

**THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN
COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON THURSDAY
31 JULY 2008**

PAEDIATRIC ENHANCEMENT PROJECT, ROYAL HOBART HOSPITAL

Mr PETER ALEXANDER, DIRECTOR, FACILITIES MANAGEMENT; **ASSOC. PROF. JOHN DAUBENTON**, DIRECTOR, PAEDIATRICS; **Ms JULIE VIECIELI**, NURSING CO-DIRECTOR, WOMEN AND CHILDREN'S SERVICES; **Ms MICHELE TROBBIANI**, NURSE UNIT MANAGER, WOMEN'S HEALTH OUTPATIENTS; **Mr JOHN PADAS**, PROJECT ARCHITECT, ARCHITECTS DESIGNHAUSE (CRAWFORD PADAS SHURMAN); **Mr BILL COCHRANE**, MANAGER, MAJOR PROJECTS, FACILITIES MANAGEMENT; AND **Ms LARRAINE MILLAR**, DIRECTOR, CLINICAL SUPPORT SERVICES, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Thank you one and all; members we are outnumbered so we had better be focused.

Thanks for the site tour this morning. Brenton and I have seen the confined spaces within which other areas of the hospital have been working the past and it was pleasant to visit and see how it has all changed with the neonatal area to a much better facility than was in existence a couple years ago when we were last there.

We will proceed now to your formal presentation, however that is going to proceed. Peter?

Mr ALEXANDER - Thank you, Mr Chairman. I will just do a brief introduction and then pass to Dr Daubenton.

We welcome this opportunity to bring this project to the review. It is something that we are very pleased to get ahead with, as you saw today. Although it is a fairly moderate scale, it will offer a significant service delivery improvement and that will hopefully improve the throughput of patients, shorten waiting times and provide a higher level of care.

The project is primarily designed to improve the outpatients for the care of children and will have the added benefits of establishing audiology suites and oral health facilities within the hospital and the capacity for a dedicated space for cystic fibrosis. Associate Professor John Daubenton will lead the discussion. He will discuss the current situation, as you saw it today, and address the clinical issues and the need for the project.

John Padas is the project architect. He will discuss the plan program and show how this will support the need that John Daubenton identifies. Obviously we are happy to discuss any other questions that you have, particularly in relation to investment compared to the planned project of the new Royal - that sort of issue.

CHAIR - Thank you. Dr Daubenton.

Dr DAUBENTON - The purpose of my presentation is to make the case for why we need this project. The Royal Australasian College of Physicians, the Paediatric Division, brought out a document, a statement of principles for paediatric services in Australia, and I have a copy of the whole document here if it is required. I have highlighted just a few of the points that they make in it. First, that high-quality services need to be available and accessible and appropriate to the needs of Australian children, and this is fundamental to ensuring their optimal physical, psychological, emotional and social development. Australians value highly the health of children and families and health policy resource allocation and funding methodologies should be consistent with that priority. It is recognised that children's health and wellbeing provide the platform for life-long health, and I think this is important because if you get it right as children, you probably have less expenditure on adults.

Accommodation and facilities must be separate from those provided for health care of adults and facilities and equipment must be designed, provided and maintained to ensure children's safety, emotional wellbeing, sense of belonging and optimal development. I think these are very important principles. There is an expectation that these will, in the near future, become part of the accreditation process for hospitals and, rather than just principles, become a requirement for places to be accredited.

The paediatric enhancement project deserves just a little bit of history so we understand where it has come from. During the 1980s there were two paediatric wards in the Royal Hobart Hospital, 20 beds in each ward, which gave a total of 40 beds. The outpatients was a combined area with adults with, I think, one or two rooms available and some of the specialist clinics were actually run from the ward area rather than from an outpatient area.

In 1997 the Queen Alexandra Maternity Hospital was given over to become the Hobart Private Hospital and at that stage paediatrics was reduced to one 25-bed ward and the small clinic with three consulting rooms and a treatment area, that you saw this morning.

In addition, there was the closure of the St Johns Private Hospital paediatric ward which means that the ward at the Royal is the only facility for inpatient care of children in southern Tasmania, and I think that is very important. The end result is that there are 25 beds in southern Tasmania compared with 30 in the northern part of Tasmania. One has to remember that the Royal Hobart Hospital is the statewide referral centre for a number of services of which my own special service, the paediatric oncology, is one of them. I think the number of beds in the north of the State is appropriate and I think there is a shortage in the south of the State, and that is evidenced by the overcrowding that we have.

As we got into the twenty-first century, there was a growing recognition of the inadequate service facilities for children at the Royal Hobart Hospital. That has already resulted in some significant improvements. We have had an improvement in staffing. I am one of those people. It took a number of years to fill the position that I am currently in but I came here just over three years ago. We have also had the neonatal and paediatric intensive care unit which has made a very big difference to critically ill children and newborns.

It is also important to note that there have been changes in practice. The first thing is that there has been improved survival of patients, so there are more children requiring health care who have survived serious illness. There are now far fewer transfers interstate to hospitals in Melbourne or Sydney. A good example of that I can quote from my own experience is that before I came here as the sole paediatric oncologist, most of the children requiring treatment for cancers were sent to Melbourne for at least part, if not all, of their treatment. Since I have been in the State and been able to provide a service with the skills that I brought, we have had 53 new children with cancer and of those, only 17 have required any time in Melbourne. The rest have been treated completely within Tasmania, with the assistance of not just my work but that of doctors both in Launceston and Burnie who co-manage patients with me so that they can get appropriate treatment close to home. That has made a big difference to the costs of sending patients interstate but it has placed far greater demands on the services within the Royal Hobart Hospital.

There has clearly been a move towards outpatient care, and that is appropriate, so the outpatient area has become more and more important and obviously has become too confined. I have mentioned the paediatric oncology service. We have had an increase in the load of juvenile diabetes. Tasmania currently has the highest percentage increase of juvenile diabetes in the whole of Australia and the reasons for that are being researched but are not entirely clear yet.

We have had a new service where children now with serious illness are being provided with the opportunity to have ventilatory support at home. Five years ago this did not exist. Simon Parsons, one of our intensive care specialists, introduced this and although it is a small number, obviously having them out of the hospital makes a big difference. This service requires a home and we hope to have that in the new outpatient area.

We have also opened an eating disorders clinic. Unfortunately this is a growing area with the psychological problems that many teenagers get.

The funding for the paediatric enhancement project was applied for in early 2006 through the normal processes and a decision was made to approve just over \$2.6 million of capital improvement funds to make an improvement to the paediatric facilities. The reason that has not been spent yet is that there was a delay in finding an appropriate space in the crowded confines of the current Royal Hobart Hospital but eventually with the completion of the new emergency medicine department it became evident that that area was available for some further redevelopment. We then went through a process of identifying within the hospital the highest priority and the paediatric area was identified as the highest priority by the hospital administration.

The paediatric enhancement project also comes with recurrent funding for staffing and this is a list of the various staff people that we will be getting on board in addition to those that we already have. This will allow for a proper functioning of what will be a larger area, requiring some more staff to run it.

The whole project encompasses these five areas: the outpatient facility, the inpatient area, an audiology area, women's clinics and the dental facility. I am going to touch on each independently.

The outpatient facility has a large number of things that it is responsible for. Firstly, there are the general outpatients, patients that are referred by general practitioners or others. There is the ambulatory care unit which is designed to provide procedures, infusions and care for children who do not require admission to hospital but require this to be done in hospital. As you saw, that current area is not adequate for that.

The paediatric oncology and haematology service includes the cancer service, a significant service for children with haemophilia and some other blood disorders. That area is currently shared with ambulatory care and in the new plan it will be much better to have that as a dedicated area. An amount of \$100 000 has been donated by Camp Quality towards that improvement.

Regarding diabetic clinics, we have mentioned the increase in diabetics. We have specialised clinics for patients with cystic fibrosis, eating disorders, and there is a continence clinic. There are a lot of children with bed-wetting problems who need help.

Regarding the newborn follow-up clinic, we have seen the nice new facility. The graduates from that facility, the newborns from that facility, often are complex patients who need follow up and they need to be seen in a clinic area.

We have visiting specialist clinics currently in cardiology, neurology - genetics I have highlighted there because they used to come to that area. We have not been able to accommodate them this year and we are hoping to re-establish them in the paediatric area when we have more space. Endocrinology clinics come as well.

I have mentioned the home care service, children getting high-level care in the home. This is very appropriate but the people running that service need a home and we hope to have an office for them as part of the new clinic. The surgical clinics is another significant area, and those will be increasing because we will be getting a second paediatric surgeon. The service cannot cope with only one surgeon.

Regarding the future needs, I have mentioned the paediatric surgeon. Child and adolescent mental health services are an incredibly difficult area at the moment. Effectively there are no acute child and adolescent mental health services because there are no child and adolescent psychiatrists on the staff at the Royal. That is busy being addressed and we hope to have one in the near future with money from the paediatric enhancement project. But they will require an area to deliver their outpatient services.

We need an increase in certain areas in the visiting specialists, including areas such as rheumatology and gastrointestinal diseases, all of these being highly specialised fields where we get specialists over two or three times a year to see difficult patients and to give us advice on their management. It is far more cost effective to bring one specialist down here than sending dozens of patients over to Melbourne, but we need space for that.

I have mentioned the genetics. We would be able to increase the number of general clinics with our existing staff, and we spoke about the waiting lists.

Regarding the present situation, you have seen that there are three consulting rooms, two offices - one actually houses four staff members in it - there is a 12-week waiting period

for the general clinics at the moment and there is a seven-to-eight-week waiting period for the surgical clinics.

Each room has two sessions a day, morning and afternoon, and if you multiply that by, say, four weeks, you get 120 sessions available in the clinic area that we currently have. The table on page 8 details all the clinics that we should be running and if you work it out on the basis of those personnel and clinics, we currently would need 190 sessions to accommodate all of that properly, so we are obviously not able to do that at the moment. So 190 sessions would need an increase of at least two consulting room over the current three. We also need a consulting room available for when we have emergencies coming in. There is nothing worse than getting a new patient with a serious problem and having sub-optimal circumstances under which they have their first interview or consultation. So we need one consulting room for that, and that is why we have asked for six new consulting rooms in this facility and that will meet our current and probably our expected needs. Of those 120 sessions, four of them in every four weeks are used up by the visiting interstate specialists, and I have mentioned the problem with the urgent cases.

You have seen our waiting area. On a typical busy clinic day you can see some of the parents standing in the corridor because there is not space for them to sit down. This is the treatment area. The little girl on the left has leukaemia, the little boy in the car has a kidney tumour and the little boy in the pram also has leukaemia.

So the proposal is to have six consulting rooms, one that will be available most of the time for urgent consultations. There will be a separate area for the ambulatory care service - and, as I mentioned in our walk-around, that will allow us to deal with some of the patients, who currently get admitted for certain day services, in the outpatient area and take some of the pressure of the overcrowded ward.

We will have a separate area for the oncology haematology service with three rooms which will include an office, a treatment area and a therapy area where they can receive their chemotherapy and infusions.

We will have appropriate office space for the clinic nursing staff, the ambulatory care staff, the oncology staff, the cystic fibrosis clinic staff and the home care service, plus the support services such as the reception, waiting areas, toilets and things like that.

With this we will have a child-friendly environment on the lower ground floor with easy access off the street, particularly for people being dropped off with prams or children in wheelchairs. We will be able to offer a much improved service in a far better work environment, and I think we must not underestimate the effect of the work environment. The current work environment is challenging for staff and in a situation where the recruitment and retention of staff is difficult in Tasmania, we need to have facilities that do not make people want to leave. We need to make them want to work there. As I said earlier, we hope with these improvements to be able to, within the existing staff complement, bring down the waiting times to less than four weeks. This will be done by a combination of not cancelling clinics when we have visiting specialists and by increasing the number of general clinics within our existing staff, which is entirely possible.

The next area is the paediatric inpatient space. As we have said, this is a 25-bed ward now. It is the only admitting facility in southern Tasmania. The only alternative for the more complex patients is transfer interstate and if you have a sick patient with complex problems that you are sending interstate, that requires air ambulance evacuation. That is very expensive so anything that we can do to lessen that cost will be put to better use for patient care in Tasmania.

Children not infrequently have to be housed in adult wards and we all know the sort of pressure the adult wards are under so even the adult wards will benefit if we have more space because we will not be occupying any of their space, or certainly less of it. We will be able to get by with cancelling much less of the surgical cases if we have appropriate bed spaces to house them afterwards. The project aims to create an additional four inpatient beds, as I showed you in the area where the clinic currently is down the end close to the paediatric ward and this will help the situation tremendously.

The next area is audiology. I am not an expert in this but this was given to me by the chief audiologist. The paediatric audiology gets over 60 referrals a month from various sources. They also run the Tasmanian cochlea implant outreach services. There are 30 patients who have had implants and about 20 a year are being referred for assessment. They have also started something which is a really good innovation, which is a universal newborn screening. This allows you to pick up early babies who are deaf to take appropriate steps to improve their hearing so that you do not end up with a two-year-old that cannot talk because he cannot hear what is being said to him. This screening service will result in around about 200 babies who do not pass the screen requiring a more formal audiological assessment and this will be done in the new facility that we hope to create. At present the audiology services are a mixture of things all over the place - a converted ward on level 5, a little space in the speech pathology department, Australian Hearing in Battery Point and a consulting room in the ear, nose and throat department. Sometimes the children have to have multiple appointments to get the different services. We hope to be able to have that all in one; good service in the same area as the paediatric area where you have properly sound-tested testing suites, the cochlea implant treatment room, the infant testing room and the office and reception. There has been an anonymous donation of \$100 000 towards the purchase of the audiology booth which will go in there, so that is in addition to the funding already available that the health service has agreed to.

I am not an expert on women's clinics, I do not work in that area, but we do know that as with paediatrics, the space that they have been allocated has been very inadequate since the move of the women's services from the Queen Alexandra hospital to the present site. Women's clinics will benefit by taking up some of the space that is vacated by the paediatric clinic and by a refurbishment and rearranging of some of their services on that floor. We believe that this can be done within the existing budget so that women's services will also benefit from the paediatric enhancement project.

The reason the dental facility is being placed there is that this was the only remaining area in the hospital that was open for redevelopment and they needed to have a proper dental facility in particular for difficult complex patients, such as people with heart disease, people with cancer requiring dental services where this is difficult to deliver in a distant clinic where you may need the support of the hospital and the specialists in the hospital in order to make decisions about whether their dental care can take place at this

time and if they need any help. If they have problems while they are having their dental care then the hospital facilities are available. I believe this is a much-needed facility but it is being funded independently by the oral health service. But it will be co-located in that area.

I want to finish with this. It is a poem from a Nobel prize-winning poet from Chile. She says:

'Our community is guilty of many errors and many faults but perhaps the worst would be abandoning the children, neglecting the fountain of life. Many of the things we need can wait, the child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer, "Tomorrow", his name is "Today".'

I say this because, although there are plans for a new Royal Hobart Hospital, I do not believe I will ever work in it because I will be retiring in eight to 10 years and I believe it will take that time to open it. The children need these services now, so we cannot wait.

CHAIR - Thank you, doctor. Are there any further presentations before we proceed to questions?

Mr COCHRANE - John was going to run through the design and how that design meets the service needs that have just been advised.

Mr PADAS - You will see from the floor plans that it is a very functional layout. We have attempted to provide a solution which is a very good value-for-money solution in that it is highly functional and no excess money is spent on superfluous design elements.

We intend to use materials that are very cost-effective, durable, functional and satisfactory to the infection control department. We intend to spend a bit of money on providing a bit of delight to the children's play area, which is something that will perhaps distract and engage them while they are there and relieve them from any undue stress that they may be feeling at that time.

The existing structure, which is basically a grid of columns, is going to remain as is so that once again we do not use any money that we do not need to be spending. We have had to demolish some existing walls because the current layout that you would have seen - those of you who have been down there - did not suit the needs of this facility. So basically the partitions are all new but the columns are existing and are remaining intact.

We have retained the existing location off Argyle Street and put a bit of money into providing an airlock for climate control at the entry. As you can see, it is again a pretty simple layout but we believe quite functional.

One of the areas where some costs might have been used up was in carving up the existing slab to provide plumbing fittings. We started by trying to locate new plumbing fittings as close as possible to existing ones, once again to avoid spending unnecessary money.

You will also see a floor plan for level 3 C block, which is the short-stay ward in women's services. This has recently been the subject of some review and we are just getting sign-off on that at the moment. The ground floor at Argyle Street, which is H block, has been laid out in detail and signed off on by the various stakeholders from the hospital. C block on level 3 is not as detailed but we believe that we will have that signed off on quite soon.

We would hope that construction of the program we are working on, depending of course on the outcome of today's committee, will be completed by May 2009, which would mean awarding contracts to the successful tenderer in about October 2008. That would give us approximately eight months, one month of which will be used by the Christmas period, so seven months to complete the two pockets of work.

CHAIR - Thanks, John. Does that complete the formal presentation, Bill?

Mr COCHRANE - I think so, Mr Chairman. The only thing that I might add is that within our current cost plan we are relatively comfortable with where we are at with the costings and, as I mentioned, we think we have the capacity to perhaps do a little more work on level 3 C block to make a much better outcome and overcome those currently advised deficiencies.

CHAIR - Okay. Members of the committee, the forum is now open for questions.

Mr BEST - It is good to see something really positive happening to try to address some of the issues. I want to congratulate all those involved who have obviously put a fair bit of effort into this to finally get it to where it is at.

Starting with the women's services, we saw that there is a high need there, so this project has that added benefit. Is there involvement of some of the staff with the planning aspect, because they are working there all the time? I read on page 16 of the report that there was an outline of consultation and governance and then a structure chart. Could you fill me in about what might be happening there?

Ms VIECIELI - In terms of the planning, Michele and I have worked closely with all the staff - Michele particularly with the staff who work in the area - and in another tier of that, the medical staff specialists who work in that area as well. So it has been quite broad and quite inclusive, to the point where some of the nurses who have partners who are architects have done lots and lots of re-sketches as we sift through the many ideas to see what is functional and what will work. So the involvement has been quite good.

Mr BEST - It is obviously not just the paint and reflooring -

Ms VIECIELI - No.

Mr BEST - in some of the corridors and small rooms are you going to address some of those issues?

Ms VIECIELI - Yes. One of the things we have looked at is functionality, separating functions, because at the moment they all cross each other, so putting together the functionality, separating out the staff areas from the patient areas, maintaining privacy.

We had a number of principles that we needed to embrace in whatever work we wanted to do.

Ms TROBBIANI - And safety issues.

Mr BEST - Safety, yes.

Dr DAUBENTON - I think the reason the women's area is slightly behind is that this phase has to be completed before anything can be done there. The priority was to get that phase ready to run, with ongoing planning for the area upstairs, which has to wait for this to be completed.

Mr BEST - I guess I am questioning back to front. It is just that I was interested in that.

Ms VIECIELI - It was two of the medical staff specialists who have come up with some of the really innovative ideas for that area, and then the nurses have drilled down the more operational, functional side of it.

Mr BEST - That must add then to some of these issues of retention of people, to have a sense of empowerment in where you are working.

Ms VIECIELI - Yes.

Mr BEST - Hopefully that is going to be a positive. We see on the news all the time a sense of hopelessness that people are not engaged.

Ms TROBBIANI - It has been very inclusive and they have been given many opportunities to have their say. Lots of consideration to workplaces that are not very conducive to positive outlook have been addressed and we believe that this project will enhance our environment very much.

Mr BEST - It would be always great to have more money but it is a realistic budget, isn't it, for both projects? I note a comment in the report about some private donations, so obviously you have had people who have been charitable enough to want to -

Ms VIECIELI - It was more for the paediatric element than the women's element. That means that less of this funding needs to be spent on paediatrics so that creates some availability with the women's side.

Mr COCHRANE - The current budget, as is in the report, shows that we have an amount of approximately \$300 000 for lease equipment, which is relatively generous given that we do have the donation fund sitting at the back of it. That has given us a bit of flexibility to be able to do some more work on the women's health clinics.

In addition we have audiology, which is basically a purchase of a proprietary item in the audiology booths - apparently you can buy those booths as an off-the-shelf item - and they will be purchased and donated to the hospital and then they will be incorporated into the works.

Mr BEST - We saw the slide about one of the moves that made things a bit tighter with the private hospital in 1997. I do not want to go over old ground but I am intrigued as to how that came about.

Mr ALEXANDER - Before any of our time.

Laughter.

Mr BEST - Nobody would have even realised the future, I suppose, in that sense. The Government must have made a bit of money out of that, I suppose.

Mr ALEXANDER - As I say, I was not party to that but some of the arguments which are still very valid are the integration of the private health system with the public health system, and it is much easier to attract doctors if they can treat private patients as well as public patients. Throughout Australia the co-location of private and public is seen as a very key element and the planning for the new Royal assumes a strong private presence there.

When the Queen Alexandra was passed over, yes, it was leased and there was some funding stream from that. There was thought to be some synergies in sharing some of the spaces and use of some of the operating theatres and things. That has not eventuated to the extent it did. At the time, I guess, there was a thought that in the same vein as a paperless office, there were going to be a lot more outpatients and less beds and the prevailing wisdom was that bed numbers would reduce. It has not been the case and it never will be the case because the more demand you meet, the more demand you are able to identify. At the time that part of the hospital was passed over it was understood to be the best thinking at the time but it put extensive pressure on the remaining private hospital.

Mr BEST - It probably has not turned out to be, unfortunately. I am not trying to put in you in the hot seat but I think it is interesting -

Mr ALEXANDER - I used to build roads in those days.

Laughter.

Mr BEST - So you cannot be held accountable for that one.

I am led to understand that it is fairly irretractable, that the lease with - is it Healthscope? - we cannot do anything there in terms of floor space.

Mr ALEXANDER - In getting that space back?

Mr BEST - Yes, pretty much.

Dr DAUBENTON - Dr Liz Hallam, the previous medical co-director, was engaged in discussions with the Hobart Private Hospital to lease back the third floor of the private hospital, which is where you came this morning to the lecture area, directly through the door - on the same level. Unfortunately the hospital, in the interests of their shareholders, wanted so much money for the lease of that space that it was not practical.

Mr BEST - I guess the fine print of that arrangement from 1997 is pretty tight in the sense that we have nowhere to go.

Mr ALEXANDER - No, we cannot initiate any action, they can, because we have to pick up the shortfall, if there is one. Up until a few years ago, the Mersey hospital was also leased out to private and when that was not found to be viable, the State had no choice but to go back and take over the service, but we cannot initiate that action in any other way than by agreement with them. As was said, it is expensive.

Mr BEST - How much space have they got? Is private using all of their space or do they have space that they are not really using?

Mr ALEXANDER - I do not know, to be honest, it is not part of our service.

Dr DAUBENTON - At the time when we were negotiating that area was underutilised, but I do not know what they are doing there now.

Ms VIECIELI - Apparently they use the level 3 for rehabilitation in maternity services.

Ms MILLAR - Yes, they have just opened a rehabilitation ward there.

Ms VIECIELI - One side of the area is rehab, the other side is maternity.

Mr BEST - What is the life of this 1997 agreement - forever?

Mr ALEXANDER - No, it is until 2019.

Mr BEST - A long time.

Mr ALEXANDER - Yes, it is. It is an issue for planning of the new hospital because the agreement does continue even if there is a move of location of the hospital.

Mr BEST - Was it a one-off deal with the private provider or do we continue to get funding from them in regards to this space?

Mr ALEXANDER - It is not a deal that I have been involved in, I am sorry, but it does involve an ongoing lease payment and there are various other financial arrangements for the provision of services in both directions.

Mr BEST - Sure. That is all I have. I think it is a really good project and having gone with Mr Harriss through the old DEM - and I think we were told at the time that part of that plan was to free up that space but it had not been decided who would have it - I totally agree with your quote from that poet in Chile about children. Who can argue about that? We want to get this thing done.

Mr GREEN - The project from my point of view is totally warranted. I would also like to place on the record my thanks to all of the people who have done the preparatory work for today. I know there is a lot of work required and it is part of the process, some would

say unfortunately but it is necessary under our system as it stands at the moment. I want to thank you all very much for that and for showing us around.

I am not for one moment going to try to intercept anybody with respect to the work that has already been done. I can see at a glance that there is an absolute requirement for all of the things that you have pointed out to us quite clearly and I would also like to put on the record my thanks on behalf of the Government and certainly government members on this committee to the staff who have been working in those areas for their tolerance over that time. It seems to me that that must have been extremely difficult and in this day and age it is probably unacceptable so that means that this money is not before time. I understand the constraints because that has been pointed out to us from a heritage point of view with respect to the building as it stands at the moment. I also place on the record that I do not agree that heritage issues in such a facility ought to be taken into consideration. Sure, there is a place for heritage but my view is that when we have situations that apply like this commonsense ought to prevail and we should be allowed more flexibility in such facilities. I want to put that on the record as well, Mr Chairman.

Other than that, my only concern, and I am sure you have taken it into consideration, is that the budget does allow for more staff to be employed. Obviously the facilities as they are designed will be able to accommodate those new staff, is that correct?

Dr DAUBENTON - Yes.

Mr GREEN - I wish everybody every success with the project and I hope that it starts on time and finishes on time.

CHAIR - I want to work through some comments and questions that I have raised from my study of the document which has been presented to us. First of all, I go to page 5. The third-last paragraph talks about the level 3C block redevelopment and that there is a need to upgrade building services such that they will be compatible with contemporary standards and building codes. I was unsure as to what that meant. Does that mean that there are many areas of not only level 3 but other levels in that same block C that need upgrading sometime down the track? Is this the opportunity we are taking to upgrade those building services to contemporary standards on that floor alone or is there a need down the track to look at other floors because they are not of a contemporary standard?

Mr ALEXANDER - I am probably best placed to answer that. That is initially a 1938 building. There has been a large investigation into the whole of the existing Royal as a base case for the business case to replace the Royal Hobart Hospital. To answer the question why wouldn't you just refurbish this one, any building complies with the standards of the time it was built and even under the Building Act 2000, provided you maintain those standards you do not have to reach contemporary standards, as you would know. So it is a pretty broad interpretation of what a contemporary standard is. We take the absolute view that irrespective of what the paper regulations and standards are, our patients' safety and our staff's safety is absolutely paramount. The reason I say that is that even things like floor slab thicknesses in that building do not meet current fire retardation standards so whatever you do, we are not going to meet absolute current prescriptive standards. The approach that we have to take is to do an alternative, what is called a performance-based approach, and there is a major consultancy under way at the moment. We expect to spend something like \$750 000 - we do not have the figures yet

but that is the sort of order of cost - on upgrading fire services through the existing Royal within the next 12 months and we will manage that out of recurrent funds. The performance-based approach is simply illustrated by the following. If you expect to have a two-hour fire rating in a floor slab and you cannot achieve it, if you can prove that you can get people out in an hour - to the satisfaction of the appropriate authorities, the Tasmania Fire Service and the clinical accreditation issues - then they are the issues we are dealing with. The whole points to the fact that the building is coming to the end of its useful life.

Mr COCHRANE - We will be striving to ensure that in the areas we refurbish the environmental conditions, heating, cooling and light levels will meet contemporary standards. We will have the required number of air changes and be able to maintain a design temperature of 20 to 21 degrees, irrespective of ambient conditions outside. We have some work to do on H block on the mechanical services, but our main heating and cooling plant is in very good condition. It services that area, so we will be changing duct runs and plenum chambers and fan coils, but our primary services are all in good condition.

CHAIR - The report on H block indicates that, if possible within the available budget, you will enhance the entrance. You also said that the budget looks good at this stage. Is it anticipated that the entrance off Argyle Street will be tarted up a bit?

Mr COCHRANE - It is funded within the current cost plan.

Mr PADAS - We have done minimal work to the front entrance. We realise it is not the most beautiful canopy in Hobart. We think we can give it some surface treatment to bring it up to our time. We think the air lock is necessary and there is a chance to use the glass to the air lock to do something colourful and playful. We have identified it as a paediatrics facility. Because we want to provide a good value for money solution we would not spend an extraordinary amount on it. It would be quite a simple solution.

Mr COCHRANE - Outside the current paediatric project we have some work to do to satisfy Hobart City Council from the DEM project where we made temporary parking on Argyle Street. We have to tidy that up to a contemporary standard. This will probably give us the opportunity to spend some money of the other Argyle Street entry, the main entry, not the dedicated entry to paediatrics. We will enhance that whole area and make it more attractive.

Mr ALEXANDER - Over the last few years we have had buoyant economic times. While that is good for everyone, it has made our pricing unpredictable. It depends on when you go into the market and on other jobs coming up. We have found in the last 18 months that prices in metropolitan areas have probably levelled off and standardised a bit, but we always have to have some contingencies. Occasionally there are elements that fall under the nice-to-have category, depending on the tender prices we receive. We fully intend to do that. The internal environment is really affected by being able to put in that airlock.

CHAIR - The report indicates that staffing issues are being progressively resolved. Is it anticipated that you will be at the required or desired staffing levels at the projected opening time?

Dr DAUBENTON - Staffing involves a number of different areas. At the medical level the new funding has allowed for a new paediatric surgeon, which is about to be advertised, and a new gynaecology oncologist, which is an extra but is very necessary. That is going to be advertised in the next few months. It also allows for a child and adolescent psychiatrist, also to be soon advertised. It further allows for support nursing staff. Those positions need to be progressed and they are being worked on.

CHAIR - Are you confident, given the time frame presented to the committee -

Dr DAUBENTON - We may not have all the staff required at the time of opening but we will certainly be able to start the service. Our existing staff feel very constrained in the current space, so just by having that extra space we will offer a better service with the existing staff complement without any improvements.

CHAIR - On page 6 of the submission, which gives an indication of projected demand and the impact of the new Royal and so on, the first footnote indicates that the department has the capacity to influence the demand for acute services to the extent that the department invests in primary health, including satellite facilities and the like. That is a pretty broad statement. I understand what the graph is suggesting between the black and blue lines, so what is in the pipeline such that demand can be managed or lowered at this facility as a result of providing satellite services?

Mr ALEXANDER - The three key facilities in planning to support the Royal are the integrated care centre planned for Clarence - that is combined with a federally funded GP super clinic; a tier 3, which is almost an integrated care centre, in Glenorchy; and another in Kingston. Overall the Tasmanian Health Plan is trying to limit the number of people who end up in beds, because that is the most expensive end of the program. The earlier we can intervene in people's potential ill health and reduced the effects, the lower the cost and the better the throughput. The facility in itself is adding to that. Dr Daubenton was saying that being able to treat people in a better out-patient environment saves their going into a bed with the required 24-hour care and so on. The generically named satellite facilities in Glenorchy, Clarence and Kingston are being developed from a clinical perspective to try to treat people closer to home, in a lower-cost environment that is more accessible for them and where they get an appropriate level of care which need not be as acute as at the hospital.

Because we are working very hard to manage the capital investment in the existing site, in anticipation of moving to a new site, we hope to have by November a comprehensive plan of where we need to invest in the Royal and which are the key growth areas in the Royal. Just as moving out of the area next to the women's area allows a bit a expansion, some things will be drawn into those satellite facilities.

The other side of that is the economy of scale argument. It becomes uneconomic to ask doctors to spend their time driving to satellite facilities, or there is not a sufficient number of clients to provide the same service at multiple locations. A lot of people are working at how we optimise that, because the overall cost of the health system is increasing far faster than anything except iron ore at the moment. Being able to manage and staff that sustainably is exercising everybody's planning at the moment. We are trying to substitute demand on acute services by getting people into more convenient and

faster day surgery areas and intervening earlier so that they are not so ill when we first interact with them.

Dr DAUBENTON - I have had preliminary discussions with Catherine Katz about the creation of a DHHS-employed community paediatrician. One of their roles would be providing such a consultative service at specialist level at something like the Glenorchy super clinic. They would also have a role in the provision of medical services for the child protection service. There is scope to take some of the load away from this facility with those sorts of developments, but that is very much in its infancy.

CHAIR - Thank you. Dr Daubenton, you referred to the previous paediatric ward in St Johns Hospital and the fact that that closed a few years ago. As a matter of interest, how many beds did that have available which have been taken out of the system? It doesn't matter if you cannot answer it, it is just a matter of interest.

Dr DAUBENTON - I do not know the answer to that question.

Mr MILLAR - Fourteen.

CHAIR - Fourteen out of St Johns and we downsized from 40 to 25, so we had 40-plus the 14.

Dr DAUBENTON - Somebody didn't do the maths.

CHAIR - Absolutely.

I do not have any further questions but I make an observation and that is, sharing the view of both Mr Best and Mr Green, that what we have seen on the ground again we saw with the previous neonatal area, staff and professionals working in extremely confined circumstances. I was alarmed to read in the report of many issues - and as I said on site, this is a warts-and-all submission which you have provided to the committee, and we appreciate that; there is nothing being hidden, you have alerted us to the fact that there are some important and sensitive medical procedures being undertaken in corridors and without privacy and that, I think, needs to be addressed as a matter of urgency.

I thank you for both the site visit and for your presentation before the committee today. We will deliberate on the submission before us and hopefully be in a position to make a decision regarding this project in the very near future.

THE WITNESSES WITHDREW.