

THE PARLIAMENTARY STANDING COMMITTEE ON THE ROYAL HOBART HOSPITAL DEPARTMENT OF EMERGENCY MEDICINE MET IN ROOM 2, PARLIAMENT HOUSE ON WEDNESDAY 6 APRIL 2005.

ROYAL HOBART HOSPITAL DEPARTMENT OF EMERGENCY MEDICINE

TED RAYMENT, CHIEF EXECUTIVE OFFICER, ROYAL HOBART HOSPITAL, **DR ALASTAIR MEYER**, DIRECTOR, DEPARTMENT OF EMERGENCY MEDICINE, RHH, **ANNE BARWICK**, CLINICAL NURSE MANAGER, DEPARTMENT OF EMERGENCY MEDICINE, RHH, **PETER ALEXANDER**, MANAGER, FACILITIES MANAGEMENT BRANCH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, **WILLIAM COCHRANE**, SENIOR PROJECT MANAGER, FACILITIES MANAGEMENT BRANCH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, **TIM PENNY**, PHILP LIGHTON ARCHITECTS, **ANDREW SHURMAN**, CRAWFORD SHURMAN ARCHITECTS, AND **IAN BENNETT**, HEALTH SCIENCE PLANNERS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome to this more formal side of the inquiry into the project today. Can we at the outset, as we always do, thank you all for the tour which we had this morning. It was both informative and, I have to say, very much an eye-opener for the committee members. Quite frankly, I do not know how people work under the conditions that prevail at the moment. It was one of those experiences by which I think every committee member has come to an appreciation of the commitment of the staff in the Emergency Services to see that you still deliver a quality of service with those constraints upon you. So thanks very much for the tour this morning and the information which was shared at that time.

Just by way of information at the start and it is important to mention this right at the outset - the message which we have, of course, is for this committee to consider funding of \$11.1 million in round figures. The submission indicates that, with cost escalations in the building industry and demand versus supply at the moment, the expected project cost will be \$15.4 million in round figures. Clearly the jurisdiction of this committee is to consider the approval of a project to the tune of \$11.1 million. Clearly again the documentation which we have in front of us is for a project which will cost \$4.3 million more than that. Our suggestion would be this, I think, that we will continue on with the inquiry. It is appropriate that we do that. We have had the site tour, we have a message under which to operate from the Governor but we would need you to come back to us with a new message which reflects the total expected cost because if as a committee we were to approve this project under that message you would be authorised to spend \$11.1 million. That needs to be facilitated fairly quickly depending the outcome of the committee's deliberations today, so we would expect you to move that along fairly expeditiously.

We had a similar situation recently with a road project in the Huon. We simply went through the first stage of the inquiry, took the evidence and the department clearly said it wished to produce a better project. We said, 'We will suspend our deliberation until such time as you come back with an updated submission', so that is for a little further down the track.

Mr ALEXANDER - Mr Chairman, can I respond briefly to that?

CHAIR - Sure.

Mr ALEXANDER - We deliberated long and hard whether we should put up a project at this stage as in the recent experience in Queenstown where we didn't have enough money to put together a sensible project with the initial funding we waited until we had the additional funding approved. In this case we felt we did have enough money to put up under the terms of the act, and I am afraid I haven't got the section, but we had a funding-approved project for the committee to consider. Regarding the additional funding, there has been a process going on at Treasury and you maybe aware that as of last night that additional funding has been confirmed so we were pretty sure we weren't wasting the committee's time. We will take on board what you say and we will bring that to you as soon as we can.

CHAIR - We will write to you to confirm that direction. Thanks, Peter.

Mr COCHRANE - Would you like me to table that confirmation?

Mr ALEXANDER - We have confirmation of the funding from the Premier that we can table.

CHAIR - For our records, yes thanks, Bill.

Mr RAYMENT - I would like, Mr Chairman, to put the executive summary on record and to read the executive summary and then move on to introducing the presentation and then pass over to the architects.

The Hospital and Ambulance Service Division of the Department of Health and Human Services - DHHS - presents this submission to the Parliamentary Standing Committee on Public Works on behalf of the Royal Hobart Hospital - RHH. It seeks approval for the relocation and redevelopment of the Department of Emergency Medicine - DEM - in order to meet the growing emergency medical care needs of the Tasmanian community.

The new facility will be developed under the Liverpool Street forecourt of the RHH and this facility will incorporate increased ambulance access, 18 patient cubicles and an additional discrete clinical area for the specific care of paediatric patients. There will be four resuscitation bays, two seclusion rooms for the assessment and management of mental health presentations, dedicated isolation rooms and procedure rooms. An area for the management of patients not requiring admission to the DEM is also included and waiting areas have been designed to allow for the separation of adult and paediatric patients. Short-stay accommodation will be established as part of the redevelopment and this area will cater for the needs of those patients requiring extended periods of observation but who do not require admission to the hospital. This unit will provide

services to patients in an environment conducive to an overnight stay thus reducing hospital bed block. Overall, the new facility will provide for a capacity of greater than 45 000 presentations per annum compared to the 37 000 presentations currently seen each year in the department. The current physical capacity is only suitable for 30 000 presentations. The new development will meet the growing need for the emergency medical care within the community and will better enable the RHH to fulfil its role as the major Tasmanian tertiary referral acute care centre. The project will be put to tender with a view to completion and occupation by November 2006. Your consideration and approval of this redeveloped facility is sought in the accompanying submission.

CHAIR - Thanks, Ted.

Mr RAYMENT - What I would like to do is just give a bit of background of the recent history of the DEM. In December 1999, the submission that was put forward was for the period 2002-03 to 2005-06, and that submission was \$8.77 million at that time. That was the capital infrastructure program. Now the project included an expansion of the existing DEM - that you have seen - into the patient information management system or medical records area, and reconfiguration of the Department of Medical Imaging and the prerequisite works that went with that. The project issues of the DEM and the Department of Medical Imaging at the time were obviously the constraints of the available space, the cost in time for the prerequisite works, and the problem with the double relocation, logistics, disruption and the risk that would be caused to bear in terms of that earlier plan. Argyle Street public access issues would be a problem, and the ambulance bays were separated from the temporary DEM by the construction site, so the fixed components in the Department of Medical Imaging - for example, the MRI machine that some of you may have seen - limited the scope for improvement in the initial plan.

So that proposal added little extra space to the campus. In fact, had it been built, by now I think I would be sitting before you requesting more space at this point in time, for the scope was limited to the internal problems that were being encountered at the time. The RHH capital works projects were awaiting approval, and there was a need to develop an overall strategic context in which the Department of Emergency Medicine fitted in with the rest of the hospital and the services. There were Treasury and Cabinet requests at the time for the strategic asset management plan of the whole hospital in terms of projects and space, problems that we are currently addressing now.

The strategic asset management plan was endorsed by Treasury and Cabinet in January 2003, and the alternative DEM proposals were considered at that time. We had the funding approved in 2003 to 2005-06, and the information-gathering commenced in 2003. The detailed functional brief approved by the project control group was in mid-2004. The consultant team was appointed in September 2004 and the design approved in December 2004. And I started on 31 March 2003.

The issues, delay and capacity were that the original proposal had 24 treatment cubicles to be completed by the end of 2005. It is interesting because, as you will see, a couple of dot points down the existing DEM has 27 cubicles, but that is because five of those are actually in the corridor. So the estimated capacity of 26 400 patients per annum, as based on the Australian College of Emergency Medicine and the Department of Human Services Victoria guidelines, would be the number of patients that we should be seeing in

the existing facility without using the corridor. The existing cubicles have an ideal capacity of fewer than 30 000. Our current demand over this year has just gone over 37 000 patients per annum, so we have well and truly outgrown the facility. The design capacity of the new proposal is 45 000 plus, and further growth into the medical records area is one of the contingency plans we can consider.

The completion is in the second half of 2006, and the appointment of the architectural consultants was confirmed in September 2004. They have been introduced to you: Philp Lighton, Crawford Shurman and Health Science Planning architects in association. As I said before, the design was completed in December 2004 and the project is on schedule for a mid-year construction start. The proposal was submitted in February 2005 to the Hobart City Council and to the Heritage Council for planning approval. I must say that I am relieved that I am not sitting here talking about the original proposal that was put forward just prior to my arrival.

The design process: the schematic design is based on a schedule of accommodation in the functional brief. It is being developed, as we said this morning, in consultation with the executive user group which meets weekly, and there are fortnightly formal meetings with the consultants. So the process is the consultation, analysis, development, presentation, review, revision and acceptance.

The site options and proposal is that, of the range of options considered by the Royal Hobart Hospital strategic asset management plan, because of the challenge in terms of the constraints within the site that we are now on, there was potential for space below the forecourt, and the advantages are that, in terms of accessibility, it does not disrupt the existing DEM. That can continue while the new DEM is being built. It allows large open floor space, and that space is approximately twice that of the current DEM in the new building. It provides a non-public link between the A and H blocks at lower ground floor level, and it allows for retention of the forecourt as a public space. As you can see from the diagram, the ambulance comes in at one side and then leaves the other side after having deposited the patient.

With that, I would like to pass over to the architects to move to the next part of the presentation.

Mr PENNY - Mr Chairman, what we would like now is the opportunity to talk about the health planning, and so Ian Bennett might steer us through that with Alastair, and then both myself and Andrew might then come back to that and just talk about the architectural issues associated with the project.

Mr BENNETT - We will start with the upper level obviously to put it into context. As we talked about previously and as you have seen on the site today, this will give you the full picture. We have the existing hospital here, Argyle Street and Liverpool Street. The ramp going down comes from this area close to Campbell Street, down through underneath and back again up close to the exit to Argyle Street. Ambulances come from Campbell Street or from Liverpool Street from the roundabout, through down and then exit north of Argyle Street or through the city further along Liverpool Street.

The site constraint we had was that we were limited in our planning. Even though the original program suggested that we need more space than we have actually used, it is limited by the outline of the existing buildings and an area of undercroft in this area here.

Mr HALL - Excuse me, could you speak up a bit, please.

Mr BENNETT - Okay, sorry. This plan in outline indicates the area of new building, which is within the excavated area. We have colour-coded the various functional areas: the yellow clinical areas, brown staff areas, the observation ward and medical imaging.

Mrs NAPIER - Could you give that again, please.

Mr BENNETT - The yellow areas are the clinical areas, including the public waiting area and entrances. The brown is the staff facilities. The area there in the slightly darker brown is the observation ward - the short stay ward - and at this end here we have some meeting rooms which are staff areas and above that we have medical imaging.

The floor level of this building relates exactly to the floor level of the building we were in this morning. There is a facility for connection to that building through this corridor here and a connection through here into the medical records section, so there is a direct connection through to Medical Records from Emergency, which is a very important relationship.

You can see from the key plan the area where this larger scale section is. This is the area we call one of the 'hot areas' of the clinical areas. It is actually the resuscitation and trauma area. We have four trauma bays with direct access off the ambulance parking and the ambulance discharge area, through an airlock and through into a holding area and then through into each of those three areas.

This particular bay here, or this room here, also has the added facility to be used as an isolation bay. There is a direct access from the ambulance entry, through into an airlock and through into the separated area, and that can be sealed off. As Alistair mentioned this morning, if we get an incident with SARS or some similar nasty problem we can bring people in and isolate them in there without contaminating the rest of the Emergency department.

Each of these bays will have X-ray facilities, with a gantry over the top of each of the areas. Once the patient is in there they don't have to be moved. They can be stabilised within that area before they transfer them to other parts of the hospital.

You have the reception and triage area between this trauma resuscitation area and the general ambulant entry, which we will come to later, and that supervises the ambulance bays, the airlock as you come in and back onto the other side. This room is the security area, and you saw this morning how important that was, and that security bay has access directly out into the general clinical area, back into the ambulance bays, back into the resuscitation area or out into the waiting room, so it is very centrally located. The brown area is the offices and they are slightly more generous than Alastair's office and other offices you saw this morning, and it is noted what the individual offices are. The director's office has an overview of the ambulance bay. It also has ease of access through into the trauma area, as well as being relatively isolated from the hurly-burly of

the public space here, but he is readily accessible. We have other offices and a meeting room and combined library adjacent.

In relation to the staff specialists' office you were in this morning in the existing facility, for those staff specialists we have four rooms instead of the one large area, and we have four rooms that are shared by two people in each room, so we have made spaces for the staff specialists. We have a room for nurses for their write-up. We have a specialist equipment nurse and an educational nurse sharing an office, secretarial space and the office for the clinical nurse manager. This connects to the main circulation system and we have staff facilities - change rooms, toilets and showers, male and female, and we have the staff lunch room. The tea room is quite large. The circulation continues through to the observation ward, and we will see that on another slide.

This is the main acute area, and the entrance for ambulant patients. The ambulant drop-off is through this area here, and they come through an airlock into reception and general triage and the waiting area to the right. The airlock serves two functions, one as an air lock obviously, but it is also a security screen at particular times of the day. That door can be controlled from the reception area so people come into this area and they are vetted and screened before they can come through into the general waiting room.

Mr BEST - Wouldn't your ambulance be on the left there?

Mr BENNETT - This is ambulant.

Mr BEST - Oh, I am sorry, I didn't hear what you said.

Mr BENNETT - These are the walking patients. That is the ambulance area there, and the triage and reception area is between the two.

Mr BEST - Sure, thank you.

Mr BENNETT - The waiting area has been broken down into three separate functions. One is the general waiting area, which is this larger area, and then we have a separate area for paediatric patients, so parents with children can be isolated away from other people within the waiting area and feel safe and secure and keep their children away from other people. We also have a special facility for patients with potential respiratory problems, so they can be isolated again away from the waiting area so that we do not get cross-infection. They are put into this area and we have separate exhaust ventilation allowed for that area.

The normal procedure will be that the patient will come in, be triaged and their condition will be determined, and they will either be told to wait or they will be taken directly through into the general acute treatment area. In this general acute treatment area we have individual bays all the way round surrounding a central staff station and that central staff station is raised above the general floor area so that the staff within that area have a good overview of all of those spaces. We have two isolation rooms for disturbed patients and they are able to be overviewed from the staff station directly. They are able to be accessed from the ambulance bay discretely or from this area without interfering with the rest of the function of the department.

Associated with this we have a dedicated area, a gynaecological area, for gynae patients with its own ensuite and a large sliding door to the general acute area. When it is not needed as a gynae room it can be used as a general treatment bay and that is overviewed by the staff station there. On the opposite side to that we have a dedicated eye room and that is either accessible from this side or directly from the waiting room. If somebody has a problem they are directed into there, again without having to go through the general acute treatment area.

Extended from that we have what we call 'a quiet area' where there are four bays where patients who need to be in a quiet area can be put, away from the general hurly burly of this space and also included in that area we have another isolation room. This isolation room is for immune compromise patients and it is positively pressured rather than negatively pressured and that has its own associated locker and toilet. There might be somebody who is undergoing chemo for cancer treatment or is in a similar situation.

Below that we have a dedicated paediatric area with four paediatric bays - they are quite large bays - and a dedicated paediatric treatment room with its own staff station which supervises that area. That area for paediatrics is accessible close to the paediatric waiting area directly through to there without having to go through the adult treatment area, or a patient can be brought directly through from the resuscitation room into that area.

Below that we have a fast-track area for patients who come in and might need Panadol or a bandaid or something - slightly more serious than that - but the idea is that, rather than clog up the working of the acute area where the high-powered work is done, these patients are brought directly into the fast-track area, they are seated on a chair, they are talked to, they are stitched up or given a Panadol and then they are sent home immediately. That area has a small subwait area associated with it and that subwait is available for use for relatives or friends of paediatric patients.

The location of this related to medical imaging is important because a lot of medical imaging patients, particularly general x-ray, come from this area where they are fast-tracked through rather than come through this area, so if they come in with a broken arm or collarbone they are fast tracked through here into x-ray and then back out quickly.

At the rear along this main circulation spine we have a number of important rooms. You saw the minor procedure room this morning. At DEM we have two minor procedure rooms - one here and one here - and we have a clean store located between the two accessible from each of those two areas so that we don't get a problem with the storage of consumables that we have within the existing system of the DEM.

This access through here leads to this new corridor here which goes through to a lift which will access the theatres and the ICU immediately above, so it is a fast-track area to theatres without having to go through any other department.

I am just repeating what I have said essentially, the subwait area for patients gives access to fast-track with eyes and gynae. There are six fast-track treatment areas; there are four small bays and there are two what we term 'lay-down fast-track' which are really minor doctors' consulting rooms essentially.

In the medical imaging area we have a general x-ray room, we have an ultrasound room and a CT scanner room. There is some office accommodation for allied health staff who work in that area as well - the paediatric, eye and gynae emergency.

That is the Medical Imaging Department which is the general x-ray and within the general x-ray we have an OPG machine which is for x-raying the mouth and teeth and a CT scan room with a common control room and reporting room immediately shared between the two. Ultrasound is located here and that is accessible from here or from the back corridor or directly from the acute treatment area.

We have made provision for the general x-ray access doors to be immediately opposite the doors from the acute treatment area so patients can be taken straight in without too much of a long trip. Immediately below that we have the connections through to Medical Records and we have two meeting rooms, one as a seminar/staff education room and the other as a telemedicine room. They can be opened up so that we have one large meeting area for large seminars or large education programs. There is room for 25 people in each of those so we can usually fit 50 people in those two areas when they are opened up into one space.

The next area we haven't touched is this area to the right here. Perhaps if we just dwell on this for a moment. One of the advantages of the Emergency department within this area, apart from the logical consideration of it being the only real area available, was that we have access without difficulty to the three areas of the hospital. We can go through to the lifts where the existing DEM is from this area to the building above; we can go back through this way to the lifts in the building off Campbell Street; and we can connect through to the new lift in this area here, which is behind the existing building and goes directly up into theatre.

Mrs NAPIER - What particularly is that new lift providing which you don't currently have?

Mr BENNETT - It means we can get direct access from the Emergency department through to theatre without having to go through other areas. That lift will be a dedicated lift with a swipe card for emergencies so it will have priority from Emergency. The lift shaft is already there and we will be reconfiguring that and installing a new lift within that existing lift shaft.

Mr BEST - So you are not using the same lift then?

Mr BENNETT - No, it is a food services lift but the lift shaft is large enough for a proper bed lift.

Mr BEST - Right.

Mr BENNETT - This is the observation ward or a short stay ward, which will be controlled by DEM. It goes within an area of undercroft that exists. It is already excavated down to most of the level currently. We have 10 beds within that area: there are eight in an open plan configuration and we have two single beds with their own ensuite for maybe patients who require isolation. The central staff station has an overview of these patients and also of the entrance. We have located the entrance in this particular area because it is accessible from the Campbell Street building through a new set of doors here without

having to go through DEM or you can access from DEM. The other added advantage is we are able to bring an ambulance through to this back door so that if we have a patient who requires isolation we can bring them through into here again without compromising the integrity of DEM. The huge advantage of this is that we were able to isolate this off from the rest of the hospital by closing these doors here, having access through here for ambulance and access through here for staff and visitors. We have an airlock at the entrance and this will be set up as an isolation ward so that it will have the proper HEPA filtering and exhaust from that area, so if we do get a SARS outbreak we are able to bring the patients through into this area without compromising the rest of the department.

One important issue: perhaps there is a perception that, because we are going below ground, it will be dark and dull and dim. There are a lot of advantages in being below ground in terms of environmental sustainability. You get good insulation. You do not have the problem of heat build-up which you have on exteriors of buildings. But we are also able to bring in areas of natural daylight in key spaces such as over the central staff station in the middle of the acute treatment area. We have areas through the corridor at the rear, and we have a large skylight proposed over the waiting area and the reception area at the front.

Mrs NAPIER - Is that fresh air?

Mr PENNY - One hundred per cent fresh air.

Mrs NAPIER - Mr Bennett, you indicated that the additional 2 400 square metres that you have built into this was otherwise restricted by space. If you were building it and you had a greenfields site, would you be trying to make it a bigger area?

Mr BENNETT - The original briefing document called up a slightly larger area than we have and because of constraints, there were some minor compromises that had to be made. We worked through those with the executive user group of Alastair and Anne and we are comfortable with what we have. Alastair might like to comment.

Dr MEYER - I think, Sue, there is always going to be compromise. If we had a brand new flat bit of grass, then I think we would do a few things differently and maybe a few things bigger. So the answer to your question is that, yes, we have compromised on things.

Mrs NAPIER - What are the main compromises?

Dr MEYER - I guess the office space and accommodation is smaller and fewer than we thought.

Ms BARWICK - We have dropped a gynae, which was a private, single cubicle with ensuite.

Dr MEYER - We have dropped an X-ray room; it was on our wish list to have two X-ray rooms. And there are other constraints around that. To have two X-ray rooms we would need two radiographers, and we do not have that. So there are issues that add to the compromise. As I mentioned to you this morning, Royal North Shore went from 30 000 to 45 000 very quickly. It would be nice to have capacity for major disasters, things like

that, but how long is a piece of string, I suppose. We could keep building it forever if we had a greenfields site, and I probably would, but we have not compromised on patient treatment areas except for a few sub-specialty rooms.

Ms BARWICK - One of the other compromises was the relationship of X-ray with resuscitation rooms because of the shape, so we have rearranged to make it logical but still functional.

Mrs NAPIER - As we were going on the tour, we were talking about the potential for redevelopment back into records, I think it was. How difficult is that from this plan, if we end up needing more space?

Mr BENNETT - It is immediately adjacent.

Dr MEYER - Medical Records is here and Argyle Street is here, and so we could push through there.

Mrs NAPIER - So it is not logistically impossible to do that?

Mr BENNETT - No, it is quite feasible actually, and it was deliberately planned the way it is to facilitate that potential expansion once that space is available.

Mrs NAPIER - Which could include an additional X-ray room too.

Dr MEYER - Exactly, yes. In our meetings we have talked about continuing this corridor through the teaching area into more cubicle space or something, and the X-ray room would go -

Mrs NAPIER - So it is being built with expansion in mind potentially?

Dr MEYER - Yes. The reason some people have asked us why the tutorial/teaching area is separate from our office area, the room we were in today, that blue room out the back, is used by other people in the hospital but they have to come through our department to get to it, whereas in this model they can come via the back way in and still use it. So we are sharing our office. There is a lift just on the corner, so that other people in the hospital can book and use the tutorial rooms and they do not have to come through the patient area.

Mr STURGES - Just while we are on that area - and I acknowledge that there is a lot of work being done back here - I am just curious, and in fact I made a note this morning that there is a lot of area taken up with records. Ted, you might be best placed to answer this. What sort of time frame do you envisage going from the paper record to the digital?

Mr RAYMENT - First of all it would need to be approved and funded to move to a digital record. Assuming that did happen, it would take some time, because we would be putting new patients as they come in, or existing patients, onto the system and gradually reducing the amount of records that we have. The older, historical ones would fade out, so the free space would gradually increase. The task of trying to put on record all of the records that are there would be huge. I was in the ACT when I was head of the Canberra hospital and we went through that process, and we had a scanning of records put on the

computer system. It takes a while, but when it happens you do not want to look back to where you were.

Mr STURGES - The message that I am getting from you now is that, having read the report - and I heard what you said about the minor compromises that were made too - you are going to have capacity with the proposed works for now and into the foreseeable future, and during that time this other work should be happening into the future.

Mr BEST - Project space I think we saw is 2 400 cubic metres, is that right?

Mr BENNETT - Square metres.

Mr BEST - What is the current space that you have?

Mr BENNETT - It is about half of that.

Mr BEST - Okay, so that is quite a difference, isn't it, really. Obviously there were some issues there with training space today, and space in general all around. One of the things, though, is that there was sharing of computers which, whilst it may not necessarily be a bad thing in certain cases, may not be the ideal scenario. What will happen there, then, with the layout of this plan in relation to staff? I assume that not all of those staff would need to use computers.

Dr MEYER - No. Essentially down this wall there is the director's office - hopefully it will still be mine next year - and the secretary; the clerical manager, Quentin, whom we saw in that crowded eight-person office. Two staff specialists will share each office after that, so there are 10 work stations in offices that they share. The senior nurses: Anne's office is there with her secretary - and the nurse educator's office I have lost.

Mr BEST - So most of these we saw, if I could just interrupt there, were those ones we saw with computers and so forth cramped up in little corridors maybe the width of this table.

Dr MEYER - Yes, and the allied health people have their own office down in the fast-track area, so they were in that office with Quentin, the IT chap. They will be able to stop hot-desking their computer. The next level of doctors, the registrars, will have an office that will have smaller work stations but able to seat three - I think four will fit into that registrars office - and there will be communal, if you like, computers available in the meeting room/library and also in the tutorial room. Where you saw that one computer in the clinical room where we had the nursing handover, that was a communal computer and they will be able to -

Mr BEST - That doubled as potentially a patient area too.

Mr MEYER - Yes, we put patients in there from time to time.

Mr BEST - If you are hard up for space?

Dr MEYER - Yes. As I mentioned to you today, we lost some research work because the computer was hot disk but hopefully we will be able to secure them all and people will be able to have their own work station with computer. The pharmacist has their own office

as well which is an important feature for security and drug dispensing. Just to backtrack a little, one area that we haven't mentioned, we saw that blue room off the waiting room where we speak to grieving relatives - a tiny little room -

Mr BEST - Yes.

Mr MEYER - there are two of those directly behind resuscitation.

Mr BEST - I see, you have the soft site.

Mr MEYER - Yes, it is relative to the soft site, which is our colloquial term for people who are a little bit sad and emotionally upset but don't need to be locked away. You can talk to them in a quieter room akin to a general practice office and we can park dead bodies in there for the relatives to spend time with them rather than, as you saw today, in the corridor. They can make a cup of tea and the like.

Another compromise that comes to mind is that we were trying to put another one at the other end of the department because, I suppose, of the urban myth that when you have two car crashes the families all come in and fight with each other. We were going to put one set of the grieving relatives in the rooms up one end and the other down this end. The compromise is that we have had to put them in the same area. We have never actually seen two parties fight so we are quite happy to put them together. It is a minor point, I think. There is a toilet as well.

Mr BEST - Just on that, how many people in your meeting library would that cater for, say, 12, I suppose.

Dr MEYER - That would be about the size of the blue room we were in this morning - about the same size as that teaching room we were in this morning. We would envisage an eight-seater table plus -

Mr BEST - Where you have your journals and things as well?

Dr MEYER - Yes. Our journals are stored in my office in those wooden cabinets we saw today and in various boxes around the place.

Mr BEST - Right, but some people use the computer.

Dr MEYER - Yes. As I said, nowadays most of the next generation of doctors are used to their journals being on line and some of us like sitting down and reading them on hard copy.

CHAIR - Is that all the questions on this particular area before we go to the architectural side?

Mrs NAPIER - I was going to ask relative to the drop-off space for ambulant patients, we have spots for three cars coming in there. Is it likely that by angle parking or whatever you could actually increase that number?

Mr BENNETT - You could probably fit more than the three we have shown there as a notional indication. You could probably fit another car in there reasonably comfortably. The idea would be to drop off and then the car be taken away to park it somewhere else obviously and at times that would need to be controlled. I don't think that by angle parking we could really get more in there because there is a pedestrian access parallel with Liverpool Street which you come down a ramp directly to the entrance as well as the entrance from the top.

Dr MEYER - We imagine also people will be dropping their people off at the top here -

Mrs NAPIER - You can still use that.

Dr MEYER - That is what we hope. The reality of what people practise we are yet to see. Places like the Royal Melbourne and the Alfred - and the Melbourne sees many more patients than we do - hasn't got anywhere to drop people off out the front, so it happens. That is not to say we shouldn't do it, but the aim would be to drop them off and move your car. Whilst people get used to that practice we will probably need a security or parking officer out there but it would be clearly drop-off only and move their car on to one of the car parks.

Mrs NAPIER - But it is envisaged that that grey area would be a walk-in ramp, not just for cars.

Mr BENNETT - No, the grey area is the pedestrian area.

Mr COCHRANE - And there is also direct access to the DEM from the forecourt through the lift and stairwell. There is also an alternative access point.

Mr BEST - It is a single-lane ramp, isn't it -

Mr BENNETT - Yes.

Mr BEST - in and out?

Mr BENNETT - It is two lanes, single direction but two lanes through.

Ms BARWICK - With an ambulance able to pull in there.

Mr BENNETT - One lane, sorry, and the parking lane.

Mr BEST - It depends how that goes. You may not allow vehicles down there.

Mr BENNETT - It needs to be controlled. I think it is a traffic management issue. The other thing we are suggesting is that at times when it is very busy we have a controlled access down the ramp. So if we get a major disaster we can isolate that area so that it is only for ambulance.

Ms BARWICK - And particularly if they are contaminated you can keep them outside.

Mr BEST - Mr Chairman, still on this, but just above ground, is that in this area?

PUBLIC WORKS, HOBART 6/4/2005

**(RAYMENT/MEYER/BARWICK/ALEXANDER/COCHRANE/PENNY/
SHURMAN/BENNETT)**

CHAIR - If it is still in the general amenity, which we are talking about.

Mr BEST - The above-ground parking now is gone in that sort of horseshoe area that we looked at, and I think there are a lot of good reasons for that too, for security and other reasons. So you will have drop-off here, will you? What is going to happen with the traffic there?

Mr BENNETT - There is drop-off to the main entrance to the hospital, and it is a vastly improved drop-off, in fact.

Mr BEST - That is on the outside of the horseshoe?

Mr BENNETT - Yes.

Mr PENNY - I am happy to talk to that plan, if you would like. Obviously that is your front door at the moment, and we have the limitations of the long A Block and H Block, so we still retain the horseshoe shape which was seen as important from the Heritage Council point of view. So we still have short-term parking on those edges around here, but generally as a planning philosophy we get out all the short-term carparking within the space.

Mr BEST - When you say 'short-term', what do you mean? Five minutes or something?

Mr PENNY - At the moment the space has parking for visiting medical officers. There are a lot of service vehicles such as florists - not so much goods into the hospital; that happens separately down here off Campbell Street - and incidental things that come in through the front door. We are working through a process of quantifying what exactly that is and what traffic movements there are so we can ascertain exactly how many of those there need to be in relation to the hospital's traffic management planning. But the general philosophy is to have these around here for short-term drop-off and to expand the current entry. That is happening by putting a bigger canopy over it with a bigger coverage. We saw how inadequate it was today, which is nicely illustrated when the westerlies blow. It is grossly inadequate for people coming in and out of that front door.

I think it is important to recognise that there are some limitations in relation to what we can do with the heritage-listed front of that building. You all would have noticed those decorative sandstone elements, and obviously we cannot go modifying that building fabric, so it has to be a sensible design response that is sensitive to those sorts of elements. However, the forecourt will still function in a very similar way to what it is at the moment, in that your front door is for people arriving at the hospital. This is also the 24-hour entry point for hospital staff predominantly, and in the longer term the security -

Mr STURGES - The Argyle Street entrance goes?

Mr PENNY - Yes. Well, that fits within the broader intent of how they want to manage people coming in and off the site.

Mr STURGES - Just before you move on from the horseshoe area, I know it has been a bit of a contentious issue in the not-too-distant past in relation to providing access to parking

for those doctors. Where are they going to go now? What plans do you have? I think it is relevant to this. Is that going to cause a problem?

Mr RAYMENT - We have had some proposals about where we can gain additional parking spaces close to the hospital.

Mr BEST - Just back on the horseshoe, where you have your main entrance then to the hospital, and you are talking about service vehicles, florists and so forth, I suppose - and this is part of your planning, I guess, that you are thinking about - you really want patient drop-off there, don't you? You don't really want service trucks pulling in there, or vans.

Mr PENNY - I think the hospital faced that interesting problem of how to manage that.

Mr BEST - This is something you are still working through though, isn't it?

Mr PENNY - Yes; but I think it is worthwhile noting that at the moment the current road past the front door is two lanes with a drop off. What we are proposing is that that roadway is wider, so the short-term drop off will function more effectively whilst still retaining entry into the Holman Clinic, as well as having a separate entrance in for Nuclear Medicine in that block. Within this building here is the lift and stairwell down to DEM.

Mr BEST - So you have the café on the right-hand side above ground?

Mr PENNY - Correct.

Mr BEST - And the left-hand side is some sort of foyer area to -

CHAIR - Lift and stairs.

Mr BEST - the lift and stairs. I suppose that is a little distance away, but then you can go underground perhaps to drop someone off. On a day like today, when it is raining, it is just a little way for people to go. I know there was an elderly man there, stooped over quite ill, when we were headed out.

Mr PENNY - At the moment what is proposed is that there is a large and more expanded canopy over the entry point. Ambulant entrants can still go down the ramp and that will be fully covered. In addition, you do have incidental entry and out of DEM through that. The building is designed to having a large covered area over it - you can see it there - the amount of cover in relation to the roadway -

Mr BEST - It is not that far away.

Mr PENNY - No.

Mr BEST - You can see it is actually not too bad.

Ms BARWICK - Can I just make a comment. People entering under that forward canopy should only be going to Emergency and not to the main hospital.

Mr BEST - Yes. Above ground, will the café be closed of a night? It is not going to be open past six o'clock, is it?

Mr PENNY - I think it would be fair to say the detailed management of the café hasn't been fully worked out.

Mr BEST - No, but the reason I ask is security. In the day time you have people, about which is fine. I noticed a number of signs about people controlling themselves et cetera in there but I wonder about someone presenting of a night. I don't know what might happen on a weekend, but I imagine Friday and Saturday nights might be more dramatic on occasions.

Mr BENNETT - This is why I mentioned the airlock below. People can get through into the airlock but they can't go through the next level of security until they are allowed to by the people within the building.

Mr BEST - It is secure though. What I mean to say is this building up top is secure, isn't it?

Mr BENNETT - Yes.

Mr BEST - If late on a Friday or Saturday night someone presents there urgently, and then you have someone else who has been in a punch-up or something -

Mr PENNY - That side of the building, which is the café, is secure. It is designed to be as transparent as possible so all those issues about surveillance, shift turnovers, staff arriving out of hours is able to be well monitored and this base here -

Mr BEST - That is the one I am more concerned about.

Mr PENNY - is controlled but still the detailed management of how that needs to work has not been worked through. In terms of a space it is linked to the lower level lobby but, as Ian was saying, doesn't go straight into the triage reception area.

Mr BEST - No, that is right, but that is an access for people - 24 hours, seven days.

Mr PENNY - That is the intent of it.

Mr COCHRANE - And all our external entrances will be secured and monitored by our surveillance cameras. Our security officer will have access to that vision.

Mr SHURMAN - It may well be like what happened at the New Norfolk District Hospital whereby you present at the front entry and there is a patrol on the door through the vision camera at the front, so there are strategies that we can use.

Mr PENNY - If I could just elaborate on a few other little points: one is to do with enabling works which also comes into traffic management, which we talked about on site today. Obviously it is anticipated that this is a single contract, so for the time of construction access to the front door is not going to be available. This was certainly looked at as part of the process - a thorough analysis of the benefits versus the disadvantages of whether you should split it up as a contract. Potentially those issues of retaining access to the

front door were assessed and on balance that wasn't seen to be a desirable option. So part of what we are calling the 'enabling works' requires us to be able to have the 24-hour entry off Argyle Street, for which we are currently undertaking a design process to look at how the drop-off and collection in that area can be accommodated. We are working very closely both with the traffic engineers and the Hobart City Council's traffic engineering department. Obviously Argyle Street is the preferred entry point for disabled access but at the same time on the Campbell Street side there is currently a set of stairs that go from the existing footpath down to that lower level entry lobby which, you might recall, is adjacent to the observation ward, so those stairs are scheduled to be removed and a disabled ramp is going to go in on the Campbell Street side. There is further negotiation with the Hobart City Council to remove metered parking in the short term so that we can have drop-off at Campbell Street as well, bearing in mind that both those two entry points are going to have significant increases in pedestrian traffic.

Mr HALL - One question, Mr Chairman. In regard to the skylights, and they are obviously a pretty important part of the plan there, could somebody describe those to me on the plan. How are they actually secured and what elevation are they?

Mr PENNY - I am happy to talk to that. Just on this plan, that is a skylight and that is a skylight. These are skylights adjacent to the canopy and underneath the roof here, unfortunately, is a big strip of skylights, but what that means to the plan is that over this passage way there are large skylights. Over this central workstation are skylights and within the public presentation area is a set of skylights as well. Obviously the ramp goes under the slab that goes across there and within that area there are also planned to be some skylights. The detail of those are intended to be architectural elements within the forecourt. They are not going to be things on the ground that you can walk on. They are going to be elevated, they are going to be toughened glass, so all those issues about getting onto them as well as the privacy of DEM, particularly to do with patient treatment areas -

Mr HALL - When you say 'elevated' how high?

Mr PENNY - I anticipate they are going to be in the order of 2 metres. It is worth noting that, in relation to the forecourt design, there are some elements within there that need to incorporate service aspects like intake and exhaust for air. What we have consciously done is to design those as architectural elements that are part of the architectural treatment of the forecourt so, for instance, they might be interesting elements that might become incorporated into a seating element and be clad in a high quality finish. So what that means is that you do not distinguish it as an exhaust duct; it is more a civic amenity.

Mrs NAPIER - You could have wallabies and possums.

Mr PENNY - There are plenty of possibilities. I guess what we are saying is that it is very important civic space and it will have high quality finishes.

Mr HALL - Thanks for that. I think you mentioned this morning that the actual new building comes out to its northern boundaries, right on the edge of Liverpool Street and it actually goes over the existing footpath. Was that the case?

Mr PENNY - Yes, that's right.

Mr HALL - What implications will that have for traffic management? Is that going to narrow the lanes up there in Liverpool Street at all?

Mr PENNY - No. The traffic lanes stay as they are. What it means is that the carparking, which is metered, across the front would be lost. Again that is one of those elements that came up on the planning approval and that we are working through with the Hobart City Council. They are very keen to see this as a precinct and view the design of that as a once-off opportunity. What it means from the hospital's point of view is that these might be dedicated short-term carparks associated with hospital use rather than metered parking for long-term.

Mr HALL - Right. So there is still pedestrian access along Liverpool Street?

Mr PENNY - Yes, at both levels. Obviously you can come through here as well as some pedestrian pathway through there.

Mr BENNETT - What we have done, in fact, is move the footpath back into the site from the edge of the road so you get that direct link through rather than at the edge, interfering with the traffic.

Mr PENNY - You touched on another important element about in and out. Obviously getting into the system is easy, and it is beneficial in terms of a whole facility plan point of view, because having the entry point on Liverpool Street means it is a lot more readily accessible to the northern and eastern suburbs, for instance. You do not have to do the loop around the city to come up Argyle Street, and so the roundabout off Brooker becomes the main node to coming into the hospital for those suburbs which historically have been a bit disadvantaged by the Argyle Street entry. The other thing is, of course, exiting, and we are talking again about part of the requirements of council as to how we manage the exiting out of the ramping process. One of the suggestions is that currently the lights might be relocated back from the intersection, so that ambulances exiting the ramp can have priority.

Mr BEST - There is no footpath down the ramp, is there, so that is a road?

Mr PENNY - There is.

Dr MEYER - There is from Argyle Street.

Mr ALEXANDER - Just touching on Tim's point there about ambulance access, ambulances won't be dispatched from there to emergency situations. They will drop the person off and go back to the ambulance station from there, so they will not be shooting out at high speed.

Mr HALL - Where is the ambulance station?

Mr ALEXANDER - The ambulance station is a block up Argyle Street, next to the fire station.

Mr BEST - I noticed the report talks about structural hydraulic engineering - and we have heard today plenty of positive evidence about the submission in regard to the first option, which was to redevelop what already exists. The report talks about the scenario if there was to be some other work undertaken there. The second dot point on page 23 says 'adjacent multi-storey buildings have basements and are founded at about basement level, so underpinning will not be required in those cases. A single-storey structure in front of C Block will be underpinned where required'. I know the last thing you would do is build up on top of what you have but, if that were the case, somewhere in the future expansion - not with this DEM project, so I guess it is not entirely relevant to what we have in front of us - would you have to do substantial underpinning of existing structures or foundations if you were going to build any other levels anywhere else on the site?

Mr PENNY - There are two elements perhaps to your question. Dealing with the underpinning element, on both the A and C Block side the buildings are at the lower level, so there is no underpinning required there. Obviously with C Block there is some underpinning -

Mr COCHRANE - Just where it integrates slightly.

Mr PENNY - Because really that single-storey building which is across the front of the building is very simply a slab on the ground - sorry, a strip footing - so when we build up to that, that might require underpinning.

Mr BEST - Just on clear underpinning, we are talking about additional pillars, structures to hold the -

Mr PENNY - No, not necessarily.

Mr BEST - You talk about strengthening existing -

Mr BENNETT - We are talking about taking foundations down below the founding level of existing footings. So against the historical building, the sort of single-storey section in the front is founded at relatively shallow levels on a strip footing. We are going down below that level, so to maintain the structural stability of that addition we have to provide additional concrete underneath those footings to go down to the new founding level. That is not too difficult to do, it is just a time-consuming exercise.

Mr PENNY - Yes. But the other part of your question, which is about what provision is there if you wanted to build onto what we are going to do here, I guess in our discussions with the Tasmanian Heritage Council -

Mr BEST - You obviously would not build on top of any of the existing structure because that is heritage too, isn't it?

Mr PENNY - This building?

Mr BEST - Yes, that is not an option either really.

Mr PENNY - No, it's not.

Mr ALEXANDER - I think if I could interrupt and Ted maybe can add to this. The hospital understands that it is constrained for space. The way hospitals are developing is quite different and there is very limited potential to continually bring this hospital up to cope with emerging demand and increased scope and the Government and the hospital are looking at future options which could involve satellite campuses and other things as well. I think it is recognised that there is limited potential to keep adding blocks to the model, if you like.

Mr RAYMENT - Yes, in fact we are looking at a short and immediate or a medium and long-term plan for the hospital campus and the hospital campus can be redefined and incorporated in places nearby.

Mr BEST - It is positive to hear that though because there have been a lot of things in the paper and so forth, but there are a couple of strategies running in tandem with this.

Mr ALEXANDER - There are. This is addressing a need holistically with the rest of the hospital but the long-term future of the hospital is being looked at elsewhere. Just one example of some of the things: if you look at that issue where we started this morning on the left-hand side of the 9th floor, there are issues like horizontal fire evacuation for patients which stop that being used as a patient area and things like that. The existing hospital is constrained by things like fire compartmentalisation and those things as well, so once you look at it it is quite limited what you can do.

Mrs NAPIER - You mentioned that it was going to get a fresh air system. Can you give us a brief run down on what the level of exhaust extraction system will be for the air circulation, given that you can't open the windows?

Mr PENNY - It is a conventionally air conditioned building in the sense that with specific areas it has particular mechanical services for it - and we have touched on the isolation wards. With the general treatment areas, it is a conventionally air conditioned building as we are in today. Some of that plant will not be in that area it might be on the roof of the A Block, which is where the chillers and the machinery that drives that is, but some general air in and air out will need to be designed within the forecourt.

Mrs NAPIER - The other question was about duress alarm systems. How is this going to be fitted out?

Mr BENNETT - We have a whole range of requirements relative to nurse call/nurse assist emergency call buttons and duress alarms and we are going to analyse each individual space in the requirements for that. We actually have room data sheets with requirements of what is needed for each of those areas. I recall from memory that we have duress alarms at the front entry, the triage reception area, at the central staff station, and in former paediatrics so there has been radical provision for the duress alarms.

Mrs NAPIER - That will be built it?

Mr BENNETT - It is all built in to the complex.

Dr MEYER - They are all part of Australian design standards as well. We are obliged to put them in certain areas. I think at one of our meetings two or three weeks ago we went through a lot of our call systems.

Ms BARWICK - I think even the staff room is going to have one.

Dr MEYER - Yes, the staff room as well.

Mrs NAPIER - The IT system: we have talked about moving onto an informatics system but what facility will be provided?

Mr BENNETT - We have category 6 wiring allowed for through all of the areas so every area will be wired and every area will have computer outlets. For details of the existing IT system you probably should ask somebody else about that as it is not within my sphere.

Mr COCHRANE - We have actually upgraded our normal standard that we have within Health for this facility. As you said, we have gone to category 6 over category 5. We are also making provision for fibre-optic cabling to specified areas. If we start transporting files electronically but especially if we start transporting digital images and x-rays we will have the capacity within DEM to retrofit fibre to some areas but as this project brief is developing there is every likelihood that we will actually incorporate into this project some specific areas that have fibre-optic capability.

Mrs NAPIER - I would have thought that you would build optic fibre into it, given that, as we talked to you around the hospitals, other hospital nationally and overseas are moving to paper-free systems.

Mr COCHRANE - We have certainly recognised that and, again within budget constraints, we certainly will be putting fibre-optic into specific areas, but we will have the capacity to very easily retrofit and upgrade. The actual carrier that we are putting in to carry the cables will have copper on one side and the capacity to run fibre-optic on the other, so we will be able to pull cable through there pretty easily without disruption to DEM.

Mr ALEXANDER - There are also wireless options, and the design brief said that there should be nothing in the construction which impedes future use of wireless communications.

CHAIR - Is there anything else on the architectural side that Tim or Andrew want to lead us into for further questions?

Mr SHURMAN - The main priority obviously is the DEM below, but a fair bit of effort has gone into getting all the partners to this development - the Hobart City Council, Tasmanian Heritage Council. I think Tim and I and Andrew would be quite proud in knowing that we got it through in record time, which is a major thing, but you would have to say that we have had a lot of support from the Hobart City Council and others. In today's world, when there is an issue about how architects come up with end products, then we are keenly aware of the civic nature of the proposal, as well as its requirements in terms of function. So from the point of view of the team of people - medical, planners, archaeologists and architects - I think the whole thing has come together

remarkably well. Then there is the pressure to get it done, and that is our next phase, to get it done.

Mr BEST - It is lucky in a way, from what has been said, that you did not run with the first option, with the space and trying to redevelop.

Mrs NAPIER - In retrospect.

Mr BEST - That could have happened if we had rushed in.

Mrs NAPIER - In relation to the heritage issues, I notice the paupers hospital used to be back there in the early 1800s. Based on the experience that we have had with the police buildings, do we expect much hold-up because of archeological research?

Mr SHURMAN - We have planned that into our next phase, basically, which is to have an early planning approach to archeology. We are aware of low risk there in the sense that the tunnel that traverses the site, which is about three metres by four metres, went right smack through that area. We also suspect that when the newer building was built, the hospital remained. If you saw the earlier pictures in the report there you will see the buildings and the new building behind it. Then the next picture shows you the flattening of that to create the forecourt, and we suspect a good proportion of that material is now gone. Notwithstanding that, we have been involved in other projects around the area and we realise the risks. Our biggest contingent risk, I suppose, is if we discover anything like an Aboriginal relic, but that comes under an act of Parliament of we all have to stand back in that sort of circumstance. But we are not anticipating that.

Mrs NAPIER - What is the date on the tunnel that you are talking about?

Mr SHURMAN - I think it is late 1970s, as far as we can ascertain.

Mr PENNY - Early 1980s, and because it has traversed the whole site and it goes down to a depth of some 4.5 metres, any original footprints we anticipate as being fairly substantially modified. But, just to reiterate what Andrew was saying, there is provision for archeological survey as part of the excavation process.

Mr Chairman, we have a couple of walk-throughs on this, so I think all we have left to do is show you those. Just to touch on issues as we are walking through, these elements become the skylights down into the walkways.

Mrs NAPIER - We reckon you're going to have to prune your trees. They will never get a root-hold there.

Laughter.

Mr PENNY - Obviously one of the important design features for any new building into this forecourt was picking up the axis of the original building, so the design actually reflects that originally there were two gatehouses. The Tasmanian Heritage Council really liked the idea that with the new structure on Liverpool Street does talk, in a contemporary way, of the initial gate house.

Dr MEYER - Is one gatehouse a coffee shop?

Laughter.

Dr MEYER - Just to touch on your question about the light, I think we will actually have more natural light in it than we have now. We are not really all underground at the moment and certainly most emergency departments are in the basement or at subterranean level to some degree. I struggle to think of one that I have worked in with natural light, so it actually might help us out.

Mr ALEXANDER - This is a pedestrian way through at street level.

Mr PENNY - Again, some vertical elements are about exhaust. Part of the canopy structure there has air intakes, I think, integrated with them. You can see some skylighting at the back of this building going down into the waiting area. Part of working with the landscape architect is also to pick up those elements and to make trees on a concrete deck work. That really means being able to have sufficient container size so they don't blow over, as well as being well irrigated and have drainage as well as all those sorts of pragmatic elements.

Mrs NAPIER - I think we need some sculptures there myself. I like sculptures.

Mr SHURMAN - Well, it is certainly part of the public building -

Mrs NAPIER - We could put a few possums, wallabies or wombats there or something - something to entertain the kids while they are waiting.

Mr ALEXANDER - We do have the opportunity with a separate paediatric wing. Seriously, I think in Canberra, in the waiting room there, at the reception counter if you get down on your knees it actually looks like a cartoon city. They put things in it for children.

Mr MEYER - Westmead was a bit like that too.

Mrs NAPIER - Yes, I think it is worth having something like that - so they can sit in a wombat chair while they are waiting.

Dr MEYER - They don't wait long, though.

Mrs NAPIER - We hope. With this new facility you will be able to whiz them through in no time at all. Then you just have to get your two new operating theatres and you will be fine. Can I walk up this?

Dr MEYER - Yes.

Mr BENNETT - It is actually designed for disabled access.

Mrs NAPIER - Okay, so there would be footpath differentiation, painted or whatever?

Mr COCHRANE - A handrail will separate it from your vehicle traffic.

CHAIR - Any further questions?

Mrs NAPIER - When you look at this new facility that is being developed, and it looks very logical to me, if you were looking at the additional high-dependency unit beds and the two operating theatres, which seem to be the points that are most in discussion, then they go in Argyle Street on that west side where there is some space on the building if we push it back out to the road. Is that the area that it basically can go on the footprint?

Dr MEYER - This is the building that is underneath here in Argyle Street, so with the HDU beds this part of the building gets widened out to street level.

Mrs NAPIER - And you would probably still use that same central point with the lift to get to whatever level they would be at to get them in?

Dr MEYER - Yes.

Mr RAYMENT - What we are going to do, though, is to incorporate additional HDU and ICU beds in the current area, even though it is not ideal, in the short term.

Mrs NAPIER - And down the track we are looking at expanding it?

Mr RAYMENT - Making more room, yes.

Mrs NAPIER - But the only place your operating theatres can go is out on that wing, isn't it, unless you go back out into the services area?

Mr RAYMENT - Or into the area occupied by the clinical school.

Mrs NAPIER - You could get them to move up onto the Domain.

Mr HALL - The development talks about the capacity of having 45 000 presentations in a year. How many years does that extrapolate out to, do you think?

Mr ALEXANDER - In semi-anticipation of that I printed off some of the demand statistics that we used to base this on. There is a total presentation, which is remarkably flat, of around about 3 000 presentations per month. I think that is from 2001 through to the present. There is a range of these split into categories which the hospital provided to us when we were planning it, but that gives us 25 per cent capacity now. Some of the demand issues that we are looking at, the surges, the one-offs -

Mrs NAPIER - Or the ageing profile, I would think, is the thing you are really dealing with.

Mr ALEXANDER - Certainly that, but the sort of unpredictables are cruise ships, tourist numbers, a terrorist act or something like that, and a political decision, a Federal decision around bulk-billing, for instance, may push more people to seek GP-type services rather than that. The capacity should be there now for an immediate response to some of those issues, but the extrapolated figures should last us for the next decade at least without having to go into the contingency plan of providing additional floor space. Alastair's crew have been very proactive in looking at efficiencies in work practices which help patient turnover.

Dr MEYER - The main issue that causes people to be stuck in emergency departments is that there is nowhere to send them afterwards. If all the beds in the hospital are full, then we have no access to those beds. It is termed 'access-block'. Of the 100 patients that see every day, roughly 30 of them need a bed. This hospital manages the beds very well and it is unusual for us to have access-blocked patients. Now if that falls over then we are in trouble, as has happened across mainland tertiary hospitals. So the Emergency department is really only as good in flowing people through as the hospital is behind us. That is multifactorial with nursing home patients. If we have a person in Royal Hobart who is deemed to be a nursing home patient and who cannot get a nursing home bed, which is a Federal issue, then we are stuck with that patient and we cannot access that bed for an acutely unwell person. So it is multifactorial, and what is behind us is just as important as the department we build. We could make it an infinite size. Some of them in Victoria went down that path; they built 100 cubicles in emergency departments and they are all full.

Mr HALL - Just following on from that, and it is outside the scope of what are considering today, what do you anticipate will happen with the existing facility that you have there now?

Dr ALASTAIR MEYER - We have not as a hospital decided that as yet, but we are in discussions at the moment to do that. Anne and I have been discussing the fact that we are probably going to have to run two departments for probably 24 to 48 hours so that the public gets used to the fact that we have the new one open. So, after that, perhaps Ted could answer.

Mr RAYMENT - The planning that is taking place now, which is, as I said earlier, looking at the short, medium and long-term, would factor that in, because there are, as you probably would be aware, some pressure points within the hospital at the moment which need to be addressed so we would build that in with the contingency planning. I certainly don't want to steal the thunder of the people who are actually looking at that but it will be most welcome that additional space. We will need it.

Mr HALL - Will you need additional staffing if this project is approved over and above what you have now in that department?

Dr MEYER - The simple answer is yes because we are changing the way we do our work and the first area will be the short stay unit. That is, I suppose, a more modern way of doing medicine that we started at the Royal Melbourne three or four years ago that we don't have the geographic capacity for at the moment. We would love to do it. We have support to do it but we just don't have the space to do it so that will need to be staffed. At the moment because we are a tiny unit, the footprint of our unit is small, we can actually see patients even when we are tripping over them virtually and so you can imagine somebody in trauma bay 1 and somebody down here then we are going to have to probably have extra staff. The nursing staff is modelled on the Western Australian nursing hours for patient day and so that will actually give us the correct number of staff to run it. It doesn't depend on the size; it depends on presentations and timing, department and category. We will have enough nursing staff if we can recruit them. We are actually short of nurses on that model now. If there were nurses available we would fill the positions, so we would need some for there. The nursing staff in here seem to be

all right. With the medical staff, we have fewer doctors than benchmark hospitals have for our number of patients and acuity. That is another issue and we are working towards that, but hopefully by the time we open we will have an emergency position to manage the short stay unit and the extra two or three that we need at the moment, but that is running in parallel to this.

Mr HALL - What is the estimated quantum or percentage increase then? Obviously you would have considered that staffing level.

Dr MEYER - The benchmark levels based on Australasian College for Emergency Medicine guidelines for the number of senior doctors is roughly six or seven more than we have at the moment. With the next level of doctors, the registrar, it is probably two more than we have at the moment. With the junior doctors we are probably on par with the rest of the hospitals. The nursing funding is there but we just don't have nurses and we have actually got the business case written for the short stay unit so we are ahead of ourselves with that and that requires about three or four more doctors. It is roughly \$2.5 million per annum in staffing or thereabouts.

Other things, such as ancillary staff, there is twice as much floor so we will have to have twice as many cleaners and things like that. We will need orderlies because we need to push a person who needs a CT scan from here to 65 metres down the other end of the department, so we need to improve and change our work practices. Really that is the next phase of what our team clinician team is going to be looking at - how we are going to get the patient from place to place - and putting forward business proposals for.

With a lot of what we do in the department at the moment we are just hanging together and we have this opportunity to try, with a better facility, to practise emergency medicine a little better than we are at the moment.

Ms BARWICK - One thing we are trying to do is introduce the changes now gradually so that when we get to the new department it is not 'shock, horror'.

Mr HALL - Will security arrangements be simplified by the new development?

Dr MEYER - Yes, we have spent one of our meetings on security access on how to get in and which doors will open to what level of staff and we have addressed security to us from violent and aggressive patients with our seclusion bays. The main risk of harm to the staff is violent and aggressive patients, and with the facility we have, we have to take them all the way through the department to that funny little room 22, whereas now they are right at the door and there are hopefully going to be rooms where we can look after these patients better and therefore look after ourselves better. Security from outside elements coming in, that is a bit beyond what I have been looking at with our staff, but I am sure our security people have been looking at with the team as well. Security cameras - we have gone through that -

Ms BARWICK - Lock-down.

Dr MEYER - Yes, lock down of the whole department. We actually have the capability to lock down sections of the department as well. For example, this area we are calling the quiet area can be locked down when and if we are quiet, or if we need to -

Ms BARWICK - Staffing issues.

Dr MEYER - Yes, staffing issues. If we do not have enough staff to open bays we can lock them down. We can actually lock down the paediatrics area. The fast-track area we can lock down. We have more flexibility to secure ourselves and to secure patients from other threats.

Ms BARWICK - One good thing is we have only one main public access at the moment. We have people wandering in our back entrances and getting lost and going into the wrong places. They can really only come in that front foyer now, because all of this will be restricted, even to general hospital staff as well.

Mr HALL - Just a final one, if I may, Mr Chair, to the architects. I like the concept of the bomb shelter approach, if you like. How significantly does going underground increase the costs over if, say, we had had just a greenfields site? Is it really a quantum leap for what will actually be delivered with this project?

Mr PENNY - No, I think if you look at the dollars per square metre of what it is costing us, based on our current cost plans, and if you benchmark that against any new stand-alone facilities, say, on the mainland, they are very comparable. I think there are a couple of things to recognise. One is that you get some savings because there is not a whole lot of external wall envelope that you have to build or clad or put windows in. The flip side is that you do have a lot of upper level on the podium where in fact you have some special finishes. So on swings and roundabouts it is very comparable. You do get some longer-term savings, in fact, because it is lower level, so it is well insulated. From an environmental and an energy consumption point of view it is a really good solution.

Mr COCHRANE - We have been able to maintain within this project some significant environmentally sustainable design aspects of it. The concept of the floor heating and cooling lets us cut down on the amount of air that we have to move. We are certainly moving enough air to keep it well ventilated, but it is much easier to give yourself radiant heating off the floor than to heat air and push it about. So from the perspective of operating it will be much cheaper. Low-energy tubes, all that sort of stuff, all those aspects we have been able to keep within the budget.

Mrs NAPIER - In terms of the proximity of this facility, what is the link to the new youth ward that was to be developed that was announced a couple of -

Mr RAYMENT - The paediatric extension?

Mrs NAPIER - Yes.

Mr RAYMENT - That is in the block the executive is in so -

Mrs NAPIER - In the first building?

Mr RAYMENT - In the first building yes. So it is an extension from there.

Dr MEYER - This is the nine-floor building here, so pulling us around the corner actually puts us in a sort of central command position.

Mrs NAPIER - What floor is that going in on, that youth one?

Mr RAYMENT - The same floor as paediatrics, on the third floor.

CHAIR - In your submission there is a comment on page 9 regarding the urban design elements and your consultation with the Hobart City Council, and it suggests that there might be a reduction of street traffic lanes on Liverpool Street from three to two. Is that likely to be the case, or is that not likely to happen now?

Mr PENNY - No, that is not likely to happen now. The traffic study has proven in the longer term that they would like to keep the current traffic lanes.

CHAIR - Bill, for the record, we were discussing as we had our site tour this morning, the patient amenity with the north-facing block C. With all of the construction works being undertaken, with excavators and the like, for the record, can you repeat the sort of discussion we had this morning in terms of attending to patient amenity and quietness and so on.

Mr COCHRANE - Actually we are taking two-pronged attack to that but certainly within our architectural team's brief there will be proper provision during that construction program for proper acoustic protection for the ongoing operations of the hospital. The hospital facilities management area are also undertaking some research of their own to make sure that what we promote is right by having someone have a second look at it. We are relatively confident and we have to get it right - there is no relative about it. We have to make sure that the hospital is able to function while we are undertaking a construction program.

Mrs NAPIER - Talking of sound, what kind of structure will be used approximate to where the ambulances come in and the cars are parked. Underneath and you can get a reverberation effect. What design features are being built in to make sure that it doesn't impact on the operation of the DEM?

Mr PENNY - I think you have touched on an important point. We don't want it looking like a horrible driveway going down that has no amenity, so to answer your question it will be engineered appropriately so it has acoustic control. What it really means is that it doesn't look like a horrible driveway into a commercial carpark, for instance. We would anticipate that there are going to be suspended ceiling panels and a good level of lighting, which you need immediately to the ambulance and ambulant entry points anyway. As part of the sound attenuation, that can be incorporated within the wall design, which we anticipated to be both architectural and interesting as well as functional.

Mrs NAPIER - Do you have lots of angles in it to catch the sound and whatever?

Mr PENNY - Angles, holes, cavities - basically so your energy can be absorbed, which is really what we are trying to do.

Mrs NAPIER - It is an issue, isn't it, slamming car doors, engine noises -

Mr PENNY - It is, as well as well ventilated because that is an important issue as well.

Mrs NAPIER - So that is all part of the design?

Mr PENNY - Part of the brief, that's right.

Ms BARWICK - Actually it backs onto Alastair's and my office.

Dr MEYER - So it is really important.

Mrs NAPIER - Yes, true.

CHAIR - Referring to your submission on page 26 about the old foundations from the old colonial hospital and the necessity to uncover and record them, do you foresee any difficulty there with the removal of what is likely to be discovered when excavation is undertaken?

Mr SHURMAN - The understanding from both the Tasmanian Heritage Council and the Hobart City Council - who also put in a planning requirement that we have an archeological investigation done - is that we are removing that area of the site, so it is basically a record and remove approach rather than sustaining it. That is the understanding.

CHAIR - From my point of view the submission is of a high quality. I want to commend everybody involved with that submission because the nature of the perspectives which have been produced, and also the visuals today, have obviously come together in a fairly quick period of time. In respect of our job, in the absence of working drawings - and we appreciate that it is not possible to present those to us - can I commend all of you who have been involved with that for the quality of that presentation. It certainly helps us immeasurably in assessing the project. Any further questions?

Again thanks very much for both the on-site presentation this morning and for that which we have heard here this afternoon.

THE WITNESSES WITHDREW.