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PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

Launceston Health Precinct Capital Improvement Program

Presented to His Excellency the Governor pursuant to the provisions of the Public Works Committee Act 1914.

MEMBERS OF THE COMMITTEE

Legislative Council

House of Assembly

Mr Harriss (Chairman) Mr Hall Mr Best Mr Green Mrs Napier

2009

TABLE OF CONTENTS

INTRODUCTION	3
PROJECT DEFINITION	3
Primary Objectives	3
General Scope	3
A NEED FOR THE PROJECT	6
History	6
Government and Departmental Strategic Direction	7
Increasing Health Demand	8
Existing Facility and Services	9
Limitations with Existing Services Proposed for Redevelopment	10
Surgical Services	11
Linear Accelerator	12
Car Park	14
Summary of Required Project Outputs	14
Consultation	15
Project Control Group	16
ADDRESSING THE NEED	17
Design Philosophy	17
Planning	18
Architecture	18
Building Services	19
Project Schedule	20
Project Budget	20
EVIDENCE	21
DOCUMENTS TAKEN INTO EVIDENCE	29
CONCLUSION AND RECOMMENDATION	29

INTRODUCTION

To His Excellency the Honourable Peter George Underwood, Officer of the Order of Australia, Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia.

MAY IT PLEASE YOUR EXCELLENCY

The Committee has investigated the following proposal: -

Launceston Health Precinct Capital Improvement Program

and now has the honour to present the Report to Your Excellency in accordance with the *Public Works Committee Act 1914*.

The Submission of the Department of Health and Human Services was as follows:-

PROJECT DEFINITION

Primary Objectives

The redevelopment of the Launceston Health Precinct is to provide a health service site that will ensure the sustainability of the Northern Area Health Service by:

- improving medical and surgical services within the LGH;
- improving the coordination of health care by diverting patients from the LGH (acute facility) to a more appropriate non-acute care setting such as the Integrated Care Centre (ICC);
- increase collaboration between primary and acute health services;
- improve education and research for health professionals;
- improving patient and staff access to site services and facilities.

The planning and design approach has been to have sufficient flexibility in layout to cater for changes in service modelling.

The redevelopment will provide appropriate facilities to enable staff to carry out their work in an appropriate environment with adequate facilities in compliance with accreditation standards.

General Scope

The scope of the work will include the following:

Redevelopment of the Department of Emergency Medicine

Approval and funding of \$12million has been provided by the State Government for the redevelopment of the Department of Emergency Medicine (DEM). Detailed assessment confirmed that the most appropriate location for the redevelopment of the DEM is its current site. This is due to the essential relationship with other supporting hospital services such as radiology. The new facility will include improved and increased ambulance access with ambulance parking for up to eight vehicles and 43 patient treatment spaces including three resuscitation bays, isolation rooms, paediatric cubicles, special purpose rooms, mental health assessment rooms and a short-stay/observation area. Other areas will include an interview room for sexual assault and mental health patients, a distressed relative's room, allied health areas, an education and learning room with staff and administration facilities.

To accommodate the current and predicted level of patient presentations, the floor area of the DEM will be maximised with expansion to the boundary of Frankland and Charles Streets.

Future expansion planning has required the new DEM to have the structural capacity to support a further two floors above the DEM (Levels 4 & 5).

Acute Medical Unit & Ambulatory Care Unit

A new acute medical model of care has been developed at the LGH and will be integrated as part of the DEM redevelopment. To support the new model, funding by the Commonwealth as part of a \$40million Health and Hospitals infrastructure package has been provided for the development of an Acute Medical Unit (AMU). The AMU is designed to receive medical patients for short-term assessment, care and treatment for a designated period prior to transfer to the medical ward or home as appropriate. Clinical services will be "front loaded" with senior staff to provide a short, intensive period of evaluation, treatment and supervision with an emphasis on enhancing the patient journey through DEM by allowing early transfer out or bypassing DEM thereby improving DEM access.

The AMU will be a 28-bed unit and will include an appropriate mix of single, double and four bedrooms, an isolation room, 4 high dependency type beds with telemetry monitoring, 4 monitored post-angiography beds with an associated exercise treadmill and ECG monitoring, a procedure room, consultation rooms, allied health area and staff and administration facilities.

Medical infusion services, which will initially remain located with Day Procedures Unit (DPU) until the DPU is relocated to level 5, will ultimately be collocated with the AMU on level 3 and will be developed as a stand alone unit. This will result in relieving the impact on day procedures capacity and the unfortunate juxtaposition of medical infusion patients who have to receive their infusions in the day only oncology area due to lack of infusion chairs and space in the current DPU. It is anticipated that the unit will include 6 infusion chairs with supporting facilities.

Surgical Services

While detailed servicing planning for Levels 4 and 5 of the new structure above the DEM have not been completed, the difficulties of the existing location of the Day Procedures Unit (DPU) on level 3 with the Theatre Suite (level 5) is acknowledged and essential to be located on the same level to improve patient flow. Therefore, the scope of work will include the relocating of DPU temporarily on level 3 to make available space for the AMU to be developed adjacent to DEM and once detailed

planning is undertaken, the DPU will be upgraded and relocated to level 5 with Theatre. This work is part of the Commonwealth \$40million infrastructure package.

The scope of works will include upgrading the theatre suite to contemporary sizes and standards, an increase in the recovery area to support service demands and a perioperative area for receiving and preparing patients for day only surgery.

Integrated Care Centre

The Commonwealth, State and University of Tasmania has funded \$22.4 million to construct an Integrated Care Centre (ICC) in Launceston. Assessment and planning has concluded that the most appropriate site for this facility be located on the LGH site to maximise and support the highest quality integrated care, with a particular focus on those with chronic and complex conditions. The ICC will be a focus for innovation, workforce and service reform where new models of integrated care can be developed, researched and evaluated.

The ICC will reduce burden on the acute system, improve access to integrated health services, improve client health/wellbeing, increase the opportunity for clinical placements/experience for health care professionals and increase partnerships with private providers, General Practitioners, specialists and a range of health professionals.

Renal services are a high priority need for Northern Tasmania and the development of a renal satellite centre has been undertaken as a first stage of the development of the ICC. This will be operated from a separate site but will be closely linked to services within the ICC. The satellite service will include 16 new renal stations/chairs, treatment rooms, allied health support areas, an education and learning room with administration and staff facilities.

The ICC will be a purpose built facility of 3 or 4 levels, constructed on the Frankland Street side of the LGH and at the request of the Commonwealth, the external structure must be of an iconic design.

Linear Accelerator

Approval and funding by the Commonwealth of \$7.3million has been provided to install a third dual energy linear accelerator at the LGH with additional patient accommodation within the precinct. The initiative is being progressed to alleviate current and future predicted work loads for Radiation Oncology Services and to improve the physical limitations of current patient accommodation which will improve access to radiotherapy services, particularly for patients living in regional areas.

The works scope will comprise a new bunker to house a new linear accelerator, treatment and planning areas as well as a new physics area to support the additional machine, a new patient transit lounge and additional student and patient accommodation facilities.

Intensive Care Unit

Included in the Commonwealth's \$40million, is to upgrade and expand the Intensive Care Unit (ICU) due to the ICU limited ability to meet demand due to the limitations of its physical infrastructure and bed numbers.

Detailed design for addressing the ICU are still to be developed, however the base scope of works will include redeveloping the unit in its current location with expansion into the level 5 courtyard adjacent to the ICU, increasing the number of ICU beds.

Ward Upgrades & Support Services

Most LGH wards are over 30 years old and largely unaltered, reflecting clinical practices of the time. The paediatric ward is a conversion of a former medical ward and inappropriate to its current role, particularly for at-risk and high need clients with the adjacent neonatal area being deficit in its infrastructure capacity to cope with contemporary clinical equipment as well as providing much needed space for families needing to lend support to their newborn. Currently a neonatal ICU is incorporated within the neonatal ward and has insufficient space, storage and facilities. There is insufficient natural light and noise levels are above ideal and are currently potential risk factors in the neurological development of babies in the neonatal area. There are major access issues for mothers and the NICU Retrieval Team when entering the area.

The scope of work will include ward refurbishments to address modern standards of fire control, infection control such as aseptic techniques and lighting as well as patient and staff safety re lifting devices.

Car Park

The LGH presently generates a car parking demand that exceeds the site's current capacity. The State Government has approved and funded \$15million to increase car parking. The scope of capital works will include the construction of a wrap-around and multi-storey car park, creating an additional 400 parking spaces.

A NEED FOR THE PROJECT

History

The LGH is one of the oldest hospitals in Australia and began in 1806 within a convict military hospital tent and in 1863, a 102-bed hospital facility was built and named the Launceston General Hospital. The LGH was rebuilt in 1981 on its current site and later incorporated the Queen Victoria Hospital for Women. At this time much of the equipment infrastructure from the old hospital was moved across to the new structure.

Since the LGH was established, the Hospital has continually been at the forefront of modern medical developments. Due to the dedication and commitment by the Hospital's medical and nursing staff, the LGH led the way in many medical treatments and techniques. In the 1920's and 1930's, the LGH was at the forefront of cancer treatment with a dedicated radiotherapy unit, now the Holman Clinic. Due to many medical "firsts" in modern medicine and a number of highly regarded surgeon-superintendents, the LGH was one of the few provincial hospitals that compared with hospitals in capital cities.

It has been said that the progress of medical science is the foundation of every hospital and an essential part of its existence, and because of this brilliant history, today, the LGH remains the foundation and the focus of the Northern Community. Being one of the oldest hospitals in Australia and with dedicated staff striving to always improve services, the LGH has always been there for all people of Launceston and the surrounding Northern Community.

Government and Departmental Strategic Direction

The infrastructure works in this proposal have been supported and progressed based on much of the service planning work undertaken by the Department of Health and Human Services (DHHS) within the Statewide Clinical Services Plan and Update (2007 & 2008) and the LGH Clinical Services and Strategic Asset Management Plan (2006). Recommendations from the Clinical Services Plan include the LGH incorporate new models of care, the development of an integrated care centre and had noted the already committed State funding to redevelop the ED. The LGH's Clinical Services and Strategic Asset Management Plan recommended an upgrade and expansion of DPU and the Theatre Suite, expansion of ICU and an additional linear accelerator and bunker. The plan has also shown the LGH will require more than 20 additional same day beds and almost 100 additional multi-day beds by 2016-17.

The redevelopment of the Launceston Health Precinct is also aligned with the broader Commonwealth's National Health and Hospitals Reform Commission Principles of *people and family centred*; *strengthening prevention and wellness*; *comprehensive*; *value for money*; *providing for future generations*; *recognise broader environmental influences which shape our health*; *taking the long term view*, *safety and quality*; *transparency and accountability*; *a respectful and ethical system*; *responsible spending on health* and *a culture of reflective improvement and innovation*.

Most importantly, the redevelopment supports the Department's strategic direction of placing our patients and clients at the centre of all we do by:

- Promoting health and wellbeing and intervening early when needed;
- Developing responsive, accessible and sustainable services;
- Creating collaborative partnerships to support the development of healthier communities;
- Shaping our workforce to be capable of meeting changing needs and future requirements.

Until recently, there was minimal integration with community health. In July 2009, DHHS undertook a restructure and the LGH is now part of the Northern Area Health Service. The management structure includes a Northern Area Health Service (NAHS) Executive group with the Chief Executive Officer managing both acute and community health. The structural change is aimed at integration of acute and community health services for the Northern Tasmanian community and to help avoid overlaps and to close off gaps in service provision. The restructure will increase collaboration between acute and community health services through the development of new facilities and models of care, enabling the delivery of improved quality care in both ambulatory and short stay settings.

Due to the restructure to NAHS and the Launceston Health Precinct redevelopment, an overall precinct site master planning exercise will be conducted to inform the NAHS Executive and the LGH of the precincts service and facility direction.

In March 2009, Premier David Bartlett and Health Minister Lara Giddings announced the capital funding, including how the projects will "proceed in a coordinated program of works under a unified management structure headed by the CEO", Northern Area Health Service. Capital works for the Precinct will be managed by a single integrated unit, allowing one central coordination point for all the program of works. The collocation of the Capital Works Unit together and on site of the LGH, will allow synergies between individual projects and will be well placed to obtain early warnings of project risks. The Unit will ensure a co-ordinated program while making efficient use of resources and achieving economies of scale while engaging end users in the process.

Increasing Health Demand

At the heart of our service are our patients and our ultimate aim in assessing and changing how we care for patients is to improve their health and wellbeing outcomes.

The LGH is currently experiencing a significant increase in demand across all services resulting in delays in the emergency department, delays in elective, day and general surgery, radiotherapy services and renal services. The LGH also provides the highest proportion of day only procedures per head of population in Tasmania.

Due to the LGH being the primary acute health provider for more than half the population of Tasmania, there are other inter-related factors that are flagged to have a significant influence on how the LGH must provide and manage its services now and into the future.

Environmental factors that are expected to impact on health services at the LGH are:

- Tasmania has the second shortest life expectancy nationally for both males and females (2002-2004).
- Between 2000 and 2005, Tasmania had the highest rate of mortality across all years which means that Tasmanians die at a higher rate than the general Australian population.¹
- Health risk factors, relating to the incidence of disease in the community, such as Tasmania has a higher proportion (in relation to the rest of Australia) of the population who smoke and a higher population who are obese.
- Tasmania has a greater level of socio-economic disadvantage than most Australian states and territories which is feasible to assume that socioeconomic disadvantage leads to health inequality and pressure on the public health system.
- Tasmania has the highest rate of diabetes and hypertension in the nation.

As the Tasmanian demographic of lower socio-economic standards, higher incidents of chronic disease and an ageing population increase, these factors are and will place an unprecedented health care demand on hospital services. The LGH faces a situation where we must change how we provide our services to ensure the sustainability of services for the Community. Changes to the current physical infrastructure and

¹ Department of Health and Human Services, Clinical Services Plan, May 2007.

facilities will need to occur to support the anticipated growth and demand and to ensure the success of new service models.

Existing Facility and Services

Although the LGH is classed as a rural hospital, it provides secondary and tertiary services and is the main referral hospital for residents of the North and North West of Tasmania. It is a major teaching and research hospital with linkages to the University of Tasmania. The LGH operates from a maximum 342 beds, including 296 acute overnight and 46 day beds. Like most hospitals, bed numbers are adjusted on a daily basis according to clinical need and staff availability. The LGH operates a 15-station satellite renal dialysis unit on the North West coast. There is a 20-bed acute adult inpatient Mental Health unit and outpatient services (Northside) on the LGH site.

Using a role delineation model, the LGH provides services primarily at role delineation levels 4 and 5 in medicine, surgery, critical care, aged care, rehabilitation, obstetrics and paediatrics, as well as a range of outpatient services to Launceston and the Northern Community of Tasmania. The LGH provides tertiary services in renal medicine and hepatic / upper gastro-intestinal surgery to the wider Tasmanian community. The LGH is Tasmania's only provider of brachytherapy (type of radiation therapy). The state medical retrieval service is based at the LGH and clinical support services are provided across all allied health, pharmacy, medical imaging and pathology.

The LGH is the primary emergency service provider to the Northern region and outer areas and does not have the private sector support common in other larger urban areas. When the LGH and the DEM is at capacity, it is not possible to bypass patients to the closest emergency department due to the distances involved. Patients continue to arrive to the LGH where the Hospital has a duty to accommodate them.

The LGH is the only major public acute facility in the North of the State, and provides specialist services as part of the Northern Area Health Service. The LGH provides the primary emergency service to the Northern Region and is not supported by alternative public or private sector resources as happens in other urban areas.

The LGH is predominantly over 30 years old and, although the building is in reasonable physical condition, services are hampered by the older infrastructure which constrains the LGH in its ability to adapt and change its patient care to contemporary models of care and has limited capacity to deal with modern equipment requirements.

According to the Launceston City Council, this development will be the single largest development that Launceston has undergone in the past five years.

Limitations with Existing Services Proposed for Redevelopment

Department of Emergency Medicine

The DEM provides emergency care for adult and paediatric patients and is operational 24 hours, seven days a week. DEM presentations for the 2008/09 financial year were 37,211.

Existing treatment spaces are grossly inadequate and do not meet current benchmark guidelines for the number and type of patient presentations currently being managed and predicted.

The DEM has 20 treatment spaces in total of which:

- 14 general cubicles which are too small and do not conform to current health facility standards;
- 2 resuscitation bays, again too small and do not conform to standards;
- 4 special purpose rooms, of which are used as general treatment cubicles when the department is at capacity.

Many physical problems have been identified with the existing department. These are:

- 1. The department is too small to handle current demand.
- 2. General cubicles are too few, too small and do not meet current standards.
- 3. Resuscitation bays are too small and do not meet current standards.
- 4. Special purpose rooms are insufficient, overused and often unavailable for their intended use due to the department being overcrowded.
- 5. Access to medical imaging is limited by the location of the door opening directly into a general x-ray room.
- 6. Segregation of visitors from patients within the department is difficult to control.
- 7. Waiting room and location of triage is remote from the ambulance entry.
- 8. There is no separation of paediatrics from general patients (20% of patients are paediatric and make up 15% of admissions).
- 9. Hospital transfer patients currently pass through the department to and from the ambulance and patient transport bay.
- 10. The location of Pathology on level 2 delays the transfer of specimens, as specimens have to be manually transferred between the departments.



Corridors used as treatment spaces due to lack of space.



Patients are doubled up in treatment areas due to lack of space.



Current resuscitations bays are short on space for staff and equipment needs.



Current procedure room is undersized for AHFG benchmark areas

Issues that go beyond the physical infrastructure deficit include the current traditional model of care, whereby patients attend the ED without appointment and are assessed and processed by a triage nurse and may have lengthy waits for a specialist assessment.

The new model of care for the LGH and DEM will be patient-centred with a philosophy of free communication between health care providers focussed on the needs of the patient, where the systems, organisational structures and physical infrastructure facilitate a smooth transition through these settings – *the right care, in the right setting, at the right time.* The development of the Acute Medical Unit and the Integrated Care Centre will be part of the infrastructure facilities that support the above model change.

Surgical Services

Surgical services that are undertaken within main Theatre and the current DPU, face similar issues to the DEM of deficits in area and configuration of existing spaces. Spaces are grossly inadequate and do not meet current benchmark guidelines for the number of procedures currently undertaken.



Recovery bays in Main Theatre are inadequate in size and numbers



Main Theatre issues of storage of essential and large equipment



Recovery bays in DPU are inadequate in size

Linear Accelerator

The main limitation experienced by the Holman Clinic is the ability to meet current demand for radiation oncology services and the further expand them to meet the referral target of 52.3% with two linear accelerators. Based on the current commonwealth guidelines a linear accelerator treats 32-34 patients per day. The two units in Launceston are treating around 90 patients per day (2.5 units work) and there are around 100 patients on the waiting list.

An additional unit is required with appropriate staffing resources to expand the existing service to mange this increased workload. The existing treatment and planning areas in the WP Holman Clinic cannot accommodate the installation and operational staffing requirements of an additional dual energy linear accelerator and will need to be expanded.

To accommodate the new Linear Accelerator a new dual energy linear accelerator bunker will need to be built. Patient facilities will also need to be enhanced with increased throughput. This will include new waiting area, change rooms and patient facilities including a patient transit lounge. To accommodate additional staffing requirements a new treatment planning area and new physics area will need to be built.

Patients travelling from the NW Coast and East Coast for radiation therapy are limited in suitable and affordable family-style accommodation places which are close to the LGH. Establishing six self contained family-style accommodation units in Launceston will improve accommodation capacity in Launceston for these patients who travel from surrounding areas to receive health care.

Tasmania has had difficulty recruiting health professionals to the oncology area for many years. In addition to the \$7.3million for infrastructure, the Commonwealth is providing an additional \$1.4m in training funds over 3.5 years to promote local training of radiation oncologists and medical physicists. They have also included capital funding to improve student accommodation. As Tasmania is linked with the South Australian clinical network for radiation oncology training there will be a need to house interstate advanced registrars on clinical placement in the state for 6-12 months at a time.

Radiation Therapy recruitment has mainly come from interstate students that have undertaken clinical placement in the state (over 25% of the current radiation therapy staff were recruited this way). To improve opportunities to secure these undergraduate students there is a need to improve the student accommodation available.

ICU

As with the other services flagged for redevelopment, the ICU do not have the bed capacity to meet current and forecast demand and due to its current physical infrastructure has no ability to reconfigure and increase its beds, often resulting in acutely ill patients being directed to other facilities, often outside Tasmania. The closure of the Intensive Care beds at Mersey has increased admissions from the North West coast. Surgical procedures are commonly cancelled because of the lack of capacity of the ICU to admit patients postoperatively.

Other issues that affect the ICU are again due to the current inflexible physical infrastructure to meet current infection control standards such as space, aseptic techniques and lighting. Technological advances that require space for ICU equipment, patient and staff safety such as infrastructure for lifting devices and ceiling tracks also present as issues for ICU.

Ward Upgrades (including the Neonatal Ward) & Support Services

Most of the wards are over thirty years old and largely unaltered, reflecting clinical practices of the time. Due to the age of the wards meeting infection control requirements continues to be a challenge. Pressures generally arise from the increase in space needed for equipment. This is especially an issue for the Neonatal ward as it copes to struggle with space for contemporary clinical equipment. The Neonatal ward is currently limited by:

- small floor space
- Over utilisation of the central workstation
- Bulk Storage is a major problem with OH&S issues
- Lack of natural light there is only one window allowing daylight into the neonatal ward and daylight is needed for clinical treatments
- There are no private rooms available for staff handover or for family case conferences
- There is no emergency treatment room
- The milk production area and medication area is currently a patient thoroughfare
- Infection control issues such as clean and dirty areas too close

• The inclusion and importance of family members in paediatric care has also been hampered by the lack of physical space.



The Neonatal Ward is hampered by lack of space

Car Park

The Launceston Health Precinct currently generates a car parking demand that exceeds the site's current capacity. This has been the topic of concern for staff and the broader community for some time now and is essential to be addressed to support the redevelopment.

Summary of Required Project Outputs

Project funding has been approved for expenditure during financial years 2008/09, 2009/10, 2010/11 and 2011/12.

Department of Emergency Medicine (DEM) Redevelopment:

- An increase in floor area of approximately $800m^2$ to $2000 m^2$
- An increase in total treatment spaces, from 20 to 43 with individual treatment spaces increasing in size.
- A new short-stay and observation area
- A new ambulance bay and patient pick up and drop-off, with access from Charles Street
- Infrastructure to support staff administration functions

Acute Medical Unit (AMU)

- Creation of a new acute medical unit co-located with DEM, providing an additional 28 new beds, including a 4 bed High Dependency area
- Infrastructure to support staff administration functions

Ambulatory Care Unit:

• Creation of a new unit providing endoscopy day procedures and infusion services

Level 4:

• Expansion of Level 4 above DEM will increase the floor area by 1000m²

Surgical Services Upgrade (Level 5):

- An increase in floor area of approximately 1400m² to 2400m²
- Integration of DPU with Theatre on Level 5
- A new patient admission/discharge unit, relocated closer to Theatre
- A new peri-operative area for receiving and preparing patients for Theatre
- Upgrade & expansion of Theatres and recovery area to contemporary standards
- Infrastructure to support staff administration functions

Car Park:

• 405 additional car parking bays (872 total)

Launceston Integrated Care Centre (LICC):

- A new iconic facility providing a new model of integrated services with a combined floor area of around 4000m²
- A new renal unit facility at Kings Meadows, operating six days a week with capacity for 16 renal stations

Holman Clinic Linear Accelerator & Patient Accommodation:

- A new bunker to house a new linear accelerator machine, allowing for an increase of 90 to 123 patients being treated per day
- New treatment planning and physics area
- New patient transit lounge
- Additional staff/student and patient accommodation facilities

Intensive Care Unit (ICU) Upgrade & Expansion:

• A reconfigured and expanded ICU

Ward, Allied Health & Support Services Upgrade:

- Refurbishment of wards to address modern standards of fire control, infection control, patient and staff safety
- A new contemporary neonatal intensive care area
- Innovative patient centred Allied Health areas

Launceston Health Precinct

- A Precinct Site Master Plan
- Launceston Health Precinct Advisory Group to be established

It is acknowledged that to support the capital investment planned for the Launceston Health Precinct, there is a critical need to improve current information and business system practices and applications as they are vital for both quality and safety of patient service delivery and in generating the information required for system performance management. ICT investment is vital for future service delivery and as part of the redevelopment program, investment in ICT innovations will account for ICT being a critical part of the service infrastructure.

Consultation

The consultation process has or will include the formation of various project teams. The project team includes individual project managers and officers, representation from the design consultant (Architects in Association) and medical, nursing and administrative users as well as representatives from building and engineering and stakeholders from other clinical areas are invited on an ad hoc basis to inform the design process. Depending on timeframes and critical issues, meetings may be held on a weekly, fortnightly or monthly basis and are systematically recorded and reported back to the Project Control Group.

Project Control Group

The overall project management structure for the capital works projects will include the Project Sponsor and if necessary a Project Control Group (PCG) and Project/User Teams. The AMU/DEM & Levels 4 & 5 along with the NICC will have Project Control Groups established, while the smaller or single focused projects such as the car park and ward upgrades will not require a formal PCG but will be progressed under a project management framework including reporting to the Northern Area Health Service Executive through the Project Sponsor.

The following diagram illustrates the generic governance structure. The Project Control Group level will only be applicable for the AMU/DEM & Levels 4 & 5 as well as the NICC projects.



Generic Governance Structure

The Project Control Group meet on a regular basis to enable the project to evolve in line with the project timelines, the aim being to enable an adequate consultation phase

while still allowing sufficient periods for documentation and procurement of the project.

Consultation with Onsite Stakeholders

In addition to representation via the Project Control Group and Project Teams, a service review workshop for the DEM was undertaken late 2008 where the schematic design was presented to DEM stakeholders and representatives from the LGH Consumer Reference Group. This workshop discussed the model of care and patient flow in relationship to the new design.

Preliminary plans have been displayed onsite and further briefing sessions with staff have been held.

ADDRESSING THE NEED

Design Philosophy

The design philosophy for the Launceston Health Precinct Capital Improvement Program for new works including:

- AMU/DPU (Acute Medical Unit/Day Procedure Unit)
- DEM (Department of Emergency Medicine)
- LINACC (Linear Accelerator)
- Theatres Expansion and ICU/DPU fit out
- ICC (Integrated Care Centre) and Renal Satellite
- Car parks
- Wards refurbishment and Allied Health

is to provide the best contemporary functional buildings in an environment which is supportive of staff and patients.

There are essentially three new buildings as well as additions/refurbishments to existing spaces which make up the project programme:

- The Department of Emergency Medicine and upper floors housing extensions to the operating theatres ICU and DPU being located as a 3 storey structure at the corner of Charles and Frankland Streets will enable doubling of the floor spaces currently available to the DEM to increase clinical areas on the upper levels by around 1000m2 per floor.
- The Integrated Care Centre, the next major new building apparent within the precinct site master plan is to be developed on the Frankland Street side of the site adjacent to the cafeteria entry at level 2, with its own front entry addressing the street.

This building of 3 levels and basement car park is designed to be clearly identifiable and of 'iconic' imagery to differentiate its presence on the site from the rest of the hospital precinct, The centre houses a variety of public health, wellness and preventative care functions together with the UTAS teaching hospital function and will provide the Launceston and North East region with a unique health education and clinical support centre.

- The addition of improvements and extensions to the Holman Clinic with an additional new Dual Energy Linear Accelerator Bunker with treatment areas and support offices/accommodation will be constructed alongside the existing Holman Clinic facilities. This will further enhance delivery of radiation therapy to the North of the State. This building is primarily utilitarian but will have an interior design which enhances patient comfort.
- The new proposed car park building located to the Western end of the site is a necessary adjunct to the development providing car park numbers required to meet Planning requirements.
- The concept will provide for a 6 level car park structure on the edge of a commercial zone and a 2 storey structure abutting a residential zone. This building will be open edged and protected with a fire sprinkler system.

Planning

After discussions and early consultation, the project as a Launceston Health Precinct Capital Improvement Program has been presented to the LCC for development approval.

Stage 1 of this approval will permit construction of the first package of building works for the forecourt, AMU/DPU, DEM and upper levels 4 and 5.

Stage 2 development approvals of the LinAcc and 6 level car park and site works for the ICC are envisaged as package 2 works.

Stage 3 will involve the development of the ICC and 2 level car park in Frankland Street.

Stage 4 works provides for internal fit out/additions and alterations to internal spaces for Theatres, DPU, clinical areas, ICU/CCU and ward spaces do not require a development application and will proceed to construction within the overall developed project implementation program.

Architecture

The new buildings proposed for the development of the Launceston General Hospital have differing architectural treatments as follows:

DEM and upper levels

The three storey DEM and upper levels building attached to the existing hospital has been designed to 'blend' with the current buildings through use of similar 'toned' materials and finishes, while providing a recognisable address to the new Department of Emergency Medicine. A new entry and sheltered standing area for ambulances as well as public patient drop off areas from Charles Street will increase the functionality and appearance of the LGH ensuring that the most critical public face to LGH service delivery is clearly visible.

The proposed upper levels 4 and 5 above DEM to accommodate the new Operating Theatres, DPU and clinical spaces are set back from the face of the single level DEM street frontage. Pre-cast patterned concrete, zinc panel cladding and areas of 'dark

glazing' colour provide a modulated built form and enhance discreet functions requiring privacy within the building.

Integrated Care Centre

The ICC as a separate and highly visible independent structure is designed to draw attention to new models of service delivery focused around preventative care, health education and the University of Tasmania's medical teaching facility with a community focus. Its requirement is to be 'iconic' in presentation and an example of developing sustainable design principles. In this context the architecture of this building has been conceptualised to provide a contrasting architecture to the existing LGH and incorporates an internal, naturally ventilated atrium space and external glazing to part of the northern elevation which is both window as well as photo voltaic solar collector. The internal atrium spaces also provide break-out to public meeting areas and light well to consulting spaces. Service delivery is focused on public health, wellness and education on the ground floor entry level with consulting spaces on the first floor and UTAS learning spaces on the second floor. Some areas at all three levels are shared by the three functions in an 'ethic' of service integration.

A basement car park level provides sheltered parking for up to 40 car spaces including disability access parking and two lifts provide vertical circulation. This level is also used to house grey water treatment, recycling and water recycling of solid waste material as part of sustainable operations within the building.

Car Park structure

The architecture of the car park structure, while essentially utilitarian to house 472 vehicles both public and staff, requires architectural treatment of its facades. The design incorporates some screening and patterned application of materials to break down its bulk and form. This is relevant to the higher 6 storey structure on the edge of a commercial zone as well as the 2 storey structure abutting a residential zone.

By use of these varied height architectures with additional screening, the bulk and impact on surrounding properties is minimised.

Linear Accelerator

The LinAcc addition to the Holman Clinic is essentially utilitarian, however its internal architecture or interior design will provide both patients and staff a pleasant, interesting and non-stressful environment.

Wards, Allied Health and refurbishment of Clinical Areas

The adaptation and refurbishment of existing spaces within the existing buildings at LGH will involve a high degree of functional requirement but again interior design will provide a new feel to those areas in support of patient and staff well being.

Building Services

Each of the buildings within the LGH site are serviced by a whole of site building services including co-generation. New services are anticipated for a pneumatic document transfer system from DEM to Pathology and all new buildings are to be designed to meet a sustainable design philosophy.

- DEM and upper levels 4 and 5
- Linear Accelerator

- ICC
- Car park

Project Schedule

The attached project implementation programme illustrates the time lines for the various projects to meet state and commonwealth funding targets. This programme will be further developed as the project proceeds through its procurement phases.

Staging Program

In order to minimise impact on the existing services delivery of all functions with the LGH's 24/7 operational requirement the project team has identified a series of project stages both for the site development as a whole as well as each project as it proceeds through construction and commissioning. This strategy will be further enhanced when successful contracts have been awarded and procurement proceeds.

Project Budget

The project budget of \$96,700,000 has been funded from State, Commonwealth and UTas funds.

Description	Cost (\$)
Construction Cost (inc. professional fees)	76,400,000
Professional Fees	6,202,432
Construction Contingency (5%)	3,700,000
Design Development Contingency	500,000
Art in Public Buildings	80,000
Loose Furniture & CPI Cost Escalation	16,120,000
TOTAL	96,700,000

Budget Breakdown for Program

Estimated Construction Budget for Individual Projects

Project	Construction Cost (\$)
PIMS & Level 4 void (enabling works)	500,000
AMU/DEM & Levels 4 & 5	26,829,000
Linear Accelerator & associated work	7,000,000
ICC Stage 1 – Renal Satellite	900,000
ICC Stage 2	16,258,723
Car Park	14,500,000
ICU Upgrade	4,400,000
Ward Upgrades	6,012,277
TOTAL	76,400,00

EVIDENCE

The Committee commenced its inquiry on Friday, 30 October last with an inspection of the site of the proposed works. The Committee then returned to Henty House, 1 Civic Square, Launceston whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- John Kirwan, Chief Executive Officer, Northern Area Health Service
- Dr Alasdair MacDonald, Director of Medicine, Launceston General Hospital
- John Slore, Director, Capital Works Unit, Launceston General Hospital
- Bill Cochrane, Manager, Major Projects, Facilities Management, Department of Health and Human Services
- Andrew Shurman, Consultant, Architects in Association

Background

Mr Kirwan provided the following overview of the proposed works:-

This is ... the largest capital works program that Launceston City has seen probably since the last refurbishment or the building of the current hospital, what it is for us is not only a building of new services, a refurbishment and extension of existing services but hand in hand is a redesign of how we do business. At any given time 30 per cent to 35 per cent our patients come from outside of Launceston so we are servicing people, some from the south but the majority from the north, north-east and north-west and obviously some visitors from interstate at various stages. So it is a very busy hospital, its occupancy levels are always high and in fact on contemporary standards probably too high. Across a range of areas it is on capacity and so some of the initiatives are about giving us some capacity and an amount of future proofing.

... the model is very much based on contemporary practice to help us redesign our patient flow and quality of care for our patients, our staff and our visitors. It is a coalition of a range of programs that have come together as one program which gives us certain synergies, some of which have been a long time in the waiting, such as the parking, and probably overdue; some which allows us to go forward. It is also a rare opportunity on a 30-year-old site to get some of the service models right and redesign them so what we will be doing here often cannot be done in more established hospitals simply because of physical restrictions but because of the flexibility and some negotiation skills, a lot of our staff are now being prepared to move to change and to move from where they have traditionally been. So you will see a new model of care emerge over the two to three years as we build as well and Dr MacDonald is the best placed to explain that as he is taking that leadership both within the hospital and to some extent also at a national and international level.

... the hospital is not without its faults. We do not hide behind that. It is a very busy hospital, however, and it provides a comprehensive range of services. When you go back to the Tasmanian Health Plan and others, we service over 90 per cent of the needs of the local community so there is a limited number of people who have to move outside of the area and the refurbishment and the changes will reinforce that as the primacy of our role. If I had 350 to 400 beds, which is where we are heading towards, it is still a large regional hospital rather than necessarily a comprehensive teaching hospital with the 600, 700 or 800 beds that you would see in a mainland situation.

It is also relatively self-contained. We do not have the option for hospital bypass or other areas like that. We have to deal with what comes through the front door, which adds a degree of complexity.

The Committee questioned Mr Kirwan as to whether the 2015-16 forecast level of health demand was currently being experienced. Mr Kirwan responded:-

Specifically in respect to the emergency department ... the planning work that sits behind the clinical service plan, Tasmania's Health Plan, done by Greg Hayes, predicted we would be at the activity, which is around 42 000 episodes, in 2016-17. We are at that level now, we are already there, and as you will see in the submission, and as you would have seen this morning, although today when you were there was a relatively quiet day for the emergency department, which was good and the way we would prefer it, the current configuration is both inefficient and also is not big enough to deal with existing demand, let alone the future demand. It just reinforces the need to build and also to change our models of care. We are currently growing at 18 to 19 per cent this year in the emergency department presentations across all of the five categories we admit. That is unsustainable. That sort of growth is getting into exponential growth not linear growth and that is not sustainable in any health system. Some of the initiatives that sit behind the acute medical unit, that sit behind the integrated care centre, that sit behind the technology we will be introducing as well, will end up with a model that does not necessarily mean come to the LGH, become admitted and then go out. We will change that model, which will take some time because that is the existing referral model and that takes time to change within a system such as this.

In response to questioning regarding the national and international positioning of hospital in relation to service delivery, Dr MacDonald responded:-

What we are aiming to do is part of the contemporary move both in Australia and in a number of areas around the world and that is to look at a much more efficient health system. I can give you a little bit of historical detail.

The current organ-based, specialty-based, relatively siloed system has developed over probably approaching 100 years and what it necessitates is each silo fully assessing a patient from a medical perspective. Those silos are multidisciplinary teams often, so they are discipline based. To give you the most topical analogy, when you present to an emergency department here you are seen by a series of doctors who are working in the field of emergency medicine. They are led by a specialist in emergency medicine who has a specialist qualification in that area and there are training doctors underneath them. Most of these training schemes have a component of apprenticeships so what you will find is that the training doctors are given the opportunity to do initial assessments and those assessments occur in a serial fashion in the emergency department. Because the emergency department specialists feel that they have reached a point to hand that process on to the next team within the hospital, and in my case that would be to a physician, what happens is another series of assessments occurs, usually still in the emergency department, by the medical speciality, be it general medicine, cardiology, neurology, oncology or otherwise. What that leads to is a significant number of redundant assessments and at both a national and at a State level there is a clear recognition that the work force, the time and the amount of effort that goes into such a series of serial sequential assessments is not sustainable and in that context we are working towards a much more integrated and blended medical workforce where you will see specialist physicians, cardiologists and neurologists working side by side with specialist emergency doctors rather than handing from one to the other for a series of timeexhausting assessments. So they are working together and then the junior medical staff are learning much more of a mentoring model where they are part of team learning at the same time as that process is undertaken.

Within our hospital we have the opportunity to take some leadership in this area. We have a workforce that is ready to take on some of those changes. We have a building program that will help facilitate those changes and we are fortunate to have a number of people who are integrally involved in that change process at a national level, so to speak. The dominos all come together at the same time and that is an enormous opportunity. So with the acute medicine unit, which I will use as an illustration that I will then allude to things like the integrated care centre and how the other end of the hospital has to have all the same sort of synergies at the discharge end. The acute medicine unit provides an opportunity adjacent to the emergency department for patients who are not deemed to be emergency but require acute care within the hospital, so they can come either through the emergency department or bypass the emergency department into that environment - an environment which will have senior specialists upfront and extended hours of practice with an ambition eventually to have senior staff there for the full 24/7 hours of practice, and by that I mean consultant type staff at that time, but certainly extended practice of consultant physicians at this stage on a seven-day-a-week model, then working hand in hand with the emergency specialists. That way they can reach into the emergency department and assist in the assessment of patients with complex medical needs, which at the moment is done by initial assessment by the emergency staff at various levels and then a handover process. So that there are no redundancies in the process, we can do these things at the same time.

The emergency department works with a sort of blurred boundary with the acute medicine unit and then the acute medicine unit occupies an area that is adjacent to the diagnostic services - X-ray, all the other things that you need to be close to while you are still running what we call diagnostic algorithms, trying to work out what the problem is, so to speak, and stabilising the patient so they are ready for a program of care. Once the diagnosis is made, one is stable, then they may need a course of treatment and that course of treatment might be required at home or it might be required in hospital. If it is required in hospital, the acuity is less because the course of treatment, the decisions are made and there is the different of acuity So patients who are requiring that level of acuity then move on to an inpatient ward environment, if that is required, with a different type of staffing mix that is focused on planned care and planned discharge and then they integrate with community services at the discharge end. Trying to produce again a removal of the redundancies that tend to occur. Everybody does an assessment of when somebody is ready to go home. Physio, OT, medical, nursing assessments are all done. That can be done in a built-up fashion, underpinned by the changes in IT that we will see rolling with this program of building and care innovation.

Also, the integration of the ICC will allow us to look at more admission avoidance strategies. So it is looking at a wellness model in the community. Patients referred by their general practitioners to that facility to have inputs in maintenance of good health, thus there is not a need to present to hospital to have that sort of care commenced. It can be commenced and the hospital can stay out of the equation.

So at each step, before the hospital in admission avoidance, at the transition between emergency to acute care to program management to discharge back into the community and support in the community, we are trying to remove the redundancies and get everybody supported by appropriate IT working together. As I say, it is an opportunity to do that; a new building and building changes are a great facilitator of change and, as I say, we are lucky at this stage, to have a number of people on the staff who are involved in this sort of innovation at a national level and in some cases are getting reputations internationally in that area.

Integration with the North-west Coast

The Committee questioned the witnesses as to what affect, if any, the proposed works would have on the treatment on patients from the north-west coast. Dr MacDonald responded:-

Certainly from the point of view of the patients coming from the north-west coast to the Launceston General Hospital there will be significant streamlining of that process because initial assessments will mean that those patients who have been appropriately assessed and investigated at either of those campuses will then be able to be admitted directly to the acute medicine unit and their journey of care through the hospital will commence there rather than with a long wait on a trolley in the emergency department. It produces an access point for patients are transfers and, hence, not emergencies; they are in need of acute care but they are not emergencies. At the moment, I think everybody who is in need of acute care ends up in an emergency department, whereas an emergency department should be for emergencies.

Transition to specialist care

The Committee questioned the witnesses as to how the proposed model would cater for patients seeking to transition from general to specialist care. Dr MacDonald responded:-

... There is ... no doubt that, with the changing generation of the medical workforce particularly, the traditional 24/7 general practitioner and the traditional 24/7 private specialist is not as prevalent as it was. So, in that context, setting out a facility where appropriate assessment can occur and on-referral to a suitable specialist, be that within the public sector or out into the private sector, can in fact improve access. With respect to the specific comments made this morning that led to that question, from a patient perspective there are two drivers. There is some degree of limitation in access to general practitioners in Launceston and it is likely that that

is going to go on for some time, hence there is a driver for patients to present to the emergency department. But there is also a generational change in our public who see the investment in time in the emergency department being an opportunity to receive broader assessment, a one-stop shop of medical assessment, pathology testing, X-ray investigation and specialist assessment, which in the private sector might well have them, on sequential days or sequential weeks, visiting at least five other venues other than their general practitioner. So I think there is a recognition amongst the current generation that, yes, they might wait a while but compared with a process that might take several weeks, even in the most well-honed private sector system, it can all be done in one day by investing some time in the waiting room whether that is an ideal model. However, what the Acute Medicine Unit will do at the front door of that is that it will identify patients who have acute needs and deal with them immediately - and some of those patients might have waited in the community for a referral process to occur over a number of days - and select the other patients that in fact can and reasonably should wait and be on-referred to outpatient clinics or to private interventions, either allied health, medical or specialist other interventions in the community sector.

I am anticipating that the current trends will continue, that the number of specialists, for instance, working outside the staff specialist jobs will continue to drop because we have a generation of specialists coming through who want to collect a wage, have their time off and their time on. They don't necessarily want to stay at work in the same model that the previous generation did. So the trend in the medical work force that will service that will continue as well. We just want to make sure that we are set up with an effective flow system to meet both the trends in the public and the trends in the medical work force.

Mr Kirwan added:-

We are talking about acute medicine here. One of the difficulties we have is our crossover with general practice and private health. The models we are developing in a whole range of areas are based on supporting and maintaining a general practice area. That is important for us; it is not in competition with. Some other systems we come in competition with, we are quite fair about that. We, as LGH, do not employ any general practitioners and we do not provide general practice clinics. We do employ the staff of qualified general practitioners but they work as career medical officers or hospital medical officers for us, and I think that trend will continue as well.

It is important, if you look at the whole health continuum, and that part of primary health obviously sits in the Commonwealth's domain, that that area remains strong, and in fact this model is a reinforcing of helping that.

Dr MacDonald concluded:-

... to use the acute medicine service as an example, the access points will be similar for other areas, such as surgery. It values the assessment of the general practitioner in the process. The general practitioner would perform an assessment in their practice and refer the patient directly to the Acute Medicine Unit, and they wouldn't then need to present to the emergency department.

Currently, if your general practitioner deems you need hospital care, you go from an experienced general practitioner to a junior member of resident staff in the emergency department. We are going to take that step out of the equation and unless you need emergency care, you will actually present via the general practitioner to the Acute Medicine Unit where you will get the assessment of a physician or a senior medical registrar as the next person in the line. So we are actually taking some links out and giving general practice a much better interface with the hospital system, valuing their assessments in the community and plugging them in at the level that

they should be plugged into in the hospital. It is certainly not, in our model, meant to take over in any way from them, it is recognising that some population groups are going to always access the hospital for general practice in some respects for some of their problems. But we also want to facilitate the seamless transition from care in general practice to care in an acute hospital setting.

Works program

The Committee questioned the witnesses as to how it was proposed to manage the development given the complications of the site. Mr Shurman responded:-

... certainly we have put a lot of effort into - we will not refer to that as master planning because in this sense that is another issue about service delivery, which the hospital is looking at again with Mr Ian Bennett - but in terms of this program, which is essentially that mixture of Commonwealth and State funding, particularly the DEM which we, I guess, started working on as a State program earlier in 2008, which is then caught up with this Commonwealth program and a combined effort by both State and Federal governments to improve service delivery in Launceston.

The site issues are not insignificant, and as you got a window of that from John Slore we are working very closely with the hospital, but the Commonwealth had put some pretty tight funding targets to us, so we are going to have to work around the site almost simultaneously with these projects. We have prepared a procurement model, which we have submitted to DHHS and to the hospital about how we would deal with that issue and what we will have to do in terms of the constructor to try to encourage the constructor to work empathically, if you like, with the hospital.

Mr Cochrane added:-

I suppose it would be fair to say in the program that we have that package of work happening on the Frankland/Charles streets corner. Then there is a separate package of work happening down at the back of the hospital site on the Frankland Street entry for the carpark and then further up to the LCC. They are separate construction sites for the methodology of contractual management.

Precinct committee

The Committee questioned the witnesses as to what arrangements, if any, had been established to ensure the opportunity for an appropriate level of input to the planning process. Mr Kirwan responded:-

For the building site the project control groups - and there is a diagram in (the submission) about how to manage the governance of it - the actual building of the projects, particularly the large parts of the projects, have gone through the project controls process and those project control groups are as per you would see in most other Government agencies and they are structured and all the stakeholders are involved, albeit the emergency department one has grown in its scope and has therefore caused us to actually include more people, including a rebasing recently in respect of risk management. So we have got all those issues, because that project control group is looking at what was originally only the emergency department. It has now got the acute medical unit, the ambulatory area and levels four and five, which is a large part of it. The ICC will have its own as well. The other areas are quite distinct projects. They will be run just as projects through Mr Slore's area.

The precinct advisory group is a different concept. It comes hand in hand with the creation of the Area Health Service, which happened in July. If you look at our precinct rather than the LGH city block, when you look at what we have across the

road in the direction towards the city, up the hill towards our nurses' home and potentially Drysdale House, up Howick Street in respect to the areas we have been talking about and all of those areas, what we have is quite a disparate site that is not particularly well managed as a coordinated site and what has traditionally been the case is that LGH is actually running its bit and the other bits have managed their bits, sometimes with the department and sometimes in isolation. An integrated area health model which is what we have under an area model allows us to bring those areas together and it also allows us to bring together what is happening in the greater Launceston area. The Kings Meadows example in respect to the satellite unit is a good example, including now looking at where we actually have needs for the population of the Launceston area and the Northern Area Health Service. When you look at the area and the assets we have that go to the conglomeration around Launceston General Hospital, they are not particularly well-designed or planned as a collective. What we would like to do is establish a health precinct committee involving particularly the council chamber, UTAS and others, so we can get a handle on managing the whole site. To be frank, there are some buildings that should be bulldozed. There are probably some that should be disposed of.

Mr Slore added:-

... Under the project control group there is a project user group; they are the people that go out and they are representatives from all over the area that we are developing, so they are the ones that have all the input into it that report back to the project control group. So, in answer to your question, yes, we do talk to all the staff and they have a fairly big input into it over a period of time.

Car park

The Committee questioned the witnesses as to the detail of the financial model intended to apply to the operation of the proposed car park. Mr Kirwan responded:-

The current financial model, in that we've been told nothing other than that, is that we will operate it and that is what we are proceeding on at the moment. The focus is on building it. However, there had been some discussions last year with Treasury about, for example, going to the private sector and then building and operating it. For a range of reasons, that didn't come to pass, which we are relatively happy about. What the future model is I think is unclear and, from discussion the department had with Treasury, our preferred model is that we own it and operate it, albeit we might contract out the operation and, for example, the council has expressed an interest in operating it. So the various models of what it ends up as are still unclear and there is an expectation from Treasury that they would get some return on the investment in this area and so that's yet to be finalised as well.

The Committee sought evidence of the non-standard dimensions proposed for the car park. Mr Floyd responded:-

The Australian Standards calls up different sized car parking for different sizes and different types of facilities. In hospital, the planning for a car park is the equal of a 2.6 wide car park by 5.4 metres long, with an access road, access of 6.5 metres. There is a requirement for a clear space of 2.3 metres as a volume above that car space. That is different to what is usually provided in, say, normal commercial parking where that is a bit smaller. The reason is it is a little bit more easy to access these spaces and it is considered that there is a range of different vehicles that would potentially be wanting to access these spaces, like patient transport and -

... There would also be a requirement to provide a certain number of disability car spaces, making sure that they have appropriate access. There would also be a provision for bicycle car parks. As part of the development we will be making sure

that users of the car park can easily access vertically and horizontally. We will be providing for cars around and generally trying to make it as pleasant an experience as we can. We will be designing the building so that as far as practicable it is naturally ventilated and naturally illuminated. So we are trying to keep our running costs down. We are trying to provide environmentally sustainable car parking where it is possible.

There are 405 additional spaces and it works out between Frankland Street, Charles Street and Cleveland Street, 876 plus or minus one or two. It is very close to that number. There are additional spaces around the site outside that block but that is just in that block.

Mr Slore added:-

... the on-street parking once we finish our car parks will change to time parking, whereas at the moment it is unlimited parking on northern side of Frankland Street, so that will basically free up more spaces to our visitors because our staff will not be able to park there. At the moment they are all staff who park up Frankland Street. We have also got parking behind Viewpoint which the building up on the hill across Frankland Street. That is not counted in the total spaces that are there.

Centre of excellence

The Committee questioned the witnesses as to why it was important to have a centre of excellence with respect to the siting of the linear accelerator and what difference, if any, such facility would have from training point of view on a statewide basis. Dr MacDonald responded:-

I think there is no doubt that the critical mass that occurs as a result of putting those bunkers together in one place allows us the facility for training, allows us the critical mass of physicists, radiation oncologists and other therapists in one area to provide an extended service and to fully utilise those bunkers to provide care to the whole north of the State. There are significant economies of scale that come out of that process but the most important one remains the opportunity to locally then train and mentor new staff and the retention that will occur around that. I'm aware over here of the issues around the location of that bunker and I'm also aware that, at a statewide planning level, the future intent is not necessarily to not have bunkers on the north-west coast. However that planning flow process is in place and the outreach around that. Once the sustainable critical mass is established here then there will be enough resource to look at effective outreach in the next rollout of additional services. I think it offers a northern centre within a critical mass for the next step to be further outreach.

Sustainability

The Committee questioned the witnesses as to what aspects of the proposed works, if any, may be regarded as contributing to environmental sustainability. Mr Shurman responded:-

I think we can answer that in broad terms, particularly with the hospital's cogeneration philosophy happening at the hospital here with the gas and electric. That I think embodies what the hospital is doing on a larger scale, planning for and delivering that. What we are doing with the new buildings is to try to bring them into the right sort of sustainable design, particularly the ICC where that is part of its brief to be sustainable.

Grey water collection to the degree that we can, remembering that this is a hospital and in a clinical setting we cannot do some of the things you might do, say, in an office building necessarily but we are doing that in the ICC and also looking at potential for solar collection. There are new products are out like glass which has the solar cell embedded in the glass.

It can be put in a double-glazing unit. There are some good double-glazed units. Each has a different coefficient of insulation so it is a case of how far we go with that within our budget because obviously this is at a cost. The ICC has a natural ventilation atrium, if you like, in the middle where the plan can enable that to happen. But the big effort, I think, in the hospital proper is the cogeneration.

Mr Cochrane added:-

It would be fair to say that ESD factors that are put into buildings now, 10 years ago would have been some of the first factors that we would look at cutting out if we had a cost issue. Now it is just accepted as part of the core business and the core building services and that would be the last thing you would look at in trying to delete as a cost saving. Treasury has yet to mandate arrangements for us but I am sure that will happen in due course, a green star rating for all new public buildings.

DOCUMENTS TAKEN INTO EVIDENCE

The following document was taken into evidence and considered by the Committee:

Department of Health & Human Services - Launceston Health Precinct Capital Improvement Program Submission to the Parliamentary Standing Committee on Public Works, October 2009

CONCLUSION AND RECOMMENDATION

The need for the proposed works was firmly established. The redevelopment of the Launceston Health Precinct aims to improve patient care and outcomes by providing a health service site that will ensure the sustainability of the Northern Area Health Service by:

- improving medical and surgical services within the LGH;
- improving the coordination of health care by diverting patients from the LGH (acute facility) to a more appropriate non-acute care setting such as the Northern Integrated Care Centre (NICC);
- increase collaboration between primary and acute health services;
- improve education and research for health professionals;
- improving patient and staff access to site services and facilities.

Accordingly, the Committee recommends the project, in accordance with the documentation submitted, at an estimated total cost of \$98,200,000.

Parliament House Hobart 4 December 2009 Hon. A. P. Harriss M.L.C. Chairman