2021 (No. 30)

PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

Mersey Community Hospital – Theatres and Outpatient Clinics Redevelopment Project

Brought up by Mr Ellis and ordered by the House of Assembly to be printed.

MEMBERS OF THE COMMITTEE

Legislative Council	House of Assembly
Ms *Rattray*	Ms *Butler*
Mr *Valentine(Chair)*	Mr *Ellis*
	Mr *Tucker*

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1 INTRODUCTION

The Committee has the honour to report to the House of Assembly in accordance with the provisions of the *Public Works Committee Act 1914* on the -

Mersey Community Hospital – Theatres and Outpatient Clinics Redevelopment Project

2 BACKGROUND

2.1 This reference recommended the Committee approve redevelopment works for the Outpatients Clinics and Operating Theatres at the Mersey Community Hospital.

2.2 The Mersey Community Hospital (MCH), originally built in 1962, is a four-level health facility providing sub-acute hospital services in the North West of Tasmania. The MCH specialises in high volume, low case weight, elective day surgery procedures. The hospital provides an Emergency Department, general medicine, close observation unit, rehabilitation, some cancer services and is working towards becoming a centre of excellence for short stay surgery in Tasmania. It is also the home of the North West regional Endoscopy Service.

2.3 The MCH has not had any major redevelopment and expansion works since 1962. Rather, it has been modified in an attempt to keep pace with the ever-evolving healthcare needs of the North West of Tasmania. The Mersey Community Hospital does not reflect contemporary healthcare standards as outlined in the Australasian Health Facility Guidelines and has deficiencies in operational, infrastructure and patient needs including:

- Ongoing issues surrounding patient confidentiality and privacy;
- Outdated, inefficient and redundant mechanical, hydraulic and electrical services;
- Workflow issues dictated by the existing building compromise efficiency and best practice;
- Patient flow issues resulting in "bottlenecking" and reduced efficiency;
- Workplace health and safety (WHS) issues caused by inadequately sized operating and procedure rooms and lack of equipment storage ;

2.4 The redevelopment will result in the capacity to provide an increased volume and range of health services to the local community, particularly health services that address chronic disease. This will also position the Mersey Community Hospital to meet ever-increasing and changing demand into the future.

In broad terms, the proposed works will involve:

- Additional endoscopy unit and redeveloped day procedures unit;
- Expansion of recovery and theatre spaces;

- Expanded outpatient clinics;
- New and upgraded staff facilities; and
- New and upgraded building services and equipment.

2.5 The project scope encompasses a nominal area of 2,600sqm of refurbishment to Block B, C and D, and a nominal area of 2,850sqm of new build to Block C and the new Block E. Upgrades to existing building services will be completed in addition to the installation of new building services required to facilitate the proposed works.

2.6 The proposed works will include the following specific elements:

<u>Ground Floor Block C - Outpatient Department</u>

- New Main Reception with storage space, with associated waiting area and new/refurbished public amenities. The new Main Reception will be configured to provide a welcoming and intuitive approach to wayfinding for patients and visitors;
- Physiotherapy Gym and associated Office and Storage relocated from Level 2 Block D;
- Reconfigured Outpatients Clinics providing consolidated paediatric services and an accompanying 22 person waiting room with dedicated toilet facilities. This area has been designed with the ability to isolate and operate independently from the rest of the hospital, should the need arise, through an infectious disease outbreak or other similar health event.

  The Paediatric Department will include :

  - Waiting area and public toilet with baby change facilities;
  - 5 general Consult Rooms;
  - 1 Observation Bay;
- Dedicated Audiology Consult Room;
- Larger, Multipurpose Consult Room allowing for flexible use, including visiting specialists, Child Health and Parenting Services (CHAPS) and telehealth consultations;
- New general Staff Offices; and
- Consolidated IT/Communications services, with an updated Rack Room to accommodate increased IT/Communications requirements.

<u>Ground Floor Block E – Outpatient Department</u>

- Central waiting area for 58 people connection to Main Reception in Block C. The Central waiting area will be designed to distribute visitors according to booking schedules and assist to alleviate anxieties associated with clinical environments;
- Central Staff Workroom with provisions for staff escape from adjoining Consulting Rooms;

- 13 Consulting Rooms (including 1 with Cardio Rehab capacity);
- Secure accessed staff facilities including Staff Room and Amenities;
- Rooms for Treatment, Dressing, Stomal Therapy, Gynaecology, Urodynamics, Plaster; and
- General ward amenities including Dirty Utility, Bin Room, Cleaners Store, Main Store.

First Floor - Central Core (B, C, D)

- New Admissions and associated support infrastructure configured to provide a welcoming and intuitive approach to wayfinding for clients and visitors;
- New extension over the Ground Floor Main Entry that provides a new Waiting Area for 25 people, and 2 public toilets; and
- 2 New Pre-Operative Consulting/Interview Rooms.

First Floor Block B – Staff Facilities

- Staff Change rooms and amenities including showers and toilets;
- Staff Multipurpose room;
- Staff Offices; and
- General ward amenities including General Store Room and Cleaners Store.

First Floor Block C – Recovery Ward

- Pre-operative waiting lounge and amenities to accommodate 12 patients;
- 2 Pre-operative General Consult Rooms;
- 16 Stage 2 Recovery beds, including 1 contact isolation room to allow separation for patients requiring added privacy, such as paediatrics, or patients requiring contact precautions;
- 2 dedicated Nurse Stations in Stage 2 Recovery to allow even distribution and line-of-sight monitoring of each patient;
- 12 seat Stage 3 Recliner Discharge Lounge Recovery Area including dedicated changing facility, lockers for patient belongings and, a kitchenette for staff to distribute recovery meals/snacks from General ward amenities including Clean Utility, Linen Store, staff and patient toilets, which will be easily accessed off the main corridor and away from patient areas;
- IT/Communications room;
- Direct flow to and from Block E with minimal crossover of flow; and
- 6 toilet facilities located throughout Block C to minimise distance of travel required for patients.

First Floor Block E – Day Procedure Unit

- 1 Endoscopy Room, 2 Operating Rooms and 1 Endoscopy/Operating Room and, associated Reprocessing, Set Up and Store rooms and Scrub Bays;
- 4 Patient Holding Bays;
- New Post Anaesthesia Care Unit (PACU) with central Nurse Station and 8 Stage 1 Recovery beds, including 2 contact isolation rooms to allow separation for patients requiring added privacy or contact precautions;
- Dirty Utility Room and Store;
- Central Drug Room with secure and controlled access located on 2 sides
- Floor Coordinator and support offices located off main circulation to provide unrestricted access to Block E and the efficient coordination of services; and
- Where practical, areas for quick and easy access to mobile equipment has been provided throughout in addition to dedicated Storerooms for Endoscopy, Chemical and Anaesthetics.

First Floor Block D – Central Sterile Supply Department and Staff Facilities

- New restricted access Central Sterile Supply Department (CSSD) designed to allow for one-way flow of non-sterile to sterile equipment cleaning and storage.
- Associated CSSD ward amenities inducing:
    - Sterile Stock and Consumables Storage;
    - Mobile Equipment Bays;
    - Dedicated Clean-Up Room;
    - Central Sterile Supply Department supervisor/coordinator Office;
- Unboxing Room;
- Bin Store;
- Non-Sterile Stock Store;
- IT/Communications Room;
- Doctors and Staff Offices; and
- Staff Lounge.

3 PROJECT COSTS

3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work is $21 million.

The following table details the current cost estimates for the project:

Description	Sum
Consultancy cost	$ 2,080,000
Construction Costs	$ 28,850,000
Construction/Design Contingency	$ 1,600,000
Post Occupancy Allowance	$ 150,000
The Tasmanian Government Art Site Scheme	$ 42,000
ICT Infrastructure	$ 750,000
Furniture and Equipment	$ 3,000,000
PROJECT TOTAL	**$ 36 472 000**

4 EVIDENCE

4.1 The Committee commenced its inquiry on Tuesday, 5 October last with an inspection of the site of the proposed works. The Committee then returned to the Latrobe Council Chambers, whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Richard Rainbird, Project Manager, Programming and Delivery, Infrastructure Services, Department of Health;
- Victoria Brown, Project Nurse Capital Works ,Mersey Community Hospital, Department of Health ;
- Alisdair McPhee Senior Associate, Architect, ARTAS Architects;
- Arnold Goldman (community member); and
- Steve Martin (community member).

The following Committee Members were present:

- Mr Valentine (Chair);
- Ms Rattray;
- Mr Ellis; and
- Mr Tucker.

Overview

4.2 The Committee asked the Department's witnesses to outline the need for and objectives of the proposed works:

> ***CHAIR*** *- Could you outline the objectives of this particular set of works for us and for Hansard?*
>
> ***Mr RAINBIRD*** *- Currently with the redevelopment we are looking at expanding the capacity of our outpatients and our operating theatres at Mersey Community Hospital. This is inclusive of an additional endoscope and a recovery theatre space. This will be a two-storey facility which we class at the moment as a wedge which will be placed between C and D Block. We will look at upgrading staff facilities which would account for the additional capacity that we will be maintaining or running at Mersey Community Hospital and the infrastructure upgrades which will support this new facility.*
>
> *Current objectives are basically to redevelop the Mersey Community Hospital to fulfil that capacity of having an outpatients and operating theatre.*
>
> ***CHAIR*** *- And where it fits in the wider scheme of things in terms of the Tasmanian health system.*
>
> ***Mr RAINBIRD*** *- Yes, ideally this program is about ensuring that we look at our wait list and have the service delivery or the model that's been presented to support the community on the north-west under… …the statewide White Paper clinical redesign.*
>
> ***Mr TUCKER*** *- ……How is it consistent with the Department of Health's Strategic Asset Management Plan?*
>
> ***Mr RAINBIRD*** *- The current asset management plan is focussed around the maintenance of our facilities moving forward with this facility. This is for future-proofing of this site. There has been a significant amount of work into the infrastructure upgrade to account for this, and we*

are currently developing an asset management schedule which will account for the ongoing maintenance of this site continuously.

***Mr ELLIS** - ……Would it be fair to say that the Mersey, essentially, is operating at quite a high level of capacity for what the existing building was, which maybe demonstrates the need to expand the hospital and provide more services and more space?*

***Ms BROWN** - I guess that's exactly what we're doing. We're expanding both the outpatients and the perioperative service, so, yes. I don't have any figures but I'm sure that if you looked into it you'd see quite an exponential growth over the last 20 years or so, remembering that the hospital is 60 years old. Looking at the numbers that would have presented 60 years ago, it's no wonder we've outgrown it, really.*

Design Approach

4.3 The Committee asked Mr McPhee about the approach taken to designing the proposed works:

***Ms RATTRAY** - ……You have consulted with Victoria, her team, and Richard. Can you give us an understanding of your design approach?*

***Mr McPHEE** - On engagement, a master plan was completed by Silver Thomas Hanley, who are medical architects based on the mainland. When we commenced this project, we used that as the basis of the master plan. We also used the Australasian Health Facility Guidelines document that produces guidelines and standards for all of the different rooms in a medical facility. We also engaged a health architect based in a separate architecture firm, who is also a registered nurse who effectively provided peer review on our design as we were going through. There was also significant consultation with the project working group and both Victoria and Richard over an almost 12-month period. ……We also had two separate internal design presentations to the staff and to stakeholders, where we provided a 3D walk-through of the facility. That is how we have got to where we are.*

How Has Consultation Influenced the Project Design?

4.4 Noting, Mr McPhee's description of the design approach, the Committee sought to understand what consultation was undertaken and how this had influenced the design.

4.5 The Committee recognises that consultation with clinicians and staff is crucial in designing works that are fit-for-purpose and will alleviate identified deficiencies. The Committee questioned the witnesses on the consultation undertaken with staff and the significance of this in the final design:

***Mr ELLIS** - ……I note substantial consultation with the project working group. How important is it to have clinical input in the way that we design our hospitals and refurbishments and all that sort of thing?*

***Mr RAINBIRD** - It's very important from a patient flow and a clinical infection point of view in where we're leading.*

Victoria has spent many a month talking to the specialists across the north-west and updating staff at Mersey Community Hospital. Having the right people and the key stakeholders at the table has been important. It's been challenging to get them because of their workload and capacity but the way we've done over, I think, is over and above on our consultation process for this project.

***Mr TUCKER** - … … obviously the nursing staff have had a fair bit of input on the design of this, that is correct?*

***Mr McPHEE** - Yes.*

***Mr TUCKER** - Yes, I make the comment that what I have seen with hospitals where nursing staff have had a lot of input, the hospitals actually work really, really well. I see a lot of positives in the design that is being put forward here today.*

***Mr McPHEE** - A lot of that coordination has come from Victoria, rounding up the troops. Through our weekly meetings there was really good communication, a really productive couple of hours. We would take that feedback from sketches that we may have produced and then present them again the following week or no later than two weeks for review and comment. That was just a continual process throughout and it ended up working out really well in the end.*

***Mr TUCKER** - Because they are working there every day, they see the issues.*

***Mr McPHEE** - That is right.*

***Mr TUCKER** - They know whether the problems are and what needs to be done to fix those issues to get efficiencies and things in that area, which is a big advantage.*

***Mr RAINBIRD -** We are also very fortunate that Victoria's other hat is that she is a project nurse, a nurse within the theatre, so we have that influence, that input and expertise, we are very lucky there.*

4.6 The Committee understood that allied health services would be a key user of the new outpatient consult area, and sought an understanding on what consultation had been conducted with providers to ensure the space was suitable for their needs:

***Mr ELLIS** - I might ask about allied health services. What is the input they've had in helping to design this project and how important are those services in the Mersey Hospital?*

***Ms BROWN** - I guess the main allied health stakeholder would be the physiotherapy department because we are relocating the physio gym and office space from their current location on the second floor down into outpatients. The reason for that move is that it's much better access for the public, rather than coming up and walking right through an administration building. It also allows them to link in with the consult rooms and what else might be going down there. It's a win-win all around. The physio manager and the people who use the gym were consulted, as were the cardiac rehab nurses because, again, they use the physio gym space. There was quite a bit of consultation through there.*

Other than that, the Director of Allied Health wrote, initially, at the briefing stage to provide what sort of use of the facilities they would like, what services they would like to be delivering through the consult rooms, so those needs could be taken into account. Periodically, we have been back in touch, that person has changed roles a couple of times, but they are in the loop as far as the sign-off and the design as it went through the process.

4.7 The Committee also recognised that facilities need to be designed with community accessibility in mind, and asked the witnesses how community consultation had been undertaken:

***Ms RATTRAY** - What about the community consultation as well? We know that's often where the highest level of criticism comes from, the community, once something is being developed. I'm interested in that process as well.*

***Ms BROWN** - Initially I presented this project to the community engagement group that the hospital uses, and from that initial presentation there were two representatives who expressed a desire to be involved in the process. They were consulted several times on different stages of the design via email and sharing of design plans, mostly looking at things like waiting rooms, public facilities, access, the admissions area, those sorts of things we felt that their input would be really valuable. We did meet again just before sign-off of all the plans for me to present the final submission before it went away for approval. A couple of them right through were involved but the whole group had an initial briefing and presentation on what we were doing and we asked for any feedback at the time.*

***CHAIR** - Can you perhaps give us an idea of the makeup of that group? How did you choose your members and bring them together?*

***Ms BROWN** - They are volunteers. They are people who expressed an interest in being involved. They were recruited through our Quality and Safety Unit. The idea is that they're not staff, they don't have a background in health and they represent different facets of the organisation - business people, tradesmen. There was a mother with young children who was also on the committee when I was talking to them so it was quite a varied group.*

Increased Day Surgery Capacity

4.8 The Committee was aware that one of the objectives of the project was to increase day surgery capacity. The Committee sought further information on what impacts the redevelopment would have on the provision of day surgery services:

***Mr ELLIS** - Can you give us a sense of how bottlenecking is currently occurring in the Mersey and how these works would help alleviate that, and what that would mean for patient care and patient outcomes?*

***Ms BROWN** - Bottlenecking happens in a few different places within the perioperative flow. The first place we usually get bottlenecking is the first stage recovery. At the moment, we have three first-stage recovery beds around in the theatre complex. We have two operating rooms. If they have a high flow short procedure time, quite often the recovery room will be full and we have to stop the lists while we wait for those patients to move on. Obviously, we have to have somewhere for them to go. That is the first place bottlenecking happens. The second place is in the stage two day surgery unit, where they still have previous patients in the beds and we have new admissions coming in for the afternoon, and again we have nowhere to put them because we do not have enough beds. These can all cause delays with the operating lists and potentially lead to cancellations at the end of the day, because we do not run evening shifts at the hospital. It is a day surgery unit. The new facility allows for more stage one and stage two beds. It also allows for more efficient processing of patients as far as their admission and discharge - paperwork, the use of consult rooms for admissions, the use of a discharge lounge for people just waiting for a ride or a prescription. We don't have those facilities at the moment.*

***Mr ELLIS** - And so by this infrastructure change and removing some of those bottlenecks, we are likely to see the capacity to do more elective surgeries more efficiently?*

***Ms BROWN** - Absolutely. I would like to see one to two more people on every list because I think we will have the capacity to increase the throughput by that much, just with removing some of these design issues.*

***Mr TUCKER** - On the list, you are talking per day, is that correct?*

Ms BROWN *- Yes.*

CHAIR *-… … How many extra additional day patients will it provide for in percentage terms?*

Ms BROWN *- Well, we are looking at an additional throughput of about 25 per cent by the time it is all finished.*

Type of Surgical Service

4.9 The Committee, noting the Department's submission highlighted that a 23-hour surgical service would be provided, questioned the witness as to what this meant. Ms Brown responded, noting that the type of surgery the redeveloped operating theatres and recovery suites would cater for were elective day surgeries, but would have the capability to cater for more complex surgery if a policy decision was made to offer that type of service in the future:

Ms RATTRAY *- I have a question on the service. I notice the documentation says -*

> *This development will be a 23-hour surgical service.*

Which hour don't we cover?

Ms BROWN *- It's the way it is. The White Paper stipulates that the Mersey will be used for twenty-three hour surgery. At the moment, we use overnight beds either in the close observation unit or on the medical ward for patients that require a bed. They are usually discharged before they hit the twenty-four hour mark. It is to do with the type of surgery that you do. The new area has mostly been built for high flow, high turnover day surgery patients. There will be part of 1 B that will not be re -developed that will still have some single rooms that can be used for these twenty-three hour stay patients, as well as beds on the close observation unit and medical ward.*

Ms RATTRAY *- Is the twenty-three hour surgical service arrangement part of the dollar deal that was done all those years ago?*

Ms BROWN *- That is part of our clinical service delivery. That is what we are being asked to do. As you know, there is a current review going on about what services the Mersey will be providing into the future. We are hoping to have that report next year and that will inform any future re -developments of different areas of the hospital.*

Ms RATTRAY *- But that will not impede on what is proposed here at all regardless -*

Ms BROWN *- It will not impact on what is proposed here. No.*

Ms RATTRAY *- of what comes out of that review?*

Ms BROWN *- No.*

Mr RAINBIRD *- That is more around the level of service being provided.*

Ms BROWN *- This is what we are working towards, it is the old White Paper. So the new one is what will prescribe into the future.*

Ms RATTRAY *- So we might get a twenty-four hour service?*

Mr RAINBIRD *- You never know.*

Ms BROWN *- But our operating theatres will still be able to service that if that happens.*

Mr RAINBIRD *- Correct.*

Ms BROWN *- They are spec'd so that they would be perfectly able to cope with anything that even the North West Regional Hospital delivers.*

Increasing Consult Room Capacity

4.10 The Committee understood there would be an increase consult room capacity. The Committee sought further information on the benefits this would provide for service provision:

Ms RATTRAY *-… …I am interested in the consult rooms. We were given some advice around the fact that the number would be increased. Can we have the increased numbers? And Victoria shared some information about the efficiency of the consulting rooms and the redevelopment around that. That would be useful to have on the public record. Thank you.*

Mr RAINBIRD *- I will touch on the number of rooms. This is from an outpatient's perspective. Originally, I did state 25; I was incorrect. This has 19 consult rooms currently which will be included in the outpatients clinic. We originally had proposed 21, but because additional services were being brought in to support the existing onsite we reduced those numbers to account for those services. As an example, the physiotherapy department had to come down so we lost that.*

Ms BROWN *- ……At the moment the hospital has consulting clinics in various locations around the building where spare rooms have been converted to consulting rooms. This redevelopment allows us to consolidate and have all of the rooms together in one space so that we can have a pool of staff.*

It also allows for multi-disciplinary consultation such as a consultant, a registrar, a physio, a paediatrician; different teams having rooms together where the patient can come and see multiple people at the same time. At the moment, we're spread throughout the building so it's very difficult to do that sort of thing.

Ms RATTRAY *- We also heard about the efficiency that would lead to, by having them all together and being able to see more patients.*

Ms BROWN *- Absolutely. At the moment, with any system where you don't have a consolidation of resources you have inefficiencies. Where you have staff spread across the hospital, you actually need more staff to service those rooms and to support those rooms. It all makes sense that consolidation allows for better efficiencies, less bottlenecking and fewer staff to produce the same amount of consultations.*

CHAIR *- ……With respect to the Child Health and Parenting Service, one of the dot points: 'large consultation room allowing for flexible use, including visiting specialist Child Health and Parenting Service'. How are they currently accommodated? Are they working onsite at the moment?*

Mr RAINBIRD *- No, they are still offsite, from my understanding, out of Devonport.*

Ms BROWN *- There is a room at outpatients they book periodically but, as we were saying, it has limited availability.*

CHAIR *- You are wanting to give them a permanent location?*

Ms BROWN *- It will still be a room that could be used by other people and it will be set up with little baby scales and things they specifically need built into the room.*

Mr RAINBIRD *- It is important to note as part of the consultation process it was asked: how many days? They have provided input back to us saying: 'Rather than one day a week we want three days a week or two days a week', which allows us to book and program our services out of that area.*

Staff Recruitment, Retention and Training

4.11 Mr Goldman raised the issue of staffing and whether there would be funding to provide additional staff:

Mr GOLDMAN *- …..Is there enough allocation for the extra staff?*

4.12 The Committee also sought to understand the staffing requirements which would enable the expanded day surgery and outpatients clinics to operate effectively, including measures to recruit, train and retain staff:

Ms RATTRAY *- We had a conversation as we walked around the building about the number of staff you might need into the future to provide the services in an expanded space. Would you share that with the committee, thank you, Victoria?*

Ms BROWN *- Both with the operating rooms, day surgery unit and outpatients, we will not have enough staff initially to support the full bill. When we first move in, we will run to whatever maximum service delivery we can whilst we recruit. It is going to be a great recruitment tool to have a purpose-built state of the art facility. That is a great way to get staff from other areas, other states, other parts of the state to come and work here.*

There will be quite a lot of recruitment and training that will need to happen in order to maximise the service delivery into the future.

Ms RATTRAY *- Do you see an opportunity to undertake that process prior to the completion of works? Is that something that would be considered?*

Ms BROWN *- It is going to be very difficult with the staging and decanting because we are going to be working out of a very small footprint at some stages of the redevelopment. I think it is not conducive to educating and orientating new staff. What we will do, is we will have those plans in place that as soon as we take over the new building we can recruit and start employing straight away.*

It will be very difficult to have additional staff coming into an already crowded workspace and work environment. It would be better for everybody to wait until we are ready to open those facilities.

CHAIR *- Further to that, in the grander scheme of things, with the elective surgery load building is the expectation you would be recruiting staff in the immediate location, rather than other staff coming in temporarily from other locations? Is that the way it goes?*

Mr RAINBIRD *- The way we put our advertising out is certainly open to the states, but we have not an open tender ad yet. Locally first is normally what we do within the department if they have that skill and then from there it will broaden the scope and very dependent on the resources and their capability to undertake the role.*

Mr TUCKER *- ……Following on, we discussed one to two patients improving the list today. With the retention and recruitment of staff, do you believe we will be able to get those staff levels up to be able to do those extra operations?*

Ms BROWN *- Yes. When the redevelopment's finished we will have an additional procedure room/operating room. At the moment, we have two theatres and one endoscopy and we will have a total of four rooms at the end of the project. Potentially, that is a 25 per cent increase in the number of cases we do. I do not think we will have problems recruiting to fill those rooms and provide those numbers in the future.*

We certainly have capacity and educational support to run new graduate and advancing practice programs that will train up perioperative nurses to the level we require. We do not necessarily even need to recruit experienced staff as we have the facilities and we will have the space to be able to train our own, if necessary, local staff to provide that level of service in future.

Mr TUCKER *- You have the training staff here at the moment or will you have to recruit them to do that?*

Ms BROWN *- We would potentially need some additional support but we already provide a team of clinical nurse educators and facilitators within the hospital.*

Mr RAINBIRD *-……We are finding in order to attract people to our region, you need to have the appropriate services or, at least, 'look' of that service to draw them in. The Mersey is, as you saw today, a 1962 build with facilities that have not exactly been upgraded. When you are trying to attract professionals and staff to the region, not only are they looking at their location of work, they are looking at the region as a whole.*

From our point of view, to have a state-of-the-art facility is certainly going to allow us to make it easier for our recruitment and retention of those staff within the region. That is what this design is proposing, we are going for a complete state-of-the-art facility that will, hopefully, attract specialists from around Australia - nationally or locally - to want to stay, and stay long, within the North West Regional Hospital.

Central Sterile Supply Department

4.13 The Committee noted there would be significant improvements made to the central sterile supply department (CSSD). The Committee asked the Department's witnesses to outline the improvements and the benefits the expanded CSSD would provide:

Mr ELLIS *- While we were touring we saw the existing central sterile supply department facility is quite small. Could you give us a sense of what the expansion is going to be like for that facility and what that will mean in terms of the ability to operate?*

Mr RAINBIRD *- Not necessarily focusing on CSSD, but the increased capacity of floor space we are looking at is going to be a number of around 2850 square metres on top of what we have at the moment. An increase in terms of the CSSD, it is probably going to be three to four times larger than it currently is and is going to support those four suites we are including at this stage. It is significant development, from that capacity. Overall, we are looking at around 5450 metres of redevelopment being undertaken within the Mersey Community Hospital, which is a significant-sized project.*

Mr ELLIS *- Using the CSSD as an example, what do the current limitations stop you doing and what will the expanded space allow you to do that you have not been able to do in efficiencies and that sort of thing?*

Ms BROWN *- The limitations with the current design we have is, for example, our CSSD is fragmented at the moment. The decontamination zone is right down the bottom, between the two theatres and the reprocessing, sterilisation zone is the door I showed you at the beginning of D-block. It is broken apart using this central corridor. Best practice guidelines and Australian Standard 4187 prescribe a circular flow of dirty to clean to sterile equipment, which is standard for the reprocessing of RMDs, which is reusable medical devices. The new design allows us to comply with those standards, produce that circular flow, reducing any risk of incidents with RMDs and patient safety ultimately but it also allows for the staff to work within one department and have decontamination, packing, sterilising, cooling and then back into the area all in one department.*

It also allows us to put some extra equipment in so we'll be purchasing an additional washer/disinfector which will support not only the operating room but the hospital and even some services in the community that we provide with sterilising and decontamination services.

Improved Waiting Areas

4.14 During the site visit, the Committee had seen first-hand the lack of appropriate waiting areas, especially for the outpatient clinics. The Committee understood the proposed works would provide a significant enhancement to the waiting room facilities, and sought further information from the Department's witnesses on what was planned:

Ms RATTRAY *- A follow up, in one of the areas and I think it was outside the consult rooms, the waiting area was actually a chair against the wall. Will that approach change?*

Ms BROWN *- Absolutely. It wasn't in the original design of that wing to have people waiting in the corridor. There are separate waiting areas within the consult areas but we've outgrown it and because of social distancing requirements as well we've had to move chairs into the corridor just to allow people to have somewhere to sit while they are waiting, otherwise they're standing. So it's just making the best of a bad situation but we have allowed for quite generous waiting rooms both preoperatively in the perioperative area and also in the outpatients area. We've also included a separate waiting room in the paediatric wing of our outpatients department so that the children can have a closed-door environment. This is a little bit less stressful for parents trying to juggle a few children and that sort of thing and keeping the children separate from the main waiting room.*

CHAIR *- … … You have here:*

> *… central waiting area for 58 people designed to distribute visitors according to booking schedules and assist to alleviate anxieties associated with clinical environments.*

What sort of design features are we building in to enable that to happen, out of interest?

Mr McPHEE *- … … Due to the wedge shape - the triangular shape of the wedge - and the layout of the current consult rooms, we took the opportunity to utilise the length along C block which allowed patients to be allocated within closer proximity of the consult rooms that they may be going to. With social distancing, COVID-19 and other things, we are able to disperse people*

throughout the waiting area much more efficiently rather than bundling everybody all in one room, like we are here now looking face-to-face at each other.

We also provided aspects externally, so views outside, and also a little courtyard there in the centre to provide views externally and lots of use of natural colours to help alleviate some anxieties that people may have.

Improved Wayfinding

4.15 The Committee was aware that hospitals can be confusing places to navigate and was interested to understand what measures were planned to make this easier at the MCH:

***Mr ELLIS** - What is the problem we are currently trying to address with the wayfinding and the new reception?*

***Mr RAINBIRD** - I suppose at the moment, Victoria touched on the fact we have multiple services dotted around the hospital itself just for outpatients. When people present to a main reception it is giving them the direction at that time. Having these services consolidated is an easier flow for us to determine or point them in the right direction to do so. That is really what we are generally looking at - having a central hub location that once they present, they know exactly where they need to go and the direction for the consult they need.*

***Mr ELLIS** - COVID-19 has changed things over the last 18 months, but the existing building with multiple entrances can be confusing to try to navigate your way around if you are not familiar.*

***Mr RAINBIRD** - Absolutely.*

***Ms RATTRAY** - No more confusing than the Royal.*

***Mr RAINBIRD** - There are multiple options in terms of wayfinding. As you would have noted when we walked through, there are a lot of hanging signs that give those directions. We have looked at multiple kiosks that provide this service. Certainly, as part of this project scope the colour coding and the central hub should give us that ease of access and make it easier for the community to get to the point they need to.*

Managing Construction in a Working Hospital

4.16 The Committee recognised the difficulties in undertaking construction works in a working hospital. The Committee sought to understand what systems would be in place to ensure continuity of care and minimisation of disruption to patients and staff:

***Ms RATTRAY** - Can we talk about the disruption that will occur? You might walk us through what's planned. We went to the carpark this morning and had a look at where the temporary relocatable building will be. Can you walk us through that as well?*

***Mr RAINBIRD** - One of the other components that we looked at is maintaining the operations of the hospital while these works are undertaken. Victoria, Alisdair and myself, and other services, have worked on a staging and decanting plan. That plan is broken down into a number of stages that allow us to look at decanting staff from a specific area before we go in and demolish that area and redevelop that area.*

Stage one accounts for the building of the demountable, which is the temporary outpatients, which will be located in the nurses home carpark where we stood. While that is being built, we will look at the digging or demolition of that E block zone to allow for the footings to be placed in ground for the development of E Block to occur. Once we have the temporary outpatients building we will have the capacity to decant our outpatients into this temporary

facility, allowing the contractors then to go in and demolish level 1 and the ground floor simultaneously, reducing the program. Previously, we looked at specific areas but we found that disruption would be too much due to the fact that we have a number of issues of hydraulic runs and cable runs through floors in different sections.

From there, E Block and C Block, we will then move into the theatres, which is D Block. At that stage we should have commissioned C Block, allowing the operating theatre in D Block to relocate to E Block so we can continue demolition work there, while we maintain the service of providing clinical and in this case outpatients and theatre operation.

Coordination with other THS Entities

4.17 The Committee was also interested to understand how the MCH was working with other THS entities to ensure continuity of service delivery for the community when certain services may be impacted during construction:

CHAIR - *With respect to the consultation associated with this particular development, how much consultation happens between the North West Regional Hospital and the Mersey Hospital in terms of how you are going to cope with the decanting and services that might be offered elsewhere?*

Ms BROWN *- …… The way the THS north-west works - which has suited the project purposes quite nicely - is that some of the positions are regional. For example, our nursing director of perioperative services sits in a regional position and coordinates bookings for the North West Regional, the private brokerage and the Mersey. She has been part of the design team and has consulted right the way through. We also consulted with the Director of Surgery for the North West. We did allow for that consultation and bigger picture as far as bookings, staging, how we were going to manage, reduce through-put and more long-term planning into the future.*

CHAIR - *It is not a case of services being duplicated.*

Ms BROWN *- No, the North West Regional does, as you know, different surgery than the Mersey. They have an ICU for support, they provide an emergency theatre and an on-call service, which the Mersey does not. The Mersey has a niche for elective day surgery and endoscopy. The endoscopy area is growing all the time and we would like to grow it more. This facility allows us to do that. The facilities at North West Regional only allow for very limited endoscopy services. The services we provide in each place are quite different. Having said that, Burnie are able to pick up some of our day surgery while our through-put is down.*

CHAIR *- Okay. It is complementary.*

Ms BROWN *- It is complementary, yes and it works very well supporting each other.*

Ms RATTRAY *- While the development is proceeding - should it receive this committee's approval - the North West Regional and the LGH will pick up some of the procedures that would require an overnight stay, is that correct?*

Ms BROWN *- Yes, the plan will be they will pick up some, but not necessarily only overnight. It may also be day surgery they pick up. We can utilise the government policy on brokerage to the private facility that already exists more.*

Building and Construction Materials

4.18 The Committee was aware that sourcing building and construction materials was currently a difficult task, due to a range of supply issues. The Committee questioned the witnesses on how this issue was being managed:

> ***Ms RATTRAY*** *- I am interested in the availability of products. ... ... We know with the building industry, the way it is at the present, that sometimes sourcing products has become very difficult. Do you see a flexibility around what's being presented to us?*
>
> ***Mr McPHEE*** *- With materials such as the vinyl, they would say there's not a whole lot of flexibility in swapping that out with something else, purely for the infection control needs of the hospital. With the other materials, we have compact laminate as discussed earlier. That's a reasonably available material.*
>
> *We're using other materials such as compressed fibre cement, which is readily available also. During the tender submission period, contractors normally address and identify as part of our pre-tender, or QS* [quantity surveyor] *has identified potential shortages of resources or risk for the type of build that we are proposing.*
>
> *From there we would look at what our alternatives would be, factoring cost and timeframe associated with that. Once we receive our submissions on the design that we've proposed, if any contractors or head contractor is not providing us enough detail, we will certainly ask the question around that. If they think that they cannot meet a certain product then they are to inform us of an alternative, or simply provide an alternative, and we will assess it at that stage.*

4.19 The Committee also noted that steel framing was one material that would be used instead of traditional timber due to current supply shortages. The Committee sought to explore the practicalities of this product being used in the build:

> ***Mr ELLIS*** *- On supply issues it was noted that we're looking at lightweight steel framing rather than traditional timber framing, anticipating a continued shortage when this project gets underway. Is that right?*
>
> ***Mr McPHEE*** *- We're seeing at the moment there's a global shortage with timber across all projects, not just due to shipping and the pandemic but also to climate change and the bushfires that we've seen all up the eastern seaboard. It was really a strategic decision that we made early on to design with steel. Also, from a fire-proofing, fire-rating perspective we had to limit the use of timber and those class of materials within the building. The lightweight steel framing is readily available. We haven't seen any shortages, so that for us was the best decision moving forward.*
>
> ***CHAIR*** *- Clearly, steel framing expands and contracts more than wood. Correct me if I'm wrong. When you have that happening there is a fair bit of noise - creaking and all the rest. How do you overcome that? Do you put in interfaces of some kind?*
>
> ***Mr McPHEE*** *- More so when there is direct sun and heat. When it's directly exposed to that, you'll see expansion or contraction. Within the systems that we use, or the steel framing, there is allowance for the expansion and contraction. It really avoids the pressing up against each other, if you like, which is where the noise and the creaking comes from.*
>
> *We also had an acoustic engineer engaged throughout the process, which has assisted us with the detailing of that, and from an acoustics rating perspective between consult rooms and to the exterior of the building as well. Every building, whether it be timber or steel, expands and contracts and it's a matter of the detailing as to how you minimise these things.*

4.20 The Committee also questioned the Department's witnesses on the design and type of glazing in the build:

Ms RATTRAY *- In regard to the environmentally sustainable design, the second point says that all unglazed walls, ceiling and roof cavity spaces are insulated and sealed. Unglazed is obviously without windows. Can you talk to me about how that might work? I have heard you talk about the glazing of the windows and the space between them, and that was quite useful as well.*

Mr McPHEE *- The glazing we specified for this project is a double-glazing with a thicker cavity between the glass. That gives a bit more air space and allows vibrations, if you like, to be tempered somewhat.*

Ms RATTRAY *- It's a busy highway.*

Mr McPHEE *- The base of those frames has a silicone bead, and that helps to deaden the noise as well. The acoustic engineer we worked with provided us with decibel ratings and CTR. Off the top of my head, I can't remember what CTR means; but he provided us with those ratings. The products we were choosing and the construction systems we were choosing or designing with are rated to those systems as well. We always had a constant reference point or baseline to work to, and we've met those baselines across the whole facility.*

Ms RATTRAY *- Do you see any impediment in accessing the appropriate glazing?*

Mr McPHEE *- From an availability perspective?*

Ms RATTRAY *- Yes. I am hearing it's a 12-month wait for windows at the moment.*

Mr McPHEE *- Yes, that's constantly evolving. It is getting better now. I can't comment too much on that. Supply chains pick up and slow down, unfortunately; it's the time that we live in. We have to deal with that as best we possibly can. The frames are all standard profiles. There's nothing custom about them as such, so they're readily available and easily manufactured.*

Ms RATTRAY *- Even though the design of them sort of has a lip, a deeper lip across the top than down the sides and along the bottom. I noticed that on the plan, on the façade. That's not standard.*

Mr McPHEE *- On the windowsill. That's still, essentially, a standard construction. The strategy behind that, is that we have a fire-rated and acoustically-rated wall that sits internally. What we've done, due to the lack of space that we have to get all of our services running down all of our service rises, we've moved to the external, which is where we get the depth in the façade. That has a double effect, where we've created a deeper reveal and the façade becomes self-shading, in effect, for that westerly sun, particularly. The deep angle on those ledges is also a bird control measure.*

4.21 The Committee noted that faux timber products were proposed instead of timber. The Committee sought to understand why these products were chosen:

Mr ELLIS *- … … I know there are some timber-look products proposed in the build.*

Can you give us a sense of why those were substituted for real timber and what some of the limitations may be?

Ms BROWN *- Timber, as you know, is a porous surface. It's easily scratched as well. When it is sealed with a varnish it is wipeable, but quite often that varnish deteriorates over time or is damaged through nicks or dents from furniture - particularly in a hospital environment with beds and trolleys. Once you get that damage to the varnish, it's no longer an easily cleaned surface. Our infection control department prefers to have non-porous, solid surfaces that are*

robust and can take those knocks and dents without damage to the integrity of the surface - purely from a cleaning perspective.

Additionally, some of the products that we need to use at times are quite similar to bleach and a lot of surfaces won't withstand repeated cleaning with such a harsh substance. We looked at the best fit that would meet our infection control requirements and durability requirements as well as the cosmetic feel to the room.

Emergency Department Capacity

4.22 Mr Martin recognised that this project did not involve works on the Emergency Department. However, Mr Martin did highlight the potential impact that an increase in elective surgeries may have on the Emergency Department. Mr Martin was keen to understand if there would be additional emergency beds provided and whether the operating theatre upgrades were only for elective surgery, or for emergency surgery also:

> ***Mr MARTIN*** *- ……Touching on the emergency department and I realise that it's not part of this project but it is connected. ……Even though the elective surgery is supposed to be low-risk, potentially, there is also that risk that something may go wrong and we will need additional beds, probably in the emergency department or close observation unit, et cetera.*
>
> *Throw in the population growth there as well and the predicted rises in presentations, it also highlights the need for increased acute services at the Mersey, such as HTU, maternity, et cetera. As we're developing, even with this project, it does link with other services provided at the Mersey and the need for increases in those departments, especially the emergency department.*
>
> [e.g.]
>
> ***……****Are the theatre upgrades only for elective surgery or for acute emergency surgery as well? ……Will additional beds be opened or will they still be reliant on the current bed allocation?*

4.23 The Committee sought a response from the Department's witnesses to the questions raised by Mr Martin:

> ***CHAIR*** *- ….So are the upgrades only for elective surgery or are they for acute emergency upgrades as well?*
>
> ***Ms BROWN*** *- Elective surgery.*
>
> ***CHAIR*** *- Elective surgery only. Will the additional beds be opened ……?*
>
> ***Ms BROWN*** *- So there are no additional overnight beds. But there are additional day spaces. It is a term I guess……it allows for more patients at the end of the day which I guess is what you are asking. So, no additional overnights but definitely we can see more day surgery patients.*

Does the Project Meet Identified Needs and Provide Value for Money?

4.24 In assessing any proposed public work, the Committee seeks assurance that each project is a good use of public funds and meets identified needs. The Committee questioned the Department's witnesses who confirmed that the project was a good use of public funds, as it definitely fulfilled an established need, with a fit-for-purpose facility that would be constructed to a high standard, in a way that delivered value for money:

CHAIR *- ……We always have four questions or five questions actually at the end of each of our hearings and we need to have an understanding as to whether this is or is not the case. So, does the proposed works meet an identified need or needs or solve a recognised problem?*

WITNESSES *- Yes.*

CHAIR *- ……Are the proposed works the best solution to meet identified needs or solve a recognised problem within the allocated budget?*

WITNESSES *- Yes.*

CHAIR *- Are the proposed works fit for purpose?*

WITNESSES *- Yes.*

CHAIR *- Do the proposed works provide value for money?*

Ms RATTRAY *- In other words, are they gold plated?*

CHAIR *- …… The Honourable Member is referring to the standard of the works and you might care to answer that. Are they gold plated or are they -*

Mr RAINBIRD *- Not physically gold plated but they are at a high standard.*

CHAIR *- Thank you. Are the proposed works a good use of public funds?*

Mr RAINBIRD *- Yes.*

5 DOCUMENTS TAKEN INTO EVIDENCE

5.1 The following documents were taken into evidence and considered by the Committee:

- *Mersey Community Hospital Outpatient Clinics And Operating Theatres Redevelopment*, Submission To The Parliamentary Standing Committee On Public Works, Department of Health, August 2021.

6 CONCLUSION AND RECOMMENDATION

6.1 Given the current state of repair of this facility and the function the Government has determined it is to provide, the Committee is satisfied the need for the proposed works has been established. Once completed, the proposed works will result in the capacity to provide an increased volume and range of health services to the local community.

6.2 The proposed works will offer a contemporary environment from which to deliver day surgery and outpatient services and with increased capacity. The proposed works will also alleviate a number of identified operational inefficiencies within the MCH.

6.3 Accordingly, the Committee recommends Mersey Community Hospital – Theatres and Outpatient Clinics Redevelopment Project, at an estimated cost of $36.472 million, in accordance with the documentation submitted.

Parliament House
Hobart
9 November 2021

Hon Rob Valentine MLC
Chair