeing and their ability to deliver the service that you obviously want to deliver.

Coming from the north-west coast and visiting the Holman Clinic again today and the fact that we're talking about one new bunker and we were informed where the second bunker will go if another machine comes - we're taking a terrible kicking over this on the

north-west coast, as you would understand - I want you to reassure me before I tick off on this project why it's important to have a centre of excellence with respect to the siting of the linear accelerator and the difference it will make, particularly from a training point of view on a statewide basis.

**Dr MacDONALD** - Mr Chairman, I can answer parts of that. I think there is no doubt that the critical mass that occurs as a result of putting those bunkers together in one place allows us the facility for training, allows us the critical mass of physicists, radiation oncologists and other therapists in one area to provide an extended service and to fully utilise those bunkers to provide care to the whole north of the State. There are significant economies of scale that come out of that process but the most important one remains the opportunity to locally then train and mentor new staff and the retention that will occur around that. I'm aware over here of the issues around the location of that bunker and I'm also aware that, at a statewide planning level, the future intent is not necessarily to not have bunkers on the north-west coast. However that planning flow process is in place and the outreach around that. Once the sustainable critical mass is established here then there will be enough resource to look at effective outreach in the next rollout of additional services. I think it offers a northern centre within a critical mass for the next step to be further outreach.

**Mr GREEN** - That's very important because certainly from my point of view, I need to be reassured. I was really heartened by what people said, particularly with respect to talking to some of the staff there - only one - about your ability to manage and actually have people wanting to work at the centre. That is extremely important, as I see it, from a statewide perspective so thanks very much for that answer.

**Mrs NAPIER** - Is there anything else we should have asked?

*Laughter*.

**CHAIR** - I have just one that I want to get on the record to Andrew Floyd if I can and that is with regard to the new car parking facility.

Andrew, you mentioned something to us on site about the dimensional changes to the car parking which will be provided. Can you just run through that briefly for us. I don't think it is in the submission, in the detail of that, in the height and the set out of the car park area.

**Mr FLOYD** - Yes, thanks Paul. The Australian Standards calls up different sized car parking for different sizes and different types of facilities. In hospital, the planning for a car park is the equal of a 2.6 wide car park by 5.4 metres long, with an access road, access of 6.5 metres. There is a requirement for a clear space of 2.3 metres as a volume above that car space. That is different to what is usually provided in, say, normal commercial parking where that is a bit smaller. The reason is it is a little bit more easy to access these spaces and it is considered that there is a range of different vehicles that would potentially be wanting to access these spaces, like patient transport and -

**Mrs NAPIER** - People getting in and out of their cars.

**Mr FLOYD** - Yes, people with disabilities, wheelchairs and those types of things.

**Mrs NAPIER** - We could use that at Parliament House. Half the time I cannot get out of my car.

**Mr FLOYD** - There would also be a requirement to provide a certain number of disability car spaces, making sure that they have appropriate access. There would also be a provision for bicycle car parks. As part of the development we will be making sure that users of the car park can easily access vertically and horizontally. We will be providing for cars around and generally trying to make it as pleasant an experience as we can. We will be designing the building so that as far as practicable it is naturally ventilated and naturally illuminated. So we are trying to keep our running costs down. We are trying to provide environmentally sustainable car parking where it is possible.

**CHAIR** - Thank you.

**Mrs NAPIER** - Just for the record, how many total spaces will be available by the time you have finished?

**Mr FLOYD** - There are 405 additional spaces and it works out between Frankland Street, Charles Street and Cleveland Street, 876 plus or minus one or two. It is very close to that number. There are additional spaces around the site outside that block but that is just in that block.

**Mr SLORE** - Through you, Mr Chairman - the on-street parking once we finish our car parks will change to time parking, whereas at the moment it is unlimited parking on northern side of Frankland Street, so that will basically free up more spaces to our visitors because our staff will not be able to park there. At the moment they are all staff who park up Frankland Street. We have also got parking behind Viewpoint which the building up on the hill across Frankland Street. That is not counted in the total spaces that are there.

**Mr FLOYD** - No, that is extra.

**Mrs NAPIER** - For the record, I know we talked about this back at the hospital but this will provide now six full-sized theatres.

**Mr KIRWAN** - Or more.

**Mrs NAPIER** - Or more, right.

**Mr KIRWAN** - We are yet to finish the planning on the fifth floor and on the fourth floor because to some extent the Commonwealth outspent in the Federal Budget. We had plans and we put in submissions saying this is what we wanted to do. As we said this morning, a part of the State's investment in the emergency department was, in fact, to put the foundations down.

**Mrs NAPIER** - To make it ready to build on top of.

**Mr KIRWAN** - And I suspect that that was one of the reasons we got funded versus some others because we were ready to rock and roll. We had the plans, we had the thinking. What we are now doing is doing that configuration because in the surgical areas the

current proposal is that we will move our day procedure unit and perioperative work up onto the fifth floor. In surgical management there is either one or two ways to do it. You totally separate your elective surgery work, which is underlying some of the thinking about the Mersey as an elective surgery type of hospital, so it doesn't get affected by emergency work.

**Mr GREEN** - I thought it was a very good model.

**Mr KIRWAN** - And still is. If we were a larger city. there would be a 120-bed hospital somewhere else in the city that only did elective and did not have an emergency department. That would be the model you would find around most of the capital cities in Australia, in various sizes or shapes when you come to a regional centre. But what also we have found, though, is that the thinking is by putting all of our surgical areas on the one floor we then have ability - because at the moment if we have staff shortages, which you do in some areas at some periods of time, and you end with, say, losing one nurse; you actually have to lose the whole shift or the whole session and that gives us an inefficiency for obviously cancellation and others - if you have all of our surgical nursing staff on the one floor, the ability to have flexibility and keep all of the theatres open and be as efficient and utilise your assets as much as possible then comes to the fore. That, because of our size, becomes a better model than separating them out. The other model would have been, for example, to use the ICC as the day surgery area, not that the Commonwealth may have agreed with that, but that is how you may thought that through. Instead this puts the surgical area on the fifth floor and then that gives us that ability to be more flexible, understanding that surgery is moving more and more towards day procedure operations and there are quite significant advances in the technology in those areas.

**Mrs NAPIER** - I noticed in your report you said that you have the highest level of day procedures in the State. Why is that so? Is that just because you are good at your job -

**Mr KIRWAN** - It was there before me.

**Mrs NAPIER** - or is that discount against some of the specialities that are available only at the Royal Hobart Hospital?

**Dr McDONALD** - No, I think it in part discounts against the fact the private sector is significantly bigger and day surgery work will tend to be attracted into the private sector. So I think some of it discounts for that. Some of it is because we are just doing a good job.

**CHAIR** - On the record.

*Laughter.*

**Mrs NAPIER -** We appreciated the brief around the hospital. That was very good. It was easier than interpreting these, I must confess.

**CHAIR** - We appreciate your presentations. As Bryan and Sue have said, the site visit this morning was very productive. It gave us, particularly in the DEM area, a real insight into the challenging circumstances in which you are working. We saw ditto at the Royal

Hobart Hospital some time ago and it is unbelievable that you have ambulance and then triage across the other side of the complex, as it were, before people get any sort of treatment. That highlights and brings to the focus of our attention some of the difficulties within which you work. We appreciate that. We thank you for your attendance.

**Mrs NAPIER** - Can I ask one question? I realised we had not asked it. How strong is green design, sustainability, in this rebuild?

**Mr SHURMAN** - I think we can answer that in broad terms, particularly with the hospital's cogeneration philosophy happening at the hospital here with the gas and electric. That I think embodies what the hospital is doing on a larger scale, planning for and delivering that. What we are doing with the new buildings is to try to bring them into the right sort of sustainable design, particularly the ICC where that is part of its brief to be sustainable.

**Mrs NAPIER** - Have you got water collection and all of that kind of stuff.

**Mr SHURMAN** - Grey water collection to the degree that we can, remembering that this is a hospital and in a clinical setting we cannot do some of the things you might do, say, in an office building necessarily but we are doing that in the ICC and also looking at potential for solar collection. There are new products are out like glass which has the solar cell embedded in the glass.

**Mrs NAPIER** - Is that what they call photovoltaic cells.

**Mr SHURMAN** - Photovoltaic cells, actually embedded and used in the glass so you can see through the glass as well as using it as a solar collector. So some of those things are embedded in that.

**Mrs NAPIER** - Presumably that gives you double glazing at the same time, does it?

**Mr SHURMAN** - It can be put in a double-glazing unit. There are some good double-glazed units. Each has a different coefficient of insulation so it is a case of how far we go with that within our budget because obviously this is at a cost. The ICC has a natural ventilation atrium, if you like, in the middle where the plan can enable that to happen. But the big effort, I think, in the hospital proper is the cogeneration.

**Mr COCHRANE** - It would be fair to say that ESD factors that are put into buildings now, 10 years ago would have been some of the first factors that we would look at cutting out if we had a cost issue. Now it is just accepted as part of the core business and the core building services and that would be the last thing you would look at in trying to delete as a cost saving. Treasury has yet to mandate arrangements for us but I am sure that will happen in due course, a green star rating for all new public buildings.

**Mr GREEN** - It is a hard one, especially on non-greenfield sites.

**CHAIR** - Okay. Thanks very much. I am sorry we did not need to refer to the model over there which you took great pains to bring in, Andrew.

**THE WITNESSES WITHDREW.**