

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT FLINDERS ISLAND MULTIPURPOSE CENTRE, WHITEMARK, FLINDERS ISLAND ON WEDNESDAY 19 JANUARY 2011.

REDEVELOPMENT OF FLINDERS ISLAND MULTIPURPOSE COMMUNITY HEALTH CENTRE

Ms MARIBETH HARRIS, ACTING AREA MANAGER, PRIMARY HEALTH NORTH, **Ms SOPHIE LEGGE**, PRIMARY HEALTH COORDINATOR, NORTH ESK, **Mr BARRY HERBERTS**, DIRECTOR OF NURSING, FLINDERS ISLAND MULTIPURPOSE CENTRE, **Mr BILL COCHRANE**, MANAGER, MAJOR PROJECTS, ASSET MANAGEMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, **Mr SCOTT CURRAN**, DIRECTOR, AND **Mr SIMON TONKS**, PROJECT COORDINATOR, ARTAS ARCHITECTS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Thank you for the tour of the existing facilities. It gives us an appreciation, Barry, of just the sort of changes which you would like to see occur here. We have an apology from Greg Hall who is the only member of the committee who is not with us today.

We will now get each of you in turn to take the oath and then we will proceed with the hearing.

Before we got under way, Scott was just asking whether our committee needed him to run through in any detail the larger plans. I had the impression from the committee members that the documents which we received have been sufficient to inform us as to the detail being proposed here, both in the drawing form and in the written form. So we do not need to drag those larger drawings out.

I guess it comes down to who is going to lead the introductory component from your point of view. Bill, you have drawn the straw.

Mr COCHRANE - Thank you, Mr Chairman. The department and the Northern Area Health Service are very pleased to submit this project for the committee's consideration. We are highly aware that it is a major redevelopment for the department and certainly a major redevelopment for the community and on this particular occasion we did not think that providing a formal PowerPoint presentation would add a lot more value to the information that we already have in the documents. I thought it might be prudent if I pass over to Sophie to talk about the service profile and some of the issues that they have with service delivery. I agree with what you said that our tour of the facility indicated to you what some of the facility issues are and why we consider that it is prudent to be constructing a new facility for the island.

Ms LEGGE - As you saw, Flinders Island is a multipurpose centre and that is a centre that receives both State and Commonwealth funding around its service delivery. Into the future we are looking to multipurpose centres changing over to multipurpose services and with this comes funding that becomes more flexible in the way that we deliver services so that we can adapt to the delivery of community needs and be flexible in that.

Our building at the moment does not allow us a lot of flexibility in how we provide our services. The island is obviously remote and therefore a lot of our services come from mainland Tasmania and to provide those we obviously need space and an environment that is conducive to getting people here and wanting to come here to provide services.

We are a small community - Flinders Island has only 800 people. The multipurpose centre is one of our largest employers on the island. It also has a small pocket of population to be able to get health professionals and allied health funds. So we do have to outsource and outreach for a lot of that. The centre becomes the hub for health within the island and also outreaching to Cape Barren Island and down to other extremities on the island and this centre is the way that we do that.

It certainly will not meet our needs within the next 20 to 30 years as you can see with the way the building is functioning at the moment.

CHAIR - Or even the next five.

Ms LEGGE - Yes, true. I think the staff do an amazing job here - I will just put that on the record - to work in an environment which is really restrictive in the way that they can provide their services.

One of our biggest issues is recruitment and retention of staff and we need to provide an environment that enables them to do their servicing and also encourages them to come to an environment like Flinders Island - providing adequate space, encouraging them, and being able to provide space that is confidential. We have huge concerns about our GP rooms - the layout and size of rooms. We tend to do the best we can in small facilities.

Also it is an area that we would like the community to feel that they have access to provide gathering activities and just activities that are promoting health and wellbeing in the community. Hospitals have gone well beyond the illness focus they used to be set in; it is about encouraging a wellness model now. When you have residents living in an environment, it is their home and we need to make that environment as homely as we can. We need to make them comfortable and enable them to have areas where they can socialise but also retreat to and be with their family or a friend and not in the mass of what is going on around them. Also, we need out areas that are safe and staff aren't continuously retrieving people from the community. They need to be able to access safe out areas into the garden and feel good about that.

Ms HARRIS - I want to reiterate that it is an essential health service for the island. Health facilities are social determinants of health for the community so it's really important that it has very much a community focus, that it reaches out to the community and the community feels that it is their health service and that is why we need the flexibility. Aged care goes through an accreditation cycle, as you probably saw on the wall. We are

always looking for ways to enhance services for the island, especially around palliative care, dementia care and diabetes, which is one of the bigger health issues of this generation and the generations to come. We have to look at health prevention promotion and chronic disease prevention and management into the future.

Mr HERBERTS - I think, with the Flinders Island community, they want to feel they have ownership over the health-care facility. Currently it is a place where they come, they utilise the services here but obviously there are limitations in what we can do in this current facility. With the new plans it will enhance consumer focus on wanting to come here, use the facility and feel ownership and part of something on the island. I think that's one of the big things for me, giving the community that ownership into the health service that we provide for them.

Mr COCHRANE - It may be prudent, Barry, to say how we've arrived at the design. At this point in time we have a design that is compliant with all the required standards - Building Code of Australia, aged-care accreditation, GP standards for consulting rooms and meets the Australasian health guidelines for health-care facilities, but the design wasn't developed in isolation. There was a lot of communication with community and stakeholders.

Mr HERBERTS - One of the big things that sticks out to me - and I've mentioned it a couple of times - is that we have services coming from Launceston that provide certain allied health services, drug and alcohol and psychology services. At the moment those services are co-located with the GP service. People come into here and if they're going to see the GP they sit in the one waiting room. If they go in to see the GP they go to one side and the other people accessing drug and alcohol and psych services go to the other side. We have seen a huge decline in community members accessing those services in drug and alcohol and psych for that reason - there's no confidentiality. It is a small community; people aren't going to sit in the waiting room to see a drug and alcohol worker if they know their next-door neighbour is going to be sitting in the waiting room also. To give the community full access to those services, part of the plan when we spoke with Sophie and Scott was to try to have those services isolated. In the new plan, if you come into see the doctor you go in one door into a waiting room, and then you see the doctor. If you're coming to access those other services, there is a common waiting room that will access physio, child health, podiatry et cetera, so there's going to be far more confidentiality there. I think from that you will have a knock-on effect where you'll see a huge increase in community members accessing those services. Drug and alcohol is a huge need on the island and at the moment we haven't been doing it terribly well, but hopefully with the new facility that will be addressed and we will start to address some of those problems that we are currently facing.

CHAIR - Okay, that is the delivery of the health services process.

Mr COCHRANE - If I might pass this on to Scott, we have determined the need that we are addressing and how the design and the amenity of the new facility will meet those needs.

Mr CURRAN - As you have heard, there have been a number of issues with the existing facility and one of our primary objectives was to address all of those problems that we have but also be able to do those economically, so we have broken the building down

into a number of different zones to enable us to be able to achieve this. One of the other issues we spoke about on the walk around was the need to have an easily identifiable entry and it was felt that entry should be off Davey Street directly opposite the Council Chambers, and because of the level access that we have from that entry that has determined the level of the building. It has been very evident from the walk around the number of different levels that are associated across the facility and a modern facility needs to operate on one level and that is one of the reasons we have chosen Davey Street to enable us to be able to do that.

We also needed to be able to separate out some of the services so that they could operate independently so that the whole hospital was not open 24-hours a day, and we are able to close down some of the areas that could operate independently. It was also very important for us that the ancillary services could operate independently away from the rest of the facility as well and that access to that area was easy to get to and did not affect any of the operation. It was also important for us that the aged care area, whilst being functional and efficient, still maintained a homely appearance and also was warm and inviting. These are some of the things that have determined our response to the issues in the brief we were given.

If I just run through how you would arrive and operate through the hospital, you arrive from Davey Street into the car park and from there you make a decision about where you are heading into. You can head into the main entry but we now have a separate entry for the doctors and the specialist areas. This now enables the doctors to be able to operate independently and the specialists as well. It also enables this area to be closed down and operate independently. We have addressed the issue of patient confidentiality with a private waiting room and a reception area through there. Dental services are also located in that space and there is access to toilets and tea-making facilities there too.

Upon arriving at the main entry you can then make a decision to go back off into the allied health area which is to the right of the main entry. That is the only section of the existing building we are going to reuse and that is where the aged care currently is at the moment. Those rooms will be remodelled to make good consulting rooms and offices, not very good for bedrooms but very good for consulting rooms and general rooms. You can see there that we have a discrete and private waiting area which addresses the need for privacy and separation from the main waiting areas through the rest of the facility. If you move back down you will also see that we have a separate lobby. We have created a new community meeting area which doubles the size of this existing facility that we have at the moment. It takes all the poles out of the middle and we have some additional storage area so the room can be packed up and all of the storage completely removed from the room. We have a small tea-making facility, toilets, baby change area and disabled toilets. That area can operate out-of-hours and not affect the rest of the facility.

CHAIR - That is an extension, isn't it, to what is currently there?

Mr CURRAN - Yes, that is right, that is an extension off the end. We have taken out the multilevel ramp that is there and extended that building out. It also gives us a really good view from the community area back down onto the garden that is going to be created in that area as well.

If we move back, we have reception that can control entry in and out of the facility and one of the other big issues we had was the number of different access points into the hospital which made it hard to secure the facility at night and to track who comes and goes out of the facility as well.

We have located the ambulance bay adjacent to the resuscitation area or the inpatient sub-acute and that was an important consideration as well in that we could remove the ambulance from the front entry so that if privacy was needed, the ambulance could arrive and you could come straight out of the ambulance into the resuscitation bay, and we have also located the ambulance now in an undercover area directly adjacent to that ambulance drop-off point. We have also included an ambulance training and ambulance office in that space there as well. So the ambulance is fairly well self-contained within that area whilst enjoying a good relationship with the inpatient and sub-acute area.

Around the sub-acute area we have located the nurses' station. You can see we have the nurses' handover area and the staffroom. So that really becomes the central hub of the facility and removes that from the more public areas that are at the front for people who are coming to have a general consult or a daily visit.

Moving back along where the nurses' station is, we have located the nurses' station so that they have good visual access along the corridor, good access to the four acute beds that we have, good visual access back down to the aged-care area but also good visual access back up towards the main entry, so that after-hours they are able to view and have access to all of those entry points within the facility.

We have located the ancillary services - the kitchen and the laundry - right into the back part of the site, removed that from the day-to-day function of the facility. As you can see there, we have good storage for dry, bulk storage and also cool store and freezer, a new modern kitchen and facilities for the staff who work in that area as well, with some lockers and toilets, and recreated a new laundry in that space. So deliveries and access into that area is very good and will not affect the day-to-day running of the rest of the facility.

One of the other big issues that we had, as you have seen from this morning, was the ability to take bodies into the morgue safely and discreetly. We believe now we have been able to resolve that issue. We now have good access for the undertaker or the ambulance to come into that area, good access for families to come and view, it is under cover and very discreet.

We move back down towards the east of the nurses' station, entering now into the aged-care area. We have some double doors there so that we can seal that aged-care component off. We have a patient lounge where patients can sit and watch television. We have a number of tables around there where they can sit and interact. Directly across from there we have a patient dining room. We have large sliding glass doors in all of those rooms that enable vision from the patient lounge, through the patient dining area and into the courtyard, which is accessed by staff and also by patients. You will see from the courtyard there is a ramp that comes down into the garden and that garden is secured by a pool fence that runs around the outside so that patients are able to leave the

facility, go into the courtyard, go down into the landscaped areas and be in a safe and secure environment.

We have located all of the beds in one corridor. Each of those beds has an overhead lifting rail to help with getting patients or residents out of bed. We also have en suites off each of those bedrooms that comply with the current code. They are a little larger than they are required to be so that they can accommodate changes in the code over the coming period of time and also to enable lifting machines that may need to be taken into there. Each of those rooms has access out onto a balcony. One of the key considerations of this was to enable each of those residents to have a view back towards the mountain or into a garden but also to have good solar access into those rooms so that they stay light and warm while they are able to during the day.

We have a small sitting room towards the west of that area associated with a single room so that families can come and gather in that area through there and that room can be used for that purpose. We have a number of clean linen rooms, pan rooms, store rooms and associated facilities spread throughout there with the hand basins in the corridors.

To enable the car park to be utilised by visitors for visitor parking, we also have staff car parking off James Street so that staff can park there and access into the facility straight up the stairs and into that entry, so staff who are working out of hours can have good and easy access to their car for security and safety. We are also relocating the generator, the maintenance and the equipment store over onto the other side of the site adjacent to the entry into the service access, which removes that from the day-to-day traffic for the facility and enables it to be separated.

Ms LEGGE - During our stakeholder meetings we realised that the ambulance service facilities, which were offsite originally, were needing upgrading and redeveloping. It was obvious to us that bringing them into this facility made a good relationship in supporting the volunteers, as well as providing cover for their ambulance and storage and giving them an updated facility to work in.

Mr BROOKS - While we are on the design and the layout, you were talking about the south-west corner where we have the dental services. I remember on our tour you mentioned that the kids use that dental service. What is the proportion of kids using that service as opposed to adults?

Mr HERBERTS - The school dental comes across and the majority of the school kids currently access that service. The school kids from Cape Barren also fly over. As to numbers -

Ms HARRIS - We can take that question on notice, if you like?

Mr BROOKS - The only reason I am asking it - and I am open to the opinion of the community and the people who work here - is that on the south-east corner we have a child health secure outdoor area. I presume that is a play area where they can go outside and do whatever they want, which is a great idea. The dental services are on the other wing. I'm not sure how many kids come through there and I understand why you want to

separate those services for confidentiality, but are dental services confidential? Did you look at putting it over the other side as well?

Mr HERBERTS - The service, in my time here, has been staggered, so we never have a large group of children here at any one time. Obviously their appointments are staggered so you would tend to find that when we have dental services there might be two or three school-age children at one time, so I don't think they would utilise that play area anyway.

Ms HARRIS - Dental services are by appointment. Family and child health nurses often have an open clinic so there are people who drop in for that so therefore it is allowing for the children during that time to play, whereas the oral health is more by appointment only. You come in, have the treatment and go.

Ms LEGGE - And older children probably, school-age children as opposed to preschool.

Mr BOOTH - To get to the point of being fully satisfied that the design provides everything you will need into the foreseeable future, say 20 years, is it a following-budget design or a budget-following design?

Mr COCHRANE - You may have noted from the presentation that we have a budget shortfall at this point in time that we will manage from within the department, as we have with a number of projects that we've had in front of the committee, so we haven't constrained the design to the dollars that were available. We appreciate the logistics of doing a redevelopment in a remote community such as this so we are very much of the opinion that we do it once and we do it right. If that means that we have to find some other dollars to get the outcome that's required, we think that is eminently more sensible than trying to cut things off and having to do it again at a later date where it is going to cost us more money for another tender process and re-establishment of builders and such. Of course there is a sensible envelope that that is undertaken in - there are no extravagances or that we build a facility that is larger than what we actually need.

Ms HARRIS - And ability to build on when needed as needs change. Whilst we can forecast health to a certain level into the future, we do not quite know.

Mr BOOTH - I am just concerned that the design as it is presented will be adequate and whether you, as health professionals, really think there are any shortcomings in the design and in any area at all and, if so, what they would be and whether in fact that has been identified and become part of the design brief so that you can add on as you suggest?

Mr CURRAN - We do have a degree of flexibility with the design that we have. The internal walls that we have for bedrooms are non-load bearing so in the future if we need to take any of those out it does not become a major construction issue like it is or as currently with the construction of the existing building. Because the slab is raised up off the ground, particularly through this area here, it gives us an ability to reservice that building as well so we do not have pipes that are poured into slabs. If we need to come back and change a toilet or if two rooms become one room in the future then we have the ability to do that because of the flexibility that is built into the construction techniques through the facility.

Mr BOOTH - What about from the health professionals' point of view?

Mr HERBERTS - During the planning phase - and obviously Sophie and I, as health professionals, have been part of all of those - we have been putting all sorts of ideas forward and they have all been addressed and made up into the plan so I think from my perspective, I would be quite happy to work in this facility. I think it covers all bases and all clinical scenarios have been addressed in the planning phase so, as a clinician and a nurse, I think it is a good facility and everything we put forward has been addressed in the plans.

Ms HARRIS - The other thing I would say is that this is Sophie's fourth redevelopment so she has gone from one and added and changed things in other redevelopments that perhaps have not quite worked so well from that perspective so she really has that clinician rapport.

Ms LEGGE - It has been a really good learning process going through the different developments and picking really good things that staff have said a year later 'that is the best thing' - such as the lifting frames, whereas they ooh-aahed when we first put them in because they had never used a system like that. The rest of the hospital now from the aged care, for instance, at Scottsdale, it was not put into the acute end and the acute end is everywhere now. That becomes best practice and those are the sorts of things we have been able to inform straight into Flinders which has been really fortunate.

Mr BROOKS - How many beds are there at the moment?

Ms LEGGE - There are 13 and we have put 14 in the new build to have that flexibility and certainly if our funding changes we are able to use that room very flexibly for palliative care, respite - a whole lot of things that we are unable to address at the moment.

Mr BROOKS - Following on from Mr Booth's question, we are spending \$6 million and we are getting one extra bed. Is that going to be sufficient for the long-term requirements?

Ms LEGGE - I think with the population that we have on Flinders Island - and it has been fairly stable - yes. The flexibility will come in the way that we provide services into the future. People like to stay in their homes a lot longer and we tend to find that residents do not come into our facilities until a lot later, until they are very high-need, whereas if we go back probably even 15 years ago they were coming in in a hostel environment and then ageing in process. Now we find that they do not actually come in because we can do a lot more service provision within the homes now and outreach to people and provide that understanding of wellness earlier on and obviously you live longer and healthier. That is the plan.

Mr HERBERTS - And also a way to move forward with healthcare delivery and primary health is to try to address some of these problems in-home and put the services in their own homes. They are in familiar surroundings, family are aware of that, as opposed to uprooting them and bringing them into a clinical facility where you try to make it as homely as you possibly can but it is still a clinical facility.

Mr BROOKS - For acute ones, is it sufficient?

Mr HERBERTS - Yes.

Ms HARRIS - And the ability to provide respite to support them staying at home and to give a carer a break or even to give a person who lives alone a bit more care and socialising. It is looking at that whole model.

Mr BROOKS - Obviously in a year's time we don't want to say, 'We need another couple of million dollars. We need more beds'. It is part of this committee's job, in my opinion, to make sure that we have at least taken that into account in the design stage.

Ms LEGGE - We find on Flinders Island that we have times when we have empty beds. The more flexible model of a multipurpose service allows you to take funding and put it into the home, as opposed to only getting funding for fixed beds. Sometimes we can't fill our beds over here and, because of the inflexibility of living on an island, we don't bring people from mainland Tasmania over here to take up a bed space. We tend to only provide the beds for this community, where in other communities people will move from, say, Scottsdale to Deloraine to find a bed. People don't tend to come to Flinders Island, so you are only looking after Flinders Island and outer islands as opposed to other aged-care services that are taking the needs of others across communities.

Mr COCHRANE - The other aspect of that is that all the inpatient rooms as they are designed at the moment give us the flexibility for aged care. We can accommodate high-need aged-care patients in all of those rooms.

Ms WHITE - You have obviously done a bit of modelling around the demographics but also you mentioned the highest needs from the community for particular services, including diabetes and drug and alcohol services. With the plan you have developed, do you think it has sufficient capacity to meet that demand? Assuming the modelling for the future shows that demographics will be pretty stable, you can be fairly confident that an extra bed will cover it for a little while, especially if you have empty rooms? Considering where the need is for services, is the design sufficient to accommodate that?

Ms LEGGE - What we've found in the facilities that we are upgrading and redesigning is that even our acute rooms, as such, will have access to put a computer in or wireless so we can move a bed, pull it out and accommodate a visiting service provider into those rooms. The rooms are large enough to do that. We have done that quite a lot in our other facilities that have that ability to do it now. That now provides four extra rooms that, if you don't have an inpatient, you are able to block a room off for the day and use that for a visiting service, and we have done that. That has become probably one of the greatest assets in our new modelling, I think.

Ms WHITE - With the design of this, you see that that is functional? Obviously the inpatient rooms are down the other end from where the ancillary services are.

Ms LEGGE - You become very flexible. We are used to flexibility here.

Ms HARRIS - There are some advantages to flexibility, especially in a small environment because people work better together and they are not so siloed off in rooms. There are advantages to hot desking and those sorts of things in health facilities.

Ms WHITE - 'Hot desking', what does that mean?

Ms HARRIS - It means you come in and occupy the room and the desk for the day. You don't bring your belongings and people don't have sole ownership of the space when you need to be a bit more flexible in that space.

Ms LEGGE - At the moment we have two general practitioners here but that won't always be the case, and it hasn't been in the past. Within that wing also we have three consulting rooms so there is the flexibility. It's not often that we have two doctors working at the same time. At the moment even they are meant to negotiate afternoon and morning or days off and days on so that they have that time out. Those rooms become flexible in that specialists coming over can also use those consulting rooms. We are going to have a lot more space than we have at the moment.

Ms HARRIS - And the ability to run group sessions - chronic disease prevention and management group sessions.

Ms WHITE - Going back to the budget shortfall, where do you see opportunities to raise the extra money that is required? With the demolition of this part of the building, is there opportunity to salvage some of the materials for sale and those sorts of things or will it have to come from other budgets elsewhere?

Mr COCHRANE - Not necessarily, until we tender the works and get the appreciation of the industry of what they see it is going to take to build this building on Flinders Island, we will not know whether we have a budget shortfall or how much that budget shortfall will be. One of the first things that we will do when we have a successful contractor is lock ourselves in the room with them and their subcontractors and go through a value engineering session and go through the specification, line item by line item, to see whether we can identify any savings. If that is not successful within the department, we have an expansive capital program and some projects, believe it or not, we bring in under budget. So with the proper approvals through the department and Treasury we can transfer funds within projects.

The other avenue that is available to us is asset sales. If we relinquish an asset and it is no longer required by the department, we can sell it - we did that recently after we built the Smithton District Hospital. We had two facilities that we were able to sell and they were in the business district and realised a reasonable return on that money. That money comes back through Treasury and because the department has an approved strategic asset management plan, we get a minimum of 75 per cent of that money and that money is then put back into general revenue within the department to be reinvested in service delivery initiatives and that comes back through asset management services, the branch that I work with and, again, in discussion with the department, we see if we can reallocate that to the point of greatest need.

Ms WHITE - Could you explain this: you have a price there for construction costs and then site works. Is the site works the demolition cost?

Mr CURRAN - Demolition, then levelling.

Ms WHITE - You estimated about \$200 000 for that.

Mr CURRAN - That came through with our quantity surveyors who put that together.

Ms WHITE - Thanks, I just wanted to get a better understanding of what it all meant.

Mr BROOKS - Did you make allowance for remote location costs, similar to King Island?

Mr CURRAN - Yes.

Mr BROOKS - I have a couple of questions. Are there current local contractors that we will be using or a tenderer that could get the contract?

Mr COCHRANE - Certainly there are some local contractors and Scott has been doing some investigation around that.

Mr CURRAN - The most likely scenario will be that it will be a contractor from mainland Tasmania because of the pre-registration that is required. They will need to be pre-registered for a project up to \$6 million. The contractors that we have been talking to to gauge interest in this project have mentioned that the most likely scenario would be that they would utilise some of the existing resource on the island - things like project management or carpentry or whatever. But obviously it is in their interests to use people on the island because it is cheaper than flying people in but obviously there is a restricted resource on the island.

Mr BROOKS - Did you factor that into your budget or in your costing?

Mr CURRAN - Yes. We have the same remote allowance that we had and really that is -

Mr BROOKS - How much was that?

Mr COCHRANE - It is \$1.2 million I think.

Mr CURRAN - Yes, it is \$1.2 million. So it is quite a bit more than King Island and that really is the thing that is the unknown at the moment, given that our industry is in a slow-down, contractors are becoming a bit keener.

Mr BOOTH - Much cheaper, theoretically, after the floods. That is going to drive a fair bit of building activity, I would say.

Mr CURRAN - Yes. So there are a lot of unknown variables in there at the moment. So really, until we go to tender we will not really know what that number is.

Mr BROOKS - So the town would have the capability to accommodate it if we had to bring every resource in or the majority of resource in from Tasmania?

Mr CURRAN - That will be up to the contractor to decide how he does that.

Mr BROOKS - But you included that in the cost obviously?

Mr CURRAN - Yes.

Mr COCHRANE - Yes, if we were building this in Launceston we would not have any budget problem whatsoever.

Mr BOOTH - If the worst case scenario was that you were not able to source the additional funding, can you still develop the thing and get an adequate facility and what would you leave off if that were the case? Or don't you contemplate that as a possibility?

Mr COCHRANE - From my perspective I am highly confident that we will secure additional funding if it is required. This has been discussed right through our chief financial officer up to the minister's office, it is not me sitting here in isolation and saying that is the issue. It is an issue we have had with remote location with the Queenstown project and new hospital there. We had a budget shortfall and we presented it to the Parliamentary Standing Committee and at that point in time we were anticipating about the same sort of amount, about \$600 000 to \$700 000. When we did get the tender it came in at \$1.6 million. It was just what the industry was demanding -

Ms WHITE - Over?

Mr COCHRANE - Yes, over - to build in a remote location like Queenstown. One of the issues they had was getting staff who wanted to go to Queenstown and work through the winter around there so they were having to pay over the odds of the salary costs that we would normally expect. What we have actually found on Flinders is that this is a very desirable location to come to and people are keen to come here and work here for 12 or 18 months. And the same sort of thing again we were presented with a significant budget shortfall that we had to cover off and again we will undertake value management sessions, value engineering and look for any sensible cost cuts that do not affect the required outcomes to manage that cost.

Mr BOOTH - Could I ask someone to go back to the demographics that you are talking about in terms of assessing the future needs? With the diabetes issue, which a lot of people describe as a pandemic along with an ageing population and so forth, have they all been factored in for the Flinders Island demographics specifically and has there been some sort of study with regard to that?

Ms HARRIS - There have been some studies on diabetes. In primary health we have a diabetes educator who comes to the island three or four times a year and some of that is funded out of the Royal Flying Doctor service funding but they are also part of our primary health service so they could come as often as they are needed. They have been doing some work around people with diabetes type 2 to look at what the need is and where the greatest need is in the northern region.

Mr BOOTH - I was wondering whether there will be adequate aged-care beds, for example. I do not know the population demographic here well enough to be able to say whether you are going to have that problem but because it is a small island you cannot share resources as you were saying before and you cannot just shift someone off to another hospital. Those sorts of things obviously are pretty critical and I am sure you probably have considered them but I just need to understand myself whether all that has been fully factored in. Although you do not have an inordinately large ageing population because of the stability of the place, if suddenly you find that you have a lot of older patients who require beds, both in the hospital part and the aged-care part, is the building designed to accommodate that?

Ms LEGGE - We have not had a huge waiting list ever really on Flinders Island for aged care and at times if you have one waiting placement they certainly come into our acute beds that are not full either. Our beds are there for 'just in case' and to give the community respite. You would probably on average have 10 admissions a month here into those four beds and they would come for a day or two or a week maximum, so there is flexibility for overflow, plus now with the addition of the bed.

Around diabetes and things like that, it is more about early working with communities on maintaining a healthy approach to life, getting out and walking and so on, so it is about engaging communities in those sorts of activities and that is why we can actually engage staff education around how we promote that, how we sit with groups within the community and help them work together on how they might look after their diabetes.

We also have GP North that we work closely with and they have diabetic educators who come out and work with the doctors their clients to try to maintain a healthy outcome for them so that they are living healthier and well.

Ms HARRIS - When there are patients with complex care needs the outreach support comes from the Launceston General Hospital through education, through Telehealth, through sending a staff member over to educate staff here so we are on an as-needs and individual basis. There is a lot of resource put around individual needs.

Mr HERBERTS - We also have a nurse who currently works here who is our diabetic portfolio holder so she basically runs a lot of the diabetic equipment in conjunction with Primary Health North. We provide diabetic foot care through a qualified podiatrist who comes here through some funding. As part of that we train up one of our nurses to do diabetic foot assessments in the interim. We have a full-time community nurse who goes out into people's homes and then assesses people there and if we need to access Telehealth, brings them in. If there is wound involvement we can take photos, send them down the line to a wound care manager in Launceston. Currently that is what we're doing so I can't foresee that will change in the future. It is all that pre-hospital stuff.

Mr BOOTH - So that will keep them from needing to come here?

Mr HERBERTS - Yes. If it gets to a stage where they need hospital intervention, we probably can't provide that here anyway so they will come to Launceston for more acute services.

Ms HARRIS - Especially when they become unstable.

Mr HERBERTS - Obviously we can manage our acute presentations up to a certain level. If we have a concern that they are going to deteriorate in any period of time, we will weigh on the side of caution and fly them off. If the weather closes in and we have a patient who is crashing and burning I wouldn't want to be handling that patient here.

Mr BROOKS - What is the life expectancy of the new building?

Mr COCHRANE - It is 50 years.

Mr BROOKS - This one is 50 years old and doesn't meet the standard in a lot of areas.

Mr COCHRANE - External fabric and such like we would expect to last 50 years. Services, not so much but, again, we are building with a lightweight internal frame so that if we need to access underneath the building to upgrade and move services as required, we can do so.

Mr BROOKS - With the current building, have you spent a fair bit on ongoing maintenance?

Mr COCHRANE - We have over the last few years, yes.

Mr BROOKS - With the increase in footprint of the new facility, theoretically that should reduce your maintenance requirement per square metre. Will it require an increase in the maintenance budget or will it be about the same?

Mr COCHRANE - I would suggest it would be about the same. Certainly the larger items we have had to fund over the last five years such as the replacement of the heating system and the plumbing system, fixing the floors after we had water leaking underneath undetected for a while and the new sewerage system, means it pretty well puts the site in a good position to support this new facility.

Mr BROOKS - I notice you have put in your peak energy demand reduction. Are you looking at introducing the most environmentally-friendly system generations? Within the budget, what allowances have you made for renewable energy and things like that?

Mr COCHRANE - We haven't pigeonholed specific amounts, we just expect that our consultants, as part of their judicious design process, will give us some good-quality environmentally-sustainable design factors. I think you have come across Mr Cooper from Asset Management Services in your discussions on King Island. Greg is a mechanical engineer who is very strong on energy management. He is a green star professional. We will be looking to see if we can key into some programs that have been made available to perhaps look at some supporting wind generation and some other issues such as that. Not so much solar - for a large commercial building the cost of that

outweighs the return. If we can look at some sort of wind generation, we will be trying to factor that in.

Mr BOOTH - You would have solar hot water and double glazing and so forth?

Mr CURRAN - We have 10.38 laminate on the windows, which will add to the thermal massing of those rooms. We are putting insulation into walls and ceilings. The orientation of this building is a lot better. We are creating spaces where you are able to open the windows without the whole room being blown out. There are lots of little things that we are doing to aid that, without putting in the big bangers such as wind-powered turbines and all those things. We have potable water that we collect off the roof that is reused for drinking. We are using the town supply for flushing the toilets. We are being as environmentally friendly as we can, taking the things into consideration that we do have budget constraints with what we're trying to do. We are trying to put those in - low-energy light fittings and all those sorts of things are going into our buildings as standard practice now.

Mr BOOTH - Will you have a star rating that it will meet?

Mr CURRAN - No, we haven't done a green star rating back on this building.

Mr BOOTH - Will that happen?

Mr CURRAN - No, we are not getting the building green star-rated but we are using a lot of the ideologies of the green star rating system throughout the building.

Mr BOOTH - So if you just go back to the window issue again - you are using comfort glass or something are you, rather than double glazing?

Mr CURRAN - Yes.

Mr BOOTH - I think on King Island you were going to use double glazing over there for all the windows?

Mr CURRAN - Yes, there is a lot less window replacement over there though than we have here. So the 10.38 gives us performance nearly equal to the double glazing and when you consider the cost implications of going from the double glazing to the 10.38, you really cannot justify the cost difference against the benefits that you get using double glazing against the 10.38.

Mr BROOKS - The storage space in the new facility, is everyone happy with that?

Ms LEGGE - I am a storage monster. I grab every corner I can, don't you worry about that.

Laughter.

Mr BROOKS - This is our second hospital on a remote island in six weeks I would say. So it is not that we are experts, but we are getting the hang of it. But we saw a couple of areas there where the rooms in use are being used to have storage there. I just want to

make sure that we have absolutely accounted for the storage requirements, filing systems and things like that.

Ms LEGGE - Certainly on my brief and I am continuously trying to grab space for storage and drive the boys crazy, but it is important.

Mr HERBERTS - One of the things we did look at is we gave all staff members a copy of the plans and had a chat with them about it. They are the guys using this so we wanted to know what they think we need. They fed that back to us and Sophie and I, in conjunction with Scott and Simon, have sat down and nussed it out. So currently in this facility there is very little storage, whereas, in the new one there is, what I would consider ample storage at the moment.

Mr BROOKS - So you are comfortable with the amount of storage that has been allocated or planned for?

Ms LEGGE - I think the other issue is that we probably tend to hang onto things that we should not hang onto and that is certainly what we have found in some of our other facilities - people open cupboards and find things they have not used for five years. So we are trying to get smarter in not having clutter.

Mr BROOKS - The budget cost, does that include a fit-out, for example, like the x-ray bed for chest x-rays?

Ms LEGGE - There is a component, but we tend to find other ways to fund those things when we need them.

Mr BROOKS - So is that sufficient money for a \$6 million project to have \$100 000 in equipment?

Ms LEGGE - I think most of our facility equipment over the last couple of years we have been mindful, if we are going to rebuild that this needs to be able to transpose in. So we have been really ensuring with our new beds and things like that, that they are going to meet our needs into the future so that we are not having to spend money on those things. It would be more the setting up of the community rooms and things like that to making sure that they are fitted out. So that is where we would like to spend that money and we tend to get a lot of community money that comes in from fund raising and that gives them ownership of their facility as well. But a lot of our equipment will transpose.

Mr HERBERTS - Our clinical equipment at the moment can be used in the new facility, monitoring equipment and our beds at the moment. We just received six new beds from Hobart and they can be taken to the facility. Laundry can and the majority of the kitchen equipment has been purchased in the two to two-and-a-half years. That can be relocated. There are just a couple of things that we highlighted such as the x-ray bed, which at the moment have not been done. But the majority at the moment is more than serviceable in the new facility.

Ms HARRIS - There is an equipment round of budget occasionally that we can tap into for specific items. So that is over and above.

Mr BOOTH - What are you doing during the knock-down period then? When you demolish, where is everybody going to go while you are rebuilding?

Ms LEGGE - We do plan for that and we have already started moving services into other areas within the community as well and we have negotiated with the university to use the uni house which usually houses community students coming to work in the community and the doctors' surgery will move over there. For dental, we are looking at bringing a dental van over, so we will find a space within the community to do things such as that.

Mr BOOTH - Have you been funded for that external to this budget; is there some funding mechanism for that? I imagine it would be a bit of a logistical nightmare, wouldn't it?

Ms LEGGE - No, you get pretty good at it.

Laughter.

Ms LEGGE - The community is really obliging because obviously the outcome is huge for them, to get a new facility. We find that by working with council and other stakeholders within the community it is amazing what you can rally up. We have Housing Commission homes - there are three rooms there that haven't been used for a long time and we're looking at using those to put community nursing and other allied health people in. We would not need four beds for a period of time and we'd slowly bring those areas down. In George Town, which is a 15-bed facility, I think we went down to eight or nine beds for a while. LGH is very aware of that so they would keep a client for longer while we're doing that. You tend to be flexible in the way you move people around. People make do with a small desk space in the outcome of knowing what they'll have in the end.

Mr HERBERTS - I think the way the stages are being planned is that this is stage one, so this is basically a non-clinical area, apart from the GP surgery, so this is going to be built up into the inpatient facility so we can keep our current inpatient facility intact. Once this is finished and commissioned, we can then bring our residents and patients into the new facility. That has been taken into consideration in the planning phase.

Mr COCHRANE - Stage one also includes the kitchen and service areas.

Mr BOOTH - It just makes it very difficult. It would be easier to have a greenfield site, wouldn't it?

Ms LEGGE - Yes, although we're very lucky with the space on this block. We've certainly had worse to deal with.

Mr BOOTH - Scott, you mentioned the area that is going to be retained and converted, I think, into allied health. Will the doorways be made big enough, or do they need to be made bigger for a hospital bed to get into them? Is that part of the refurbishment?

Mr CURRAN - Hospital beds probably won't go into there. Wheelchair access will go into those doors. That will be for things such as child health, physiotherapy and other allied health services that aren't over in the GP area. We're really looking to try to keep that

area pretty much intact because it converts into offices and consulting rooms quite easily. To convert it to bedrooms we would have to redo the doorways, upgrade the bathrooms and a number of other things that would be quite costly. That would mean it would be touch-and-go whether you could keep it. Given the services that are going into that area, we talked about hot-desking before - they are the rooms where you share a desk with somebody, you lock your things in a cupboard and only use it for one day a week or one day a fortnight. It really is prime for that type of service delivery.

Mr BOOTH - In regard to the operation of the hospital, do you have shared services where you have private practice coming in, such as dental services and so on? On King Island they are sharing nurses, for example, and other staff. How do you cope with the OH&S, insurance and liability issues where you have a hospital nurse helping out the dentist, for example?

Mr HERBERTS - In the case of a nurse helping out a dentist, we don't really have that. With our private dental and health care providers, we enter into a service agreement with them and that is put down through Primary Health North. They are given a contract, they sign it and get back to us. They have to have proof of professional indemnity insurance and practising certification. That side of things is all covered through the service agreement.

Mr BOOTH - So there are no liability issues that could flow as a result of some sort of mixed jurisdiction?

Ms HARRIS - They normally have to have their own public liability insurance - up to \$20 million, I think.

Mr HERBERTS - Professional indemnity is \$5 million and public liability is \$20 million, I think.

Ms HARRIS - They need it to enter into that lease agreement.

Mr HERBERTS - As for them utilising our nurses, that really doesn't happen here. The private dental providers bring their own dental nurse.

Mr BOOTH - I was just using that as an example. I was just wondering how you dealt with that and it sounds as though you have with insurance and so forth.

Ms HARRIS - There tends not to be that level of sharing of staffing in a lot of our areas.

Ms LEGGE - If they do, we broker them and there are brokerage arrangements.

Ms HARRIS - The Royal Flying Doctor Service provides a service and through a service agreement with them we might provide an enrolled nurse to help run a clinic or something like that, but that is through a service agreement and through scheduling we cover off all of that.

Mr BOOTH - You mentioned I think that the RFDS has provided a whole lot of facilities here - what are they?

Ms LEGGE - Services?

Mr BOOTH - Yes, or facilities, wasn't it - some equipment or something?

Mr HERBERTS - We are in the process at the moment of working through and finalising the purchase of some equipment to formulate a rehab gym. We had discussions last week or the week before with the RFDS and have given them our research on the equipment required and I sat down with the physio in this particular instance and we worked out the budget we have and the equipment we need to formulate that and that has been passed onto the RFDS. So it is looking promising that that will occur in the near future.

Ms LEGGE - That is part of our funding for equipment that we utilise.

Mr HERBERTS - Once that is underway we can get people who have had hip replacements, knee replacements and shoulder reconstructions back on the island earlier and sooner, which takes the pressure off the public system and the tertiary referral systems. When you get them back here to their homes you tend to find that their recoveries and outcomes are much better.

CHAIR - In terms of accuracy, we might liaise with you, Bill, because throughout the report there are references to things like 'commencing in the second half of 2010'. We will liaise with you by telephone so we can get some accuracy into this before we report rather than just regurgitate your submission.

Mr COCHRANE - I am happy to do that, Mr Chairman. That pictogram on page 25 is our current program and I noticed when I looked at the executive summary that it said we had finished at the end of this year and in fact we will not be.

CHAIR - So we will do that because it is no use us, as I say, just regurgitating your submission and having incorrect references. So rather than take up any time discussing that now, that is the process we will follow.

I just want to have a look at the mention here in the submission that the original project brief was prepared in 2001. Is that accurate; is that when the original project brief was prepared?

Mr COCHRANE - I think it was. As this report says, the department, predominantly through Asset Management Services and Primary Health, could see that there was a huge issue with our rural facilities and the condition they were in. So we put together a generic brief for a lot of our primary health care facilities, our rural facilities, about what we thought they needed to do, and that was to have that combined inpatient, allied health and primary health focus. Then, of course, each hospital or facility we have until its redevelopment has discrete requirements and so a project-specific brief for each of those projects was developed to make sure the outcome meets the needs of the local community.

CHAIR - So it has been a fair while coming, then, given that original project brief was developed back in 2001?

Mr COCHRANE - It has. King and Flinders will be the final old district hospitals to be redeveloped. Since 2000 we have redeveloped all of the old district hospitals, as they were known.

Ms HARRIS - So it has been a staging process around priorities for all of our rural district hospitals to become multipurpose services and centres.

Mr BOOTH - But the design is contemporary now? It is based on today's data rather than 2001?

Ms LEGGE - Yes. It was when Primary Health was in its own entity and the big regional hospitals came under Hospitals and Ambulance that Primary Health really looked at their facilities across the State and started planning for their upkeep and maintenance. We have just come to end of that time and of course we have flipped back into the regional again. Thank goodness we've all updated - we're happy.

CHAIR - Given the nature of the community being reasonably isolated, similar to King Island, is there any need to upgrade the Telehealth facilities or does what you have here been serving the purpose?

Ms LEGGE - We upgrade them as they are needed - that is ongoing - and we have just upgraded the one on Cape Barren Island last year because we were having problems with that one.

Ms HARRIS - This one is much less cumbersome than what was here before.

CHAIR - Is the current system meeting its purpose and likely to into the near future?

Ms HARRIS - From this end, yes.

Ms LEGGE - They have gone from an almost three-phase power set-up originally to now where you can put them into any computer socket basically, which means they are really flexible. We can move them into patients' rooms and into different rooms around the building, where before we were very keyed into where it was put in the beginning and that is where it stayed, but now we can move them anywhere.

Mr HERBERTS - The cupboard behind you, the grey one, is our old Telehealth cupboard and we have gone from that to that machine there. I occasionally have it in my office to have videoconferencing and we can do that in a number of areas. Our new facility will have access for that machine in all areas.

Ms LEGGE - We have certainly been mindful about the staff spaces so we can pull those into the staff spaces now and utilise them for staff education and things within their environment without taking up the room like this, which would be a community space. That has been wonderful and we have done that in our other facilities already that have been upgraded; we have that capacity now to just wheel it, which is really good.

Mr BOOTH - Would you like to expand in regard to this end of the Telehealth circuit?

Ms HARRIS - We are looking at ways where we can have medical specialists on the other end and working in different models of health so that our GPs have access to medical specialists with the patient involved, so there will be a lot more Telehealth and videoconferencing.

Mr BOOTH - Is that currently an impediment to your utilisation of it?

Ms HARRIS - No. We use it with the diabetes educator and Barry talked about the LINC person. We have LINC people in all our sites. The diabetes educator runs education and support sessions for all the LINC people so we use it a lot through education and through meetings. As to the Telehealth side of it, we are looking at ways we can get better utilisation of it.

Mr HERBERTS - I can vouch for this as I have just been through it personally, having been in a car accident. I had a number of sessions with a psychologist in Launceston and had both face-to-face meetings and some through Telehealth and I can vouch that there is no difference. It is just as personal and the service is just as effective as sitting this far from each other, and I found it a huge benefit, otherwise I would have had to jump on a plane every time I needed to see that person and feasibly it is really difficult to do living where we live. To have access to that is a huge thing for the community.

Mr BOOTH - So are you saying that we should have done this by teleconference, perhaps?

Mr HERBERTS - You could have done.

Ms HARRIS - Except you wouldn't have had the walk-through unless it was a virtual.

Laughter.

Mr LEGGE - Our rural facilities have used Telehealth now for over 10 years so we are really proficient in it. I would say probably over half of our communities are across where we link up six, seven and eight sites together and we will have a meeting regularly each month like that. It is about engaging our big regional hospitals. They are not into that mode yet. They have not needed to be as they are self-sufficient, but because we are not and are limited in the way that we can educate staff, if you take two or three staff members out of any rural area you suddenly have an issue of how to staff on the ground or how you backfill and things like that. So for us it has been a fantastic medium for education and bits and pieces like that. We are now starting to use it more and more for patients but we do find it is really hard to get the specialists at the other end because if they are working in that busy LGH environment to go into another room to do Telehealth would be an issue for them. So we are looking at ways at our end and that is why Maribeth is talking about the other end where we can get it on their laptops and they can do this now so that they do not actually have to leave their rooms anymore, they can do it by laptop.

Ms HARRIS - And the resolution of zeroing into the wound or whatever and then being able to send all the pathology data. Certainly the CEO of the Northern Area Health Service is very committed to advancing electronic media wherever he can.

Ms LEGGE - We are taking them into our accident and emergency areas and having that link-up while we are waiting for air-lifting out and things like that. That has been a huge benefit where they can actually see the client at the other end. It is good. But it is, as I say, getting them involved in that and understanding how important it is for us to do that.

Ms HARRIS - As Barry personally found out, being asked to attend an appointment this afternoon in Launceston is not always that easy.

Mr HERBERTS - They ring up and say, 'Your appointment is at 3 p.m.' and it is 11.15 a.m. - 'All right then, start without me.'

Ms LEGGE - Resources to get community members into an appointment that takes 15 minutes can sometimes mean a four, six or seven-hour trip plus a volunteer who needs to put them in a car or a van or whatever to get them in there, only to find that they have either postponed it or it is seriously only a five or 10-minute consultation and they are back home again. It is a huge thing for an older person to do that and the resources it takes to get them there. We have linked them up - stopped the process - to do it via Telehealth and the individuals have had that five-minute consultation only to be told to go back to see their GP from now on, and you just go, 'Thanks'. We did stop that.

Ms HARRIS - Certainly with the new integrated care centre that is being built in Launceston there will be much better linkages, especially around the Telehealth side of things.

CHAIR - Onto the project schedule. Your document indicates that you want the tender advertisement to appear on 29 January. You would be aware that, even in the absence of our reporting, you are at liberty to go ahead with that process with the caveat that in the event that the committee did not support the project, the people who are tendering know that. If you are going to stick to that schedule then clearly that staging program would still be achievable, so is it still your intention to advertise at the end of January?

Mr CURRAN - I think Saturday 5 February is the date we are proposing to advertise at the moment.

Mr COCHRANE - I have taken advice from my consultant but I think he has been very generous to the builder in the time frame he has given them for some of that staging. I am hoping we will be able to pull that back a little.

CHAIR - That is fine. I just wanted to mention that you do have that flexibility if you want to exercise it in the event that we have not reported by that time.

Mr COCHRANE - Thanks, Mr Chairman. We are aware of that and we have factored into our documents that it is all conditional upon your approval.

Mr BROOKS - Just a quick one on the community room - the one that we are in, obviously - getting replaced. Are you happy with the size of that? It seems to be big enough and everyone should be quite pleased.

Ms LEGGE - Definitely, and the ability to be able to move the tables and chairs into the storage spaces means that room becomes even more flexible.

Mr BROOKS - Yes. I had to put my glasses on to see the tea room there but I did see it eventually, so that's all right.

Ms LEGGE - The other component of that is that if people are wanting to use that after-hours, we will eventually lock down access back into the hospital environment so that remains safe.

Mr BROOKS - Through that lobby doorway?

Ms LEGGE - Yes, so that people can come and then just shut down and that is secure.

Mr BROOKS - Airconditioning. I see we have some fairly new splits around and splits due to cost requirements elsewhere. It will be using split systems?

Mr CURRAN - Yes, and we are looking to pick these up and use those through other areas that we are redeveloping. So none of those will go to waste; they are all being recycled.

Mr BROOKS - And you budgeted for your airconditioning requirements?

Mr CURRAN - Yes, we have.

Mr BROOKS - Will that be in every room?

Mr CURRAN - Yes, it is, I think, at this stage.

CHAIR - Okay. Thanks very much. We appreciate the evidence which has been given. We now, of course, as some of you are aware, need to ask you to leave so that we can deliberate on the project, as we are required, in confidence, and then one way or another, we will be reporting as soon as we can.

THE WITNESSES WITHDREW.