THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT DORSET COUNCIL CHAMBERS, SCOTTSDALE, ON WEDNESDAY 13 JULY 2005.

SCOTTSDALE NORTH EASTERN SOLDIERS MEMORIAL HOSPITAL REDEVELOPMENT

Ms MAUREEN NICHOLS, DIRECTOR OF NURSING, SCOTTSDALE NORTH EASTERN SOLDIERS MEMORIAL HOSPITAL, **Ms SOPHIE LEGGE**, ASSISTANT DISTRICT MANAGER, NORTH EAST, AGED AND RURAL COMMUNITY HEALTH, **Ms SIOBHAN HARPUR**, ASSISTANT STATE MANAGER, AGED AND RURAL COMMUNITY HEALTH, **Mr ANDREW SMITH** AND **Mr GARTH MURPHY,** BULLOCK CONSULTING, **Mr BILL COCHRANE**, PROJECT MANAGER, AND **Mr BEN MOLONEY**, PROJECT MANAGER, CAPITAL WORKS, CORPORATE SERVICES WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome, ladies and gentlemen.

Ms HARPUR - I am going to be fairly brief and just give you a little bit of context, and then I am going to hand over to Andrew Smith to give you more of the detail of the project development and its design. I will tell you a little bit of background, first of all a little bit about rural health in the broader context, then about aged, rural and community health, which is the area of health that we are part of, and then Scottsdale itself.

In terms of rural health services, there is obviously a much smaller agenda and a State agenda for rural health services, which has been changing probably in the last decade with the Healthy Horizons Framework as one example which was initiated by the Australian Government in 1999 in trying to look at some of the needs for rural Australians and their health needs. One of the goals in the Healthy Horizons Framework which we are still very much working to is the goal of developing flexible coordinated services, and certainly with the redevelopments where we have those opportunities in Tasmania we look to the opportunity to make health facilities an opportunity to bring services together in a flexible and coordinated way. The Tasmania Together goals are also being reminded of, with 5 and 6 in particular being of particular relevance to us. Goal 5 is to improve health through the promotion of a comprehensive approach to a healthy lifestyle, and goal 6 is to improve the health and wellbeing of the Tasmanian community. Again by the Healthy Horizons we get delivery of coordinated services.

Just to give you a context for ARCH itself - that is the acronym by which aged, rural and community health services is most commonly known - we provide a wide range of different types of services, inpatient, residential aged care and community health services, and that is a list of the types of facilities we have across the State. We basically have about 35 facilities on the islands, right through the State, down to the island at the other end of the State, down to Bruny. We have 10 district hospitals, five multipurpose services or centres, and 15 community health centres, and then we also have

arrangements with five councils or NGO sites where we provide departmental funding but the services are managed locally by either councils or, in the case of Longford and Swansea, by a non-government organisation. ARCH itself is managed in five districts, so Scottsdale comes into the north-east district. There are the north, north-east, south, south-east and north-west making up the whole, and regional bits have their own management.

To bring us back locally to Scottsdale itself, there was a health needs study first of all in 1998 in Scottsdale, which was updated both in 2003 and 2004, and all three of those would have given some of the background to the need to redevelop this facility. We have a range of health facilities over and above the inpatient acute and community services that are based at the facility itself, one of which is a partnership we have with Dorset Council to provide regional health services programs, which is Australian Government-funded, and the community health services provided through that are based around the hospital itself and out of the Council Chambers. There are other departmental health services that visit Scottsdale, and one of those is Family and Child Health, and one of the opportunities of the redevelopment of the facility is to bring some of these services together.

What we were aiming to do in approaching this redevelopment was to provide a new and integrated facility that enables us to provide comprehensive, accessible and integrated services to individuals and communities within the catchment area, and the aim of the project is to provide a facility that is more than the hospital itself, so it combines the function of the hospital, the residential aged-care facility, but also provides the opportunity to substantially improve the facilities for the community health services that contribute to the community in the improvement of health and wellbeing, so to provide an integrated and coordinated overall facility.

I think that just gives you a little bit of background to then move on into the design itself and the overall approach.

Mr SMITH - I will start with the purpose of today and the documents that have been tabled and represented. Basically, in summary, we are confirming that the investment in the infrastructure is appropriate to support improved health facilities for the area, and is consistent with departmental strategies and management plans that are in place. The design has gone through a range of valuation stages, reiterations on the design and involvement with stakeholders to ensure that what is being put on paper and being put out to tender is suitable for this area and for the needs of the community, and that what we are trying to do is value for money. They have been the main aims of the whole process.

We will start with our budget. Construction is bordering on the $3 million mark in round terms, and then there are other components that make up the total budget. As you can see there are buildings, there is an allowance for furniture and equipment. There is the fit-out, which is a small component for the facilities in operation. There are some funds available within the budget for minor works that are needed. There are professional fees. There are contingencies initially to cover design changes, but long term, once it is out and being constructed, any issues that arise on site. That basically gives you the total budget of $3.7-odd million. Within that at the moment there is a 9 or 10 per cent

contingency which the consultants were not able to use and some of these other items basically are outside. So the main building is approximately the $3 million.

Going back a step, that budget originally was a total of $2.9 million and then with the increase in building works additional funds come on line later.

Mr MALONEY - So the additional funds were primarily to address inflation of building costs within the industry.

Mr SMITH - Yes. There is a fairly large impost on tendering at the moment where tender prices are increasing rapidly, based on the buoyancy of the construction market, which makes it difficult for estimation to occur, but also difficult for budgets that have been approved in prior years to when the project commences.

The main focus of the redevelopment and the design approach is to make sure that the facility can remain in operation while the works are undertaken, so that has been a major part of our approach collectively as a project team. This diagram we are displaying here is part of the tender documentation that will be going to the contractors. There is a text that accompanies the preliminaries of the contract which basically describes the process of how they are going to effect the work.

Zone A is the new extension generally to the James Scott Wing, with the majority of the works occurring outside the existing building line, which allows the contractor to make a good start and get a lot of work under way before they even enter into the existing facility. So that is a good, sizeable portion of the project which will attract contractors to make a good start and get on site and make a good presence on site. There is a small section at the tail end of that initial zone where they will take over some bedrooms, and presently there is scope for those areas to be relocated within the hospital where there are spare bed areas available.

Once Zone A comes on line, that is contractually handed over to the facility as a separate apportion on the building contract, so it has to be fully functional before any works are handed over in the next stages. That allows complete access for the residents and staff and services for 14 new bedrooms as part of the extension, and what that means is then in Zone B four bedrooms and some of the existing wards can progressively be upgraded with capacity in the new section to take care of the residents. The main aim there is that by February the additional five aged-care bed licences are to commence. So the project has a very tight time line and it is basically to allow the facility to take up those licences that have been granted, because if we lose those there are funding implications.

Zone B is basically the balance of the James Scott Wing, which is the high priority which was determined at the value management workshop, and there are smaller areas that occur within the hospital progressively, and some of these areas can commence. So Zone C can commence while B and A are under way. There is a schedule of when things can occur, so obviously we need to grab the new emergency before we can put physio into the old emergency, so there is a sequence that has to be followed. That has been explored, and basically it has been rationalised. The priority is the James Scott Wing additional beds by February, and then the other zones can follow on, based on a reasonable time period for the contractor not to put on increased tender costs for too short a time factor.

Basically a lot of these objectives already been mentioned. Again it is a summary of the total document. We are providing a contemporary hospital and an area for the provision of community services, health services and activities to ensure that the facility remains sustainable in the long term. There is quite a value of building stock there for the State, and obviously if that can be maintained in its life cycle for a longer period then that is looking after the State's interests.

As part of the design process we have looked at the flexibility of the current requirements, plus through the process an overall long-term plan was looked into. The current funded aspects of the long-term plan keep being designed with an overall view kept in mind, so funding later projects that come along can occur with minimal disruption.

A big issue for the James Scott Wing is to make sure it complies with aged-care standards. Four-bed wards become non-compliant in 2008; we must have single beds, though shared ensuites are okay. Generally, multiple-bed wards are a thing of the past.

The five new residential aged-care licences were discussed and basically provide facilities that volunteers and people in the area can use and be attracted to. They will help the community in the delivery of service.

The other part of the brief and process is to try to achieve areas where additional services can be offered and delivered from a central location, so to bring child health into the facility and to attract other visiting consultants to that area.

As part of the approach, the main aim with value for money was to try to achieve, where possible, relocation functions without building work involved. Looking at a global planning approach, we were able to reposition functional areas in the existing facility where possible so that the facility can operate in a better fashion and have a clearer definition of public areas and acute hospital areas. At the moment it is fairly disjointed.

Again, the aged-care standards and improvement and expansion of accommodation use the existing parts of the building where possible. It is a large building at present and by consolidating usage and a large extension, with the exception of the bedrooms that needed to be added and new licences and to convert four-bed wards, most of the project has been contained within the current arrangement.

Changing community needs - I think Siobhan has covered most of those issues. Basically, there are changes and involvement in the delivery of services, and the facility needs to be brought in line with current requirements to allow those to occur.

The existing facility was constructed in the early 1970s and has had some additional work done and some extensions to the James Scott Wing were added. The age of the building and the design approach at that stage and construction techniques, mean that it is a fairly robust and solidly-built structure, minimising building work to that part of the facility where possible and obviously reducing costs and maintaining value in the budget to be expended in other areas. As standards have evolved, it is well below areas to do with occupational health and safety, sizes of rooms, and ability of staff to assist. With current electrical requirements we have protection zones and there is a whole range of

areas where the building has fallen behind what was deemed to be contemporary standard.

Accident and emergency is currently located, as we saw on our tour, well away from where the nurses' areas are. There are difficulties there with staffing, observation, safety for staff and also being able to deliver services to the public. The ambulance service currently is occupied there, leading into the accident and emergency area. The maternity unit is located there. Physiotherapy is at the far end of the acute area so the public needed to traverse the building, if they are coming in from the outside for consultant-type services to do with a physiotherapy appointment. The occupational therapist is in a small area in the James Scott Wing.

There are several small office areas in the vicinity for the community health nurses. They are scattered around, using leftover areas, there might be two or three people sharing an office.

Radiology was recently upgraded and it was deemed, during the value management, that that should stay where it is. In the long term and in current plans that we are looking, it its location suits the plan, so that was deemed to be a valid reason to be there.

There is a small existing dental service near the front entry which, again, suits the planning and should be part of the public consultation area. It is around the central waiting room.

As to visiting services, there are offices and small areas that we use at the moment which really need to be consolidated into a clear, defined area facility so that it is clear, if you are going there for a certain function, that you know where to go to. There is an overlap of functional areas. Some offices are used by more than one person.

The operating theatre in our planning was identified as being of a very minimal use in the current services provided. Previously it may have had high usage. There is a very large area of the facility on the outskirts, planning-wise, and it would be better suited as more of a service part of the facility, like a kitchen or something along those lines, but funding-wise it wasn't deemed appropriate in this current plan to relocate the kitchen. Long term, as the operating theatre became redundant with centralising of surgery in key facilities, that is a large area of the facility that will be available. That would then allow some other upgrade works to occur. In summary, the planning is looking at current needs plus making sure that what is put in place under this approved budget can be easily added to later.

In summary of the project, the original proposal was in 2001 and funding was approved three or four years later, which is where the additional funding had to be sourced based on the increase in constructions costs that occurred. The health standards and needs of the community have changed over that time. Since the start of the project in January, we have been involved in the design and discussing with stakeholders and community on several occasions as to what their needs are and what their wishes are for this new development.

As part of that, several issues that weren't part of the original brief have come on line. They have been, where possible, incorporated. Generally, there has been an increase in

the size of the new aged-care beds to comply with current standards. We have been able to upgrade six additional aged-care ensuites so that they can be used. Currently they are not even used because they are dangerous to staff and residents.

Mechanical services - there are areas in the facility that are approaching the end of their life, like the heating system in the James Scott Wing. It is not functioning. We have been able to address some of those issues. A complete upgrade of fire safety and fire protection in the whole facility was deemed a high priority. Where possible we have created single-bed wards to replace existing double-bed wards.

A recent additional item for the budget, which was not part of the original scope was that new electrical standards required a higher standard of protection for patients in the James Scott Wing, and in six outside. Previously only the key treatment accident and emergency areas had adequate protection. Which means that a lot of the existing wards had to be rewired so that they are safe.

So by rationalising and having fairly close consultation with various bodies, the project team has been able to incorporate some of these issues without detracting from the original scope of the findings that the project should address. Ben and I deal fairly directly as a meeting point between the relevant parties that make up the whole project. So I am representing Bullock Consulting and we have some subconsultants who are working closely with us to prepare the documents for the tender. Eventually we will be dealing with the successful contractor and dealing with the project work.

We have met on a regular basis. We have had a very short time frame based on the January 2006 deadline for the aged-care bed licences. We have had generally weekly meetings and, where suitable, fortnightly meetings to ensure that issues can be raised and put out for comment and fed into the design process. We have had several sessions on site with the stakeholders and that has included presentations to the aged-care residents and their family members so that they are all aware of what is happening. We have had staff sessions. This basically ended up in the value management workshop where all the items that were described and put forward as 'this would be desirable' were tabled, given a priority, weighted, and then taken away and the project group is able to rationalise the final brief for the project so that we can maximise what was being delivered with the available funds and to achieve the highest priority items.

Some areas that were shown in the long-term plan as being hospital wards and ensuites in several years' time will be ideally used as offices or support areas. Obviously we would not treat it as a high priority to upgrade those ensuites, so we are looking at upgrading key areas and there is no wasting of the funds on areas that don't suit the total planning of the facility.

These images are based on our initial submission we put forward which showed our approach to the planning of the facility. It is the staging and collection of areas to try to achieve a better functional arrangement of the services in the facility and to allow the operation of the facility to work better for staff, patients, residents and the community.

We have 14 new single wards in the James Scott Wing with shared ensuites that meet current standards for both disabled and staff assistants' access. We have installed equipment like grab rails, nurse call systems and those sorts of items. Privacy is another

major aspect. Even though the ensuites are shared, they incorporate systems like the nurse call so that if a resident is using the ensuite from one side, the door on the other side locks, so there is enough privacy and direct access between bedrooms by one resident is prevented.

We are looking at expanding the patient lounge. At present the central lounge in the James Scott Wing provides dining and lounge facilities for the whole area for all the aged-care residents. We have added five additional residents and already it is difficult on some occasions with the current numbers. So we are basically converting the main central combined area to be a dining area and then providing additional lounge areas scattered around the facility. As to the privacy issues, when we have residents who may have difficulties with eating, or other ailments, often smaller, more intimate lounge areas that are sheltered from the public view are better and provide privacy.

Whilst the nurse station was deemed a low priority and, as discussed on site, the staff would rather see the residents looked after before the staff are given new facilities, we have managed very effectively to increase the size of the nurse station in the James Scott Wing.

Another issue is the area that currently leads directly out into the open. We have provided a courtyard area which will be planted out and landscaped so that the residents can wander through and around the facility and the staff will know they are safe.

The whole facility gets a new nurse call system, fire detection system, and that incorporates warning systems and intercommunication, with medical emergency staff carrying portable phones to talk to other departmental areas without breaching fire doors and smoke doors. So there is a full intercommunication system.

We are putting Accident and Emergency in a position close to the nurses station to make sure that the problems that are currently there with staffing and observation can be addressed. We are enlarging the nurse station so that there is adequate room for the numbers of staff, the functions required and, again, for the privacy aspect. We have upgraded in the order of 10 beds so that they are single beds with a shared ensuite, complying with current standards. We are renovating the existing public toilets off the foyer to comply with universal access requirements - that is, disabled access provisions. We are reorganising and basically rebadging doors to create a central area for consulting rooms so the public come to a waiting area and then are directly led into offices and rooms for physiotherapy, dental, X-ray, podiatry, speech therapists et cetera. It is a one-stop sort of area for the public. Areas that have become available in the planning process can be used for support areas for offices, which again has been a valuable exercise for the budget; areas with minimal work can become a functional improvement for the facility.

All the way through the design process the value for money has been a high priority. Based on the level of funding, the issues with the increases in building costs, we were mindful to maintain as much of the high-priority items as we could for the available funds.

We followed this through into the construction process and the approach to how we would build the new additions to the facilities and looked at how we renovate areas.

Previously I mentioned that the facility was fairly robust. It was constructed using wet trades and traditional techniques of brickwork and blockwork, which is a slow and time-consuming process and with the current building climate you really need to have a faster technique of erecting a building and allowing it to be wrapped and occupied so that the services can be installed. We are looking at lightweight, suspended concrete floors on steel work that can erected quickly; more domestic-style framing of roof structures so that the building can be wrapped and made weatherproof in a short time to allow all the services and fit-out to commence. Timber framing can be erected in the rain; laying bricks and blocks.

At the moment with design documentation we are aiming to tender in the next week or so, subject obviously to approvals. The tender documentation is in the final stages. Advertising is mid-July and, all going well, we will award the contract by the end of August. These dates have basically been set in place from January this year to achieve January 2006 as a priority for bed licences.

In summary, the redevelopment will provide the local community - there are 7 000-odd people in the area who rely on this facility - with an upgraded facility that meets contemporary standards and allows delivery of health and community services. The project control group has carefully addressed the design issues. We have involved the stakeholders and we have done what we can to make sire the project is delivering what is intended. We are recommending that it is providing value for money for the community and for the State in the approach and what we are delivering for the budget.

Basically, this appendix is taken from the submission where there were items that were originally in the brief, items that were then, if you like, being evolved into the recent brief and what was identified as being ideal in the long-term, and then obviously to design at this stage what has been addressed. You can see the new dining area for the James Scott Wing, for example, which is a central area. It was not included in the original brief but it has been achieved by adding additional lounge areas, converting four-bed wards, and you end up with a larger lounge area.

The large nurse station in the hospital section was given an essential rating, in the high priority. It was part of the original brief and has been carried right through into the current and long-term. It is almost a doubling of size of the current facility. That leads directly to the new accident and emergency, whereas currently that is over here. There are clear benefits. There is a minimal building extension. We have maintained, while being able to relocate and improve the functionality of the existing building.

CHAIR - Thanks very much, Andrew.

Mr COCHRANE - I believe that is the bulk of our presentation, and we are more than happy to receive questions.

CHAIR - Thank you. Any questions.

Mrs NAPIER - Thank you for the briefing today and for that comprehensive overview. You say the operating theatre is currently used probably only one day a week, and for minor surgery. If you also look at radiology, who provides the radiology services, X-rays et cetera?

Ms NICHOLS - We have a local semi-retired radiographer.

Mrs NAPIER - Employed by the Health Department or is it outsourced?

Ms NICHOLS - Employed by the Department of Health and Human Services. They are permanently based here.

Mrs NAPIER - I was just interested in comparing it with the Queenstown situation. Who provides equipment? Does the State provide the equipment?

Ms NICHOLS - Yes.

Mrs NAPIER - Okay. So it is not outsourced.

Ms NICHOLS - No.

Mrs NAPIER - And does that do full-body or just half-body or body-part X-rays?

Ms NICHOLS - No, full-body X-rays. We don't do certain scans and things like that, but we do a full range of X-rays - abdominal, thoracic, arms, legs, back.

Mrs NAPIER - Treatment with TeleHealth and so on sometimes uses those facilities and then taps into, if need be, a specialist, whether they might be at the Royal Hobart or wherever. Where are the TeleHealth facilities in this facility?

Mr SMITH - As part of the nurse floor and fire protection upgrade, communications are being provided to the consulting areas. The current standard of network wiring is all that is required for Telehealth to be plugged in anywhere in the hospital. It is a standard network.

Mrs NAPIER - Okay, so that will be built into those consulting areas that are to be developed.

Mr SMITH - Most of the Telehealth unit, if you like, the trolley with the equipment, can be wheeled to any area, plugged in and can be worked through.

Mrs NAPIER - Okay, so it is planned to have it in this facility?

Mr SMITH - Yes.

Mrs NAPIER - And while we are talking about that kind of thing, what is 'electrical body protection'?

Mr SMITH - Basically any procedure that would be linking a person to an electrical appliance which is then plugged in. You have probably heard of RCD protection, which is residual current device. If you attempt to get electrocuted somehow, the switch will flick off in only milliseconds. This is a much more stringent version of that.

Mrs NAPIER - It is like a circuit breaker but it's almost instant. Generally, something that is attached or inserted into a person needs to have this high level of protection because there is a direct risk; there is something connected to the person. If there was a procedure in the James Scott Wing requiring that they be taken to the hospital section, the hospital is deemed to be requiring an upgrade of all the circuits. There is that circuit breaker function at the required level to protect the patients. That is the current Australia standard that has come in this year.

Mrs NAPIER - It has just come in this year. What time frame was allowed for not just this facility but for other facilities to be compliant?

Mr SMITH - Generally, under the building acts and code, it's okay if the facility isn't having any major work done. This is a grey area if, say, it's a minor work you paint the room out. When it was constructed it would be deemed to comply. Certain things have to be upgraded. Often there is a risk to the public from broken glass beside doors, so some facilities required upgrade for evolved standards. I am not sure about what time there is for other facilities. Based on the level of work occurring in this facility, it must be done.

Mrs NAPIER - Because it's being upgraded?

Mr SMITH - Yes.

Mrs NAPIER - We did discuss this when we were at the hospital, but just for the record, the dental area is deemed as being desirable. I am familiar with the fact that there isn't a dentist in Scottsdale. If the dental area was to be enlarged, would you expand into the boardroom? How would you expand that? I think in a Deloraine equivalent, the dental facilities there were developed such that if you were going to provide a package to attract a dentist into Deloraine then everything was there for them to work in. What are we looking at here in this facility?

Mr SMITH - At this stage, it was identified as part of a future master plan for the facility. It was extended and provided with more storage space. Apparently the corridor area running past it leads to the existing board or meeting room, which is at the moment being maintained. Long term that corridor would disappear, which would provide some 20 per cent increase in size for that small dental area; they could take over the corridor, plus some storage facilities that are being looked at. At this stage, in the current budget and the prioritisation of what was required in the hospital in the James Scott area, that was a low priority. The upgrade works that are being documented, if you like, have kept that environment for any works occurring nearby. So there is scope in the long term for something to happen there if funds are available, but at this stage no work is happening.

Mrs NAPIER - I accept that. What kind of funds are you looking at to develop the equivalent of the kind of facility that was provided at Deloraine, or at least something that would attract a dentist, whether a private or public dentist?

Mr SMITH - At the value-management workshop the overall cost that was tabled was in the order of approaching $5 million for the whole facility, incorporating all the works. The funds that are available at this stage are in the order of $3 million. But there are a whole lot of other things that are involved. With dental, you would really have to explore a

layout for it and then have it costed. It is a bit hard when you don't know whether it is adding another chair or adding five chairs.

Mrs NAPIER - Quite often this hospital provides respite care for younger people with a disability - and I am particularly familiar with one from Bridport. What plan is in mind for respite facilities for young people with a disability? Quite often young people with a disability need a spot where it is noisier. You might argue that we will develop other kinds of facilities closer to town or whatever. What is the thinking at the moment about the capacity for this hospital in providing respite accommodation for young people with a disability?

Mr SMITH - I suppose, as a starting point, the aim of the redevelopment is to consolidate those sorts of functions to a central location. The overall guidelines for the project were to achieve that. As far as a dedicated respite bed is concerned, at this stage there is nothing in the plan that says, 'I'm definitely a respite bed' but by upgrading some of the existing wards in the acute section, and even the provision of the office near the James Scott Wing new entry which we are constructing there, that can link into the first ensuite. Even though the door isn't indicated, we are providing in the documents that a doorway is built and plastered over basically so that, if a door is needed for that function, a door can be fitted. But by converting the two and four-bed wards to singles with access to a shared ensuite, then depending on demand and patient numbers in the facility, there is privacy available and rooms can have that dual purpose. I suppose our prime approach has been where possible to have flexibility in the usage of rooms. The respite function can occur in either the aged-care rooms or in the acute area.

Mrs NAPIER - Rather than having a dedicated space?

Mr SMITH - Again, it is supply and demand. If the hospital is full and there is an incident, a flu outbreak or something, obviously acute beds would be a higher priority than a respite bed. Where available, I am sure they would be utilised.

Mrs NAPIER - I noticed on the list outside the staffroom there was a reference to a salon for hair and beauty. They were saying that Cosgrove had one. What was the rationale in terms of why you decided not to include salon and beauty facilities as a separate room?

Mr SMITH - Probably the tightness of the time frame and the budget constraints to achieve high-priority items. Secondly, as we discussed on site, with ageing in place, as residents move into a facility, their bedroom becomes their home. So as their needs evolve they don't get moved to another area of the facility. What is common practice, as we saw today, is that hairdressers, podiatrists, physiotherapists, masseurs will go into that person's home - their bedroom. Some larger facilities which have more of a marketing drive from the private sector to attract residents will include small areas for a small salon or a massage and aromatherapy area. But generally in facilities of this size in the nature of the local community there would not be anyone to run a separate facility - a small salon or something. It would just become an area of the wing that would probably be used once a month, so therefore it is better for the residents to have that area in high-priority usage and their bedrooms are used for those personal touches, if you like.

CHAIR - On that matter, if I might intervene, I am familiar with the Eldercare facility in the Huon. Prior to the new facility being developed, that service you have just described,

Andrew, of providing hairdressing and so on in the unit was seen as totally undesirable and inefficient by both the residents and those providing the service. I hear what you are saying about the nature of this and the small size of it and so on but, if we are talking about occupational health and safety for other areas, then I would have thought we should be addressing that OH and S challenge as well for a hairstylist to provide a proper and efficient service in a properly fitted-out facility. I see that as a deficiency and I am glad Mrs Napier raised it. I am not personally convinced that you should be - and I will use the word 'dismissing'; I know that is not what you are doing but I am struggling to find an appropriate word - dismissing that in terms of the residents receiving the service in their unit. I personally do not think that is appropriate because it is a specialised service which needs to have a properly fitted-out facility to deliver the service, for OH and S reasons if nothing else. So I think that should be considered.

Mr MOLONEY - I think that is quite a fair statement. Also, I think the addition of the diversional therapy room certainly provides an expanded capability for the unit to provide those types of patient services, so I think the addition of that diversional therapy room will give the facility more flexibility in providing different types of patient services. It is a real plus for the development that is being proposed.

Mrs NAPIER - The only other major question I have is: is the courtyard that is in between the acute and the James Scott Wing - before we were talking about people who tend to wander a little bit at times - to be enclosed?

Mr SMITH - Yes.

Mrs NAPIER - It did not show it here. Is that still an entrance for the James Scott Wing?

Mr SMITH - Currently that is used as the major entrance. Under the redevelopment that will not become the major entrance. The one that we looked at when we were in the corridor -

Mrs NAPIER - The side one, the one towards the car park?

Mr SMITH - Yes, that is being provided with a small awning for a lot of weather protection for drop-off from vehicles. The courtyard is being fenced and made secure with a decorative-style fence, and linked to the nurse call system. There is currently a laundry activity with storage of dirty linen for collection from the Launceston Linen Service that occurs in a small part of that courtyard, so that activity needs to be retained by having a locked, secure courtyard. The gates can be unlocked by nursing staff through the nurse call system and monitored so that the residents are safely contained.

Mrs NAPIER - Quite often you do see a lot of people coming backwards and forwards through that particular doorway. Sometimes it is good to see a new face coming in and out, but at the same time it could also be distracting.

Mr SMITH - The side of that courtyard, the James Scott wall that bounds that courtyard, at present is a utility area with bathrooms, storage and pan rooms. That now becomes a lounge area which opens out into that courtyard, so it provides residents with a degree of dementia a small area through the courtyard into the lounge, and it provides another secure area as an outside space. There have been some incidents that we were made of

aware of with people wandering around the facility after hours, so with the new extension, basically there are safe courtyards so that the residents have a bit more privacy and can feel a bit more secure.

Mrs NAPIER - In terms of the servicing that goes through there, is that to be redirected through the corridors?

Mr SMITH - It is mainly the linen service. Staff take soiled linen out there in trolleys. There is a device there that empties the trolleys into the Launceston Laundry Service cage or trolley, if you like, that the truck takes. So really it is a matter of the truck stopping there -

Ms NICHOLS - Three days a week.

Mr SMITH - They wheel the trolleys out through the gate of the courtyard.

Mrs NAPIER - So it is only going to occur occasionally?

Mr SMITH - Yes, three days a week.

Ms NICHOLS - The physiotherapy department is being moved, so at the moment quite a bit of traffic goes through that end of the physiotherapy area. Physiotherapy will be where Accident and Emergency is, so that traffic will no long be there.

Mrs NAPIER - That will reduce.

Ms NICHOLS - Yes.

Mr SMITH - So by consolidating all those public contact activities to the main entry and the reception area and the waiting area, we are able to confine the public access to the facility.

Mrs NAPIER - That will be much better.

Mr SMITH - At the moment they are coming and going from everywhere.

Mrs NAPIER - It will be much better for the staff, too, I think, rather than having to rush from one end of the building to the other. You have explained how the tender process will be staged to accommodate existing use; is it intended that it will be released as one tender?

Mr SMITH - Yes. It is under one building contract and within the contract there are sections that are called separable portions, so the three phases or three zones that are identified make up the overall building contract. What it means is that they can be handed over in stages. So the building starts on site but the handing over of completed sections can be monitored and given them deadlines during the contract.

Mr COCHRANE - It's not an unusual process. We have used the same process with redevelopment at Deloraine and the New Norfolk District Hospital redevelopment. It

was in distinct separate proportions that allowed it to keep the existing facility functional while undertaking the work.

Mrs NAPIER - That is good.

Mr STURGES - I would like to place on record my thanks to the working party here today for a very informative site visit. During the tour of the facility I asked a number of questions and received responses to that and I thank you for that. I also thank the working party and the team behind the scenes for the preparation and delivery of a very comprehensive presentation today at the formal process of this hearing. I would also like to commend all of you for the consultative and communication process that you have engaged in with the stakeholders and the community. I think it is very important when you are redeveloping something as significant as this that you do just that. Thank you very much for the effort you have put in and I commend you for your consultative approach to this, too.

CHAIR - I am interested in the occupancy level of the acute-care beds at the moment.

Ms NICHOLS - I think it is about 65 per cent at the moment. It has varied between 65 per cent and perhaps 70 for the last few years.

CHAIR - With that being the case, would there not have been some capacity to maybe convert those acute-care beds to aged-care services?

Ms NICHOLS - The aged-care beds are in a separate wing. I think we will be losing a couple of these if it goes further down the track.

Mr MOLONEY - We are seeing a reduction. With the addition of the five aged-care beds, we are also seeing in parallel a reduction of the acute beds from 23 to 20 at this stage. It is seen that a number of those beds previously may have been occupied by patients who were probably more appropriately accommodated in the aged-care wing. It is a balancing act to offset, but it is appropriate given the current level of usage.

CHAIR - Again, I refer to my experience of other facilities. There has been some rationalisation with other facilities around the State to in fact achieve savings by conversion to aged care, and then more money may well be available for the facility by a different management process. That is why I was interested in the occupancy levels. That is reasonable but in terms of the 23 you have there are a few sitting vacant on a regular basis.

Mrs NAPIER - Following on from that, how often would you be full?

Ms NICHOLS - I did do the figures. There were about 20 occasions over a 12-month period where we didn't have any beds. So we have 100 per cent occupancy on 20 occasions in a 12-month period.

Mrs NAPIER - So about 20 days.

Ms NICHOLS - Yes.

Mrs NAPIER - Do you take overflow from the LGH?

Ms NICHOLS - Not necessarily overflow. We take pre and post-surgery, especially when they need a hip placement or following surgery, so there is no real primary surgery. Occasionally we have taken aged-care people waiting for placement.

CHAIR - The submission suggests that, for instance, the relocation of kitchen, X-ray and theatre have not been included. I am interested to know what sacrifices or compromises, if you like, are being undertaken as a result of not proceeding with those works at this stage. And then, quickly, if I might add to that, Andrew mentioned that surgery facilities may well, if I understood you, in the future be relocated, so in my mind there is the possibility of surgery ceasing at this facility in the long-term. Is that a possibility?

Ms NICHOLS - At the moment we have Amanda Young who visits once a month. The surgery that is being done at the moment probably does not need a theatre to the extent that we have. The theatre that is there now there used to be for major surgery. So it is a lot of space there for four or five hours a month. The type of surgery that we do could be done in a much smaller area and without all of that equipment that we have with a primary theatre.

Ms LEGGE - And a room for sterilizing, of course, we don't do that any more. That is done in a central location, obviously, for best practice and safety.

Ms NICHOLS - We don't do general anaesthetics, which we did in the past. The chances of getting a GP with the appropriate anaesthetic requirements in a rural area like this is fairly remote. Those days are long gone.

CHAIR - So then to the original part of the question, what sacrifices or compromises are you enduring, I suppose, as a result of not proceeding with the relocation of kitchen, theatre and X-ray?

Ms HARPUR - Nothing really. We are right in the footprint of the building and it is providing all of the most important things that we wanted to achieve.

Mr MOLONEY - I guess it is probably primarily operation efficiency; I suppose that is the easiest way to define it. There is no reduction in services. The same number of services are being provided with what is being proposed there. In the longer term, if we were to relocate the kitchen and the theatre, we could see some operational efficiencies. It is a grouping of functions. Like-for-like services are placed together so that there are efficiencies.

Ms LEGGE - It seems like you did not really need to be walking straight into the kitchen area. That really should have been in a service area, rather than a staff kitchen facility which can be at the back of a building.

Mr COCHRANE - I suppose it is fair to say that we sought a funding submission primarily for the aged-care upgrade when the original funding submission was put in. When we started the project we took a holistic approach to the whole facility, and so we undertook that master planning exercise and then prioritised what our requirements were. It has provided us with a blueprint for the sensible future development of the site in line with

any service delivery changes, so we now have these options laid down and nothing we are doing at the moment will prevent that from happening in the future.

Mr SMITH - The initial design overview for the whole facility was based on a greenfield site for our hospital and aged care. That would be the ideal arrangement. Would you have the kitchen near the front door? No, you would have it somewhere else in the service area. It is that sort of basic approach to planning. The initial layouts that were developed and costed, which ended up at the higher level, have been looking at the global picture and have incorporated those ideal planning approaches. With the services facilities, the entry areas would form the forefront. Looking at the prioritisation that has occurred, the cost to relocate the kitchen and the cost to create a new, smaller theatre are justified.

CHAIR - If you don't meet the construction deadlines for the aged care and therefore the licences for the five new beds expires, what process is required to get an extension for those licences to stay valid?

Mr MURPHY - Just on bed licences, I guess the experience I have had with aged care - and I have worked with age care from the mid-1960s right through to the current day - is that I have found that with the allocation of beds by the Commonwealth the main criteria is to demonstrate that the project is happening so the beds can be taken up. In the event of any unforseen delays, it is a matter of the facility contacting the Commonwealth and keeping them informed at the appropriate time of any possible delays. As long as those delays were credible - and it has happened in that way in the past - the bed licences are maintained.

The most important thing is to commit a date, which has been done, to demonstrate that the bed licences will be taken up in February 2006. The worst-case scenario that can happen is probably delays due to weather constraints or availability of materials. Andrew has mentioned that the choice of materials is going to allow that construction program to be expedited. At this stage - we have had discussions during the committee meetings in regard to the time frame - it is realistic to have the beds taken up by that particular date. It goes right back to the original submission and program that it had to be maintained to allow this to happen and this program has been maintained right through to this time.

Mr SMITH - As to the approvals and the tender process, there has been a time issue there. Once a contractor becomes part of the project team, the construction program is issued through to the department and then the regular site meeting minutes and they are given copies. So basically they are aware of how the progress is occurring. They can see by mid-January that it is going to be mid-February for completion to occur. They are well aware of it; it is not a surprise for them.

CHAIR - Thank you very much again for the site tour and the comprehensive nature of your presentation today.

THE WITNESSES WITHDREW.