PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON WEDNESDAY 16 FEBRUARY 2022

ROYAL HOBART HOSPITAL EMERGENCY DEPARTMENT EXPANSION STAGE 1

CHAIR (Mr Valentine) - For the record I would like to introduce members of the committee that are on this side of the table. We have Felix Ellis, Jen Butler, Rob Valentine, Tania Rattray and John Tucker, committee secretary, Scott Hennessy, and Rosemary Johnson from Hansard.

Welcome to this hearing in relation to the Royal Hobart Hospital Emergency Department expansion, phase I. We have no apologies, we are all present. The secretary will now read the message from Her Excellency the Governor-in-Council referring the project to the committee for inquiry.

Ms PATRICIA ALLEN, NURSING DIRECTOR, CRITICAL CARE CLINICAL SUPPORT, ROYAL HOBART HOSPITAL, **Mr ANDREW HARGRAVE,** DIRECTOR, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, **Mr MARK LEIS**, PROJECT MANAGER, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, **Mr SCOTT VERDOUW**, DIRECTOR, JAWS ARCHITECTS, **Mr TOM NOVAKOVIC**, ARCHITECT, JAWS ARCHITECTS, Ms EMMA HUCKERBY, DIRECTOR, EMERGENCY DEPARTMENT, ROYAL HOBART HOSPITAL, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. I need to read a statement before you give evidence so that you are well aware of circumstances.

Thank you, first of all, for the tour this morning. That was very informative as these tours always are. It certainly adds to our understanding, the siting of a project, et cetera. We are pleased to hear your evidence today. Before you begin giving your evidence you need to be aware that a committee hearing is a proceeding in parliament. This means it receives the protection of parliamentary privilege. It is an important legal protection that allows individuals giving evidence to a parliamentary committee to speak with complete freedom, without the fear of being sued or questioned in any court or place out of parliament. It applies to ensure that parliament receives the very best information when conducting its inquiries.

It is important to be aware that this protection is not accorded to you if statements that may be defamatory are repeated or referred to by you outside the confines of the parliamentary proceedings.

This is a public hearing and is being broadcast, and members of the public and journalists may be present and this means that your evidence may be reported.

Do you understand?

Messer's HUCKERBY, HARGRAVE, VERDOUW, ALLEN, LEIS and NOVAKOVIC - Yes.

CHAIR - Thank you. I welcome any members of the public who maybe tuning in today to hear this particular reference.

Would you like to make an opening statement?

Mr HARGRAVE - Thank you, Chair and members. In March 2019 the Tasmanian Government, following the release of the Royal Hobart Hospital master plan and recommendations made by the Clinical Planning Taskforce, announced the commencement of stage 2 of the Royal Hobart Hospital redevelopment.

The Royal Hobart Hospital redevelopment stage 2 was to include an expansion of the emergency Department to meet growing patient demand; a comprehensive refurbishment of A block to provide temporary space for additional beds; an expansion of the ICU in its current location, providing space for an additional 12 beds and retaining close physical linkage to medical imaging; and a refit of J block to meet additional demand and provide for new clinical uses.

A further announcement in relation to the expansion of the ED was made by the Minister for Health in September 2021, committing to an acceleration of the opening of 25 new emergency beds by the end of 2022 to assist in dealing with an increase in demand.

The second announcement and the resulting project are specifically the subject of today's Parliamentary Standing Committee for Public Works meeting, and represent the first phase of the broader emergency Department expansion as part of the stage 2 of the Royal Hobart Hospital redevelopment. The project team has termed the project ED expansion phase 1A.

As Mark Leis to my left here, the project manager for the Emergency Department project and Mr Scott Verdouw, representing the Department's consulting architect, Jaws, will describe during the course of our meeting, the redevelopment of the Emergency Department in a working hospital brings a high degree of complexity in relation to staging of works to enable an expansion of services while continuing to provide a high level of patient care and a suitable working environment for clinical staff.

The Parliamentary Standing Committee report that you have describes the project in more detail. The project team will do the very best to answer any questions you may have in relation to that, or take on notice any questions that we cannot provide to the committee today.

Through you Chair, if I may, I would now like to defer to Emma Huckerby, Director of the RHH Emergency Department and Trish Allen, Nursing Director, Clinical Care, Clinical Support and Investigations to elaborate on the demand currently being experienced by the Royal Hobart Hospital Emergency Department.

Dr HUCKERBY - The Royal Hobart Hospital Emergency Department opened in 2007. It was constructed to accommodate 45 000 patients per annum. We exceeded that in the 2009-10 financial year. Last calendar year, we saw more than 72 000 patients and it is expected that we will be up to 95 000 patients within the next five years.

This means that when patients arrive in the emergency Department, the beds are often full of the patients who have arrived before that. Some of this is because of access block, but we have done a lot of work with admitted patients staying in emergency Department beds.

There has been a lot of work on flow and expanding inpatient services, so we know now that even when everyone in the emergency Department has been in the Department for less than four hours - achieving full best practice patient flow - we can still be ramping up to eight ambulances. It is a function of just the number of patients coming in per hour and the number of beds that we have in the Department.

This is why the whole expansion is occurring and is being planned. It is also one of the reasons why this initial step to create a decant space within the emergency Department is so critical: we cannot afford to close any of our acute beds to build the next lot of beds.

So, number one, this is being put in place as a strategy to allow us to get through the rebuilds. It's also put in because this is what we want; this is a final thing. This is not something that's going to then be repurposed and changed as part of the rebuild. We would ultimately be aiming to have this ED short-stay unit in as a function. Then, finally, with COVID having occurred, we're very aware that there are times when we need to manage potentially infectious patients in a way that's separated from the rest of the non-infectious patients. So, the way this is being structured, having the capacity to have an entrance, even though we won't be using it normally, through a different way into that area, we will be able to provide emergency care to a separated group of infectious patients if required in the future. So, it's future-proofing for future pandemics as well.

Ms ALLEN - If I may just add, this also is an area for our model of care as a short-stay unit, which is an important part of the ED care, patients who require more than four hours of care but less than 24. It gives us an opportunity to observe patients, to sometimes, often provide them with that higher management of care and then stabilise them for discharge within the 24-hour period. There's a lot of multidisciplinary care that happens in that environment - allied health, nursing, medical support staff. So, it would be great to have a purpose-built area because currently that is in an environment that was originally designed as a medical ward.

CHAIR - I can understand that. Obviously, the redevelopment of the whole Royal Hobart Hospital over the years is a complex project. I'd hate to be the project manager. It's a very complex project and to have to do it while the hospital is operating and to figure out how you're going to decant at every step, everything that you revamp, you've got to have a decanting site. I think the committee understands the complexities associated with that, given the references that we've dealt with over the last few years, with the Mersey and other locations.

Ms RATTRAY - Chair, we're obviously becoming very familiar with the Royal Hobart Hospital and not as patients, aren't we?

CHAIR - You believe that this might not be the last one we see?

Ms RATTRAY - I believe so.

CHAIR - I think that's the case. The way we normally do these things is to work our way through the submission so that we don't miss anything. You can direct the question to whoever you believe is best to answer it as we go through. I'm going to go to page 3, which is the introduction. I want questions from that page if any member has one. Yes?

Ms RATTRAY - My question might go to Dr Huckerby. In regard to your reference to the significant challenges with ambulance ramping, which we regularly hear about in the

community: this proposed change is going to somewhat address that. Would it be fair to say that we'll never be able to address something like that fully or know if we can? Is this just part of that journey?

Dr HUCKERBY - Yes. I think this is optimising the capacity to reduce ramping. Ramping is a funny term because ramping is really not in a ramp. It's in an area - a corridor or in a clinical space - where they are all co-located but they are still under the care of the paramedics. Where it's appropriate, we pull patients directly from there to the short-stay unit without going through the main emergency Department. So, if we have a patient that an Ambulance brings in and they say, 'This is someone who's had a collapse', we have a quick look and say, 'Yes, the patient's probably going to need a little bit of care; some fluids and stuff like that'. But they don't need to be in the busy, noisy emergency Department and we pull them directly to short stay from that area. It definitely helps with ramping and it's a great model for that.

Ramping overall is something that has not been successfully eradicated anywhere but what you want to do is to not have it every day and for long periods. You know that for 15 per cent of the time you might have a small amount of ramping; if you have a purpose-built area that is the right size but you don't want to be ramping every day this will help.

CHAIR - So it's the exception rather than the rule.

Dr HUCKERBY - Yes.

CHAIR - Probably a Saturday night or whatever when you have high activity in the community.

With respect to ramping, I brought this up during the tour, a chain is as strong as its weakest chain. I think they were the words I used. Clearly, bed block is something that causes concern and stops people from being able to be moved from emergency out into wards and the like. Can you explain how this won't make matters worse? How will it improve that circumstance, as far as the operation of the hospital is concerned?

Dr HUCKERBY - By expanding our current 16-bed short stay area to a 28-bed area we're also implementing an expanded model of care. There will be patients who will be cared for in this area when it's created who are currently unable to be cared for in that area. That will lead to some patients having their whole care in the emergency Department, normally, but a significant number of those patients are going to be patients who normally get admitted to a multi-day ward admission who will come into this area instead.

An ED short-stay unit has a very different medical model of care than an in-patient unit and is staffed to do so. Basically, there are multiple ward rounds during a day. There are consultants rostered in that area from 8 a.m. to 11 p.m., plus senior medical registrars and other staff who are able to make decisions immediately so that when a patient is ready to go home they can be discharged, whereas in the rest of the hospital a lot of ward rounds don't have the staffing that goes for those extended periods of time. It's a high-intensity area and that helps with flow.

CHAIR - Or it might be things like pharmaceuticals not being able to be delivered at the right time to enable someone to go home.

Dr HUCKERBY - Yes, we have access to all of that.

CHAIR - That's fine. I was interested in that. In a previous inquiry we looked at this and the push-pull models and whether the wards are letting you know that they're free, therefore, you can send someone up, or whether you're pushing that patient through to the ward without them being prepared for it. Having that extra space sounds like it might work better than it does at the moment, so very good.

Ms BUTLER - Dr Huckerby, to clarify your previous statement, are you expecting there to be 95 000 presentations in the next five years?

Dr HUCKERBY - Up to 90 000 in the next five years, if we continue to grow at the rate that we're currently growing.

Ms BUTLER - In your experience, will the completion of those 118 points by 2025 meet the demand of phase 2? I know it's a hypothetical, but based on modelling.

Dr HUCKERBY - We worked out that, based on modelling, 120 will get us from 2025 to 2035, which is what the current planning and aim for this particular build is. That means that before then we need to be preparing for the next tranche of beds at that time but that's based on the modelling predictions and the expected bed utilisation for those patients.

Ms BUTLER - Do you know what the current numbers of people admitted to the short-stay unit are and what they have been over the last 12 months and maybe the 12 months before that?

Dr HUCKERBY - If we take into account that there's been a lot of changes backwards and forwards with COVID-19, because we've had a 10-bed unit then we've had a 16-bed unit with all of that. But when we went to 16 beds this last time, we were seeing between 28 and 35 patients a day through the 16-bed unit. There were times when we would get up to 40 patients a day through that area. It depends on the patients that are suitable to go down there, whether they end up being short, short-stay patients or longer short-stay patients.

Ms BUTLER - It will certainly be utilised.

Dr HUCKERBY - Oh it's very well utilised, yes.

CHAIR - At the moment what are the number of points of care that you are dealing with?

Dr HUCKERBY - Currently we have a 16-bed short-stay unit.

CHAIR - No, but in terms of 118 points of care during 2020-2025, what's -

Dr HUCKERBY - Fifty-seven is the official number.

CHAIR - Okay. That's a significant uplift by 2025.

Dr HUCKERBY - Yes.

CHAIR - Certainly more than double. That's very good.

Mr ELLIS - Chair, I wanted to get a sense - I am not sure who might have the history on this but we've got the current emergency Department completed in 2011, 45 000 presentations. What additional capacity was put in when that was first built? I mean, we are looking at less than 10 years later and we have had basically near on 50 per cent increase over the top. Did we build it basically to the current demand, or did we build it with additional capacity that then just caught up with the trend?

Dr HUCKERBY - None of us were actually involved in that initial planning but just talking back to the time, there was firstly a hope that emergency Department attendances would not go up. There was a very strong belief that community services would be able to divert people from emergency Departments. But that hasn't held up anywhere. That's worldwide. That was an opinion back in those times so they did not anticipate needing to grow in the way that we have.

Then, I don't think anyone really expected that our population has become so much more frail and co-morbid, and needing much more hospital-level care for periods of time. So each individual person is needing more presentations to an emergency Department than we would have thought back 11 years ago. The success we have in managing people with chronic illness and the elderly in their own homes is countered by them being much more frail and likely to need intensive input for a period of time before they can go back.

Mr ELLIS - When we were trying to pick the trend in building the facility in 2011, we assumed no growth because it would be out in the community, and what we have actually seen, particularly in ageing western societies, is the opposite - we've actually had more growth than we had previously.

Dr HUCKERBY - That is correct, yes.

CHAIR - Supplementary on that, is there any correlation with the level of, say, GP services that are out there in the community in any way shape or form?

Dr HUCKERBY - Yes. There is definitely a correlation but it is not the direct correlation where people think that people come to an emergency Department with a GP problem. Most people don't. What happens is that if you cannot get into your GP as regularly - so you should be seeing them monthly and you are only seeing them every two months - you are much more likely to get sick and need to go to a hospital for hospital-level care than if you can actually maintain the normal amount of access to GPs.

CHAIR - That is interesting, isn't it? It's in the hands of the individual at the end of the day, the services they might be trying to access, and if they're not inclined to do that, it could be visit to the doctor once every two years, like some, if you're well enough. Any further questions? No, well over we go. The next point.

Ms RATTRAY - This one might be to you, Trish, because in your overview you talked about the model of care. In the dot points it talks about the methods used in the new RHH-approved model of care of the ED 'includes a review of relevant peer-reviewed and grey literature'. Can I have some explanation of what 'grey literature' is? I obviously understand the peer-reviewed, but grey literature?

Ms ALLEN - That is often reports from other organisations that have done trials and tested the model. Generally, from a search engine you can find those reports, not necessarily in published literature from medical and nursing journals.

Ms RATTRAY - How much weight is put into those areas?

Ms ALLEN - I think it all adds to the whole picture. We also use some of our networks, some contemporary models with other EDs, through colleges like the Australasian College for Emergency Medicine. They're very contemporary on looking at models. The College of Emergency Nursing Australasia also look at models of care. I guess we use talking to networks, as well as looking at literature and evidence from research that's been conducted, and putting it all together. I would not say we could put a percentage split on each item. And we had a consultant engaged to complete that work.

Ms RATTRAY - You probably ended up being more confused than when you started.

Ms ALLEN - I think we found that it was actually a good exercise to go through and reassured us that the model of care direction we were heading in was the right one.

Ms RATTRAY - Thanks for that clarification.

CHAIR - Do you benchmark with any particular hospital or set of hospitals, or not?

Dr HUCKERBY - I guess we have the benchmarking for the flow and the 'seen-in' times that are the federally reported benchmarks, and we have quality benchmarks that are related to standards, and that type of thing. Our college has benchmarks that we have to meet for education purposes.

CHAIR - Getting your licence to operate basically?

Dr HUCKERBY - Yes. But we are a very unique hospital - a single major emergency Department with no other public hospitals around for diversion, providing the broadest level of care to a very broad population. It is difficult to get one hospital and measure that against another hospital. We are quite unique.

CHAIR - What are the current arrangements with the private hospitals that are nearby, Hobart Private and Calvary? I don't know whether they do it at St John's, in terms of overflow. Do you have any opportunity to call on their resources at all to deal with certain patients, or don't you work that way?

Dr HUCKERBY - We do have some diversion capacity: when we've got very high capacity issues in the organisation then we can ask and contract for ambulance diversion to the private hospitals. That occasionally happens. That's the main way it happens. When we admit a patient, if they elect to go privately and we have a consultant who will look after them in the private, then we will transfer them to the private hospital as an inpatient.

Ms BUTLER - I have a question on the third dot point. I'm not sure who is the best person to answer this question. On the third dot point we have 'targeted consultation with lead

clinicians and decision-makers'. Who makes up that group of decision-makers? What does that actually mean?

Mr HARGRAVE - Mark, did you want to answer the member's question in relation to the stakeholder group that has been engaged?

Mr LEIS - Yes, I will, with help from Emma, because we set up some workshops around the model of care. I think there were 22 people there. I believe that there was a representation from Ambulance Tasmania at that one, there were two people from the community clinical support or medical support so people from the community -

Dr HUCKERBY - Consumers.

Mr LEIS - Consumers, that's it. Two consumer representatives in that. Then Emma and obviously Trish, and their colleagues; I think you had two each with you in that group, as well as then the architects present and infrastructure services.

Dr HUCKERBY - We also had paediatrics represented -

Mr LEIS - That's right, yes.

Dr HUCKERBY - and one of our consumers is a mental health consumer, so he was providing a mental health perspective as well.

Ms BUTLER - Was HACSU consulted at all on this process?

Mr LEIS - I don't think we had a union representative at those particular model of care workshops, no.

Ms BUTLER - Okay. Were they consulted at all on any part of this development?

Mr LEIS - Through this stage, no. It's not been put up. The elements of this will go to the Capital Steering Committee and there is also the joint Unions and Management Committee, which it will go to in due course, I believe.

Ms BUTLER - Okay. Thank you.

Ms RATTRAY - You said that those people will be involved 'in due course'. Will there be opportunity for them to have input into any potential changes or, if it's approved, will that pretty much be what the development will look like and there won't necessarily be opportunity for input for changes?

Mr LEIS - I think around the consumer elements and the operability of it, yes, there will. It will need to go through as we're in the detailed planning as we speak. The floor plate itself is pretty much locked in, as all we can do; and we've met our requirements to deliver at least 25 beds and also address the model of care within that. I think there'll be more value in the next stage, where they can address their specific requirements. We will certainly make sure that happens.

Ms RATTRAY - Thank you.

CHAIR - Is there likely to be any show stoppers in there? When we're dealing with these sorts of things, we like to know that things will run reasonably smoothly and it's not going to be overtly impacted pricewise and those sorts of things.

Mr LEIS - Certainly from a clinician's point of view, and running the detailed workshops which are going at the moment, we have representation from the broader team. They're very focused on where do the power points go, where do the medical gasses go, so you can deal with the patients very quickly. I'd be very comfortable that from a clinician's point of view and from WHS principles that we'd be addressing that. From the point of view of the patient, we will probably make sure that we have a step in there where they can have a close look at that as well.

CHAIR - I brought this up a couple of times in the past, where someone forgot to talk to the orderly; and the orderly, when they're wheeling trollies around and patients on trolley beds, get to a corner, and it's not big enough, 'This is a pain, I keep hitting the wall'. There's a possibility that it injures a patient because their arm's out the side.

Mr LEIS - The thing that guides us on that is the Australian Health Facilities Guidelines, the AHFG. Scott and his team are very focused, and it is a requirement of the project that we meet those requirements and I believe the broad principles of that -

CHAIR - Corridor widths and heights of things; all of those sorts of things are taken into account?

Mr LEIS - Yes, they're well and truly taken account of in there. With some of them, the project manager and the budget are asking, 'Are you sure we have to do that? That's just a bit too big?'. But that's our guidance.

Mr VERDOUW - Being a brownfields site, you may not be able to meet all of the guidelines 100 per cent. Where there are departures, we make sure that that's been covered and run past anybody affected.

Mr LEIS - At this point we've met all of the AFHG requirements in that regard. I'm not sure if you know how broadly that's been consulted but it's Australian recognised and represented as well as with all of the clinicians' umbrella authority - the college.

CHAIR - College of Emergency Medicine?

Mr LEIS - Yes. They say that, at a minimum. I think their minimums are a fairly high bench mark.

CHAIR - They've been part of the consultation anyway.

Dr HUCKERBY - Part of the thing here is that we are talking about two different things. We are talking about the ED short stay unit and also the whole model of care for the new Emergency Department. The ED short stay unit bit is well advanced and has been consulted and everything; but the main consultation phase that we will need to have is about the whole model of care. That's where we are definitely going to be talking to HACSU and the AMA and

the ASM. All the different components need to be part of that big model of care work. We have a lot of stakeholders.

CHAIR - That's interesting to know. Any other questions on page 5? Page 6? We touched on COVID-19 and the way that was going to be handled. You might like to explain isolation arrangements and those sorts of things.

Dr HUCKERBY - We've created a pod of 28 beds that have a negative flow of ventilation that is separate from the rest of the hospital, and will allow people to be in that whole area without spreading infection to the rest of the hospital. It has the capacity to have its own entrance if required. It also has direct access to ICU and Radiology because there is a lift at the back that goes directly out.

CHAIR - ICU is very close to that, isn't it?

Dr HUCKERBY - Yes; but without even having to go through the rest of the Emergency Department. It is a really good spot if you want to have a pandemic-related area.

CHAIR - Okay. It sounds good.

Ms RATTRAY - We spoke onsite earlier today about the advantages of natural light. I would be pleased if you could put on the record, maybe Scott or Tom, what's been proposed for natural light; albeit it will be somewhat limited.

Mr NOVAKOVIC - We are limited to how much natural light we can get into the space because of the existing façade and it's pretty much one façade that we can get natural light into. We have arranged the rooms so that we can utilise as much of those existing windows as possible. Some of them are quite large to go into those patient bays, but there will have to be some mitigating features for procedure rooms so that we can make them dark as well, obviously, but we will have to get through that in the detailed design.

I think you are right about the positives of natural light. I'm sure the doctors appreciate knowing what time of day it is and that kind of thing. We have tried to incorporate that into the design as much as possible.

Ms RATTRAY - I think it was mentioned that they like to know what the weather is doing outside.

CHAIR - A question on the bays and the like. Bariatric patients - how many of those can you deal with? What's the capacity in relation to these emergency pods?

Dr HUCKERBY - There's one specific bariatric bay which is very purpose built and able to accommodate not the highest level of bariatrics but it is the next highest up; this is my non-technical understanding of the architecture. We will be able to accommodate at least one bariatric patient in a bariatric specific room.

CHAIR - That should suffice, in your experience?

Dr HUCKERBY - It should, because the model of care is a short stay unit. It's more likely that a bariatric patient will need a multiple day stay, and we need to be able to

accommodate some, but it is not going to be a big area for us as far as volume of patients going through.

CHAIR - Compared to the total?

Dr HUCKERBY - Yes.

Ms ALLEN - If I may add, those S class rooms can also be utilised because generally people are mobile in short stay so if they're able to mobilise but you need a larger bed, for instance, the larger rooms such as the S class rooms there are large enough to fit a bariatric-sized bed.

Ms BUTLER - Are there also allowances made for larger patients who may need hoist systems? Are those facilities available within that?

Dr HUCKERBY - In the bariatric room there is the overhead hoist and everything.

Ms ALLEN - Double tracks.

Dr HUCKERBY - The bariatric room is fully kitted out with all the support structures in place to support manual handling for those patients.

Ms BUTLER - That would cater as well for, say, a person with a disability who may be an amputee? That has all been designed?

Dr HUCKERBY - Yes.

Ms BUTLER - If you could run through, for the record, the question we asked today about where the entrance is that it's not a general entrance for the public. That is not where they will actually enter and the process for that.

Dr HUCKERBY - An emergency Department short stay unit has a set way of working that's a federally-defined part of IPAA. That is where it all starts from and it has to be that the patient is an emergency patient so they have to come to triage at the emergency Department and at least be briefly assessed before they actually go into the short stay unit. They don't turn up at the front door of the short stay unit for admission. They come to the emergency Department entrance and then they come through. Once they're in the emergency Department short stay unit then if they want to go out and back in there is a door that we would be able to facilitate some - we haven't worked out that level of detail. But people would be able to go in and out without having to go all the way around the block and come back in through the front, and for relatives to pick people up and things like that.

Ms BUTLER - For the record, the movement from the existing emergency Department to the short stay unit - could you run through the distance there that it's not a very far distance?

Dr HUCKERBY - The distance for the transfer of patients to the short stay unit is not very far at all. It will be relatively easy to get the patient from one area of the Department to the other.

Ms BUTLER - With ambulance admissions, how far is it from where the ambulance bay is? Not the private hospital ambulance bay but the existing ambulance bay to that short stay unit if that decision is made for them to go directly there instead of going through the emergency Department?

Dr HUCKERBY - Again, that would happen around the triage area and it would be the same distance for a non-ambulance arrival and the arrival by ambulance. That's based on the current build. When we work through the second part of the build we will know exactly how far it is from the new ambulance arrival area.

Ms RATTRAY - One of the areas that has been of interest right through this redevelopment that I've been involved in is about the equipment storage areas and medication and the general equipment. When we go to visit they are usually lined up against the hallway which is not very efficient. It doesn't look all that neat and tidy either. Assure me and the committee - I am sure they're interested - that we have enough storage area for those items that are really important but seem to be sitting in hallways as we speak now.

Dr HUCKERBY - With this short stay unit, it has the best medication room that I will have ever worked in so, from that perspective, that's fantastic. The consumables storage area is really good from a size perspective and we have identified specific bays for drip stands and pumps and ultrasounds and wheelchairs.

Ms RATTRAY - Trolleys?

Dr HUCKERBY - It won't have trolleys, extra trolleys, in the short stay part. The trolleys will be in the bed spaces so it's the next part of the build where we've got to make sure that we have enough space for the trolleys, for everything else to be able to be stored without it being in the corridors. We agree: it should not be in corridors.

Ms RATTRAY - But if there is nowhere else for it at this point in time you have to put it somewhere.

Dr HUCKERBY - Yes.

CHAIR - What is the relation to that, the multi D clinical w/r. What is that?

Dr HUCKERBY - Work room.

CHAIR - It is a work room is it?

Dr HUCKERBY -Yes. A short stay unit often has a high focus on allied health inputs, so a multi D work room is for the physios, OTs, social worker, nurse and doctor all to get together and talk about the patient and how we can best get that person home.

CHAIR - It can be a handover room as well I suppose.

Dr HUCKERBY -Yes, it can.

CHAIR - Okay. I notice here you have dirty utility -

Dr HUCKERBY - Yes.

CHAIR - but clean rooms, where you actually keep all your sanitised gear? Whereabouts is that in here?

Dr HUCKERBY - The consumables room.

CHAIR - It is in the consumables, okay. As simple as that, and the medications?

Dr HUCKERBY - Yes.

CHAIR - Okay. Thanks for that. In relation to sanitisation stations and the like, obviously people are coming in off the street. It is a very difficult thing to be able to make sure you keep everything spick and span and everybody clear of everybody else. What sort of processes or procedures have you got to make sure that happens effectively? I know you would have an infection control nurse but apart from that, the facilities that they need to be able to work properly?

Dr HUCKERBY -We have two checks to make sure that we have done the right thing with cleanliness; one is that an infection protection control nurse has been part of all our working groups so they have had a lot of input into the number of toilets, the number of showers, the number of handbasins and the placing of all of those. Then again, we have to comply with the Australian facilities guidelines which also specifies the number of showers per rooms and the number of ensuites in each area. We have complied with all of that.

CHAIR - Okay. Any other questions on page 6? Page 7?

> Talk of a secondary corridor provides an alternative path of travel for patients that may require a higher degree of privacy.

A secondary corridor, where is that on the plan?

Mr LEIS - I think it is having the two different sides to it.

CHAIR - Just to have two main -

Mr LEIS - Yes. In effect the two entries at the top as well.

CHAIR - Yes, separate entry.

Mr LEIS - Rather than just one way in and out.

CHAIR - Yes, you have multiple ways.

Ms BUTLER - What kind of acoustics and noise absorption will you have in place for that space at this stage?

Mr NOVAKOVIC - I guess we are limited for absorption in materials for cleanliness and being able to clean those materials. Anything that absorbs sound also absorbs germs and blood and all that kind of thing. We are a little bit limited in that sense but we can do things in

the ceiling for example and things like that, but there is a certain set of materials that we can use. Yes, I think that's all I can say about that.

Ms BUTLER - There's floor coverings and ceiling coverings. What kind of materials would they be? You would hate to have this beautiful facility and it being very noisy.

Mr NOVAKOVIC - I guess it would be vinyl flooring. We would have plasterboard set ceilings so there is acoustic treatment that can be done with that but the walls would be a vinyl sort of finish. I guess that really helps with the cleaning of that material and being able to wash that down. Once again, having something absorbent is not really ideal in this sort of situation.

Ms BUTLER - But it certainly will be part of the actual design and build?

Mr NOVAKOVIC - Yes, that's right.

CHAIR - I suppose there is always the circumstance where somebody is yelling their head off because they need attention and they can't be heard because it's too dampened.

Mr NOVAKOVIC - Yes, that's right. That's true. But there are enclosed areas as well that do provide acoustic privacy. Some of those enclosed patient bays would be good for them.

Ms BUTLER - So, the glass doors would provide that assistance as well?

Mr NOVAKOVIC - Yes.

CHAIR - There was a comment made in the paper over the last couple of days where someone said, to save people taking their masks and their PPE on and off all the time because they've gone through to a different patient and they've had to possibly change to go to see another patient, why don't they have an intercom system so that they can simply talk to the patient without going into the room? Did you see that? You probably didn't. I think it's in today's or yesterday's paper. It's a simple thing but they couldn't understand why that couldn't occur. Has anything like that ever been considered? Is that something you might consider?

Dr HUCKERBY - I don't know whether that works with Vocera. There's a pilot occurring with staff having intercoms to be able to talk to each other -

Ms ALLEN - It's a wearable device that you wear under your PPE that's voice-activated or tap activated. I'm pretty sure there is the option of that being part of the patient call button. But the pilot currently covers just staff being able to communicate with people outside of the room when they need assistance.

CHAIR - I thought it was an interesting one. Certainly, in this COVID era, it might have some ring of truth about it.

Dr HUCKERBY - We definitely conducted some of the consulting at the beginning of COVID by phone in patients' bedsides. Obviously, we'd have to go in and do some procedures face-to-face but, where we could, we could use phones. We did do that initially.

CHAIR - Page 8: glass stacking doors, obviously like a shower door only larger, folding in behind each other. I am assuming that means, as we talked about this morning.

If you could just explain the activation of the motion-sensor-activated doors; that it's not going to open for everybody who walks past it. How it will avoid passive opening from anyone just walking past?

Mr NOVAKOVIC - Obviously, the motion-sensored doors really help with keeping any sort of touching of any materials down. So, that's a big positive. You mentioned the problem of people walking past and potentially them opening but there's a very specific motion that has to be done, quite close to the motion sensor. So, there's no real opportunity to accidentally open a door -

CHAIR - Passively open, yes.

Mr NOVAKOVIC - Yes, exactly right. Yes.

CHAIR - We're all well aware of it here in parliament because we have one on the front door exit.

Mr HARGRAVE - Mr Chair, if I may, Trish indicated earlier today in the walkthrough that doors of that nature are already operating in the ICU.

CHAIR - So, you're well experienced with it.

Ms RATTRAY - On page 8, it talks about changes in materiality and colour, and about having softer, calming colours. Yet, in the pictures, we can see a bright green and a bright orange. Are they what you call calming colours now?

Mr NOVAKOVIC - Those images aren't so much for the colours, more for the objects that are in there. For example, the glass doors were there and also just an open patient bay as an example of something that our consultant architect has done in the past. It wasn't so much in the colours but -

Ms RATTRAY - They don't match the text, in my view.

Mr NOVAKOVIC - That's the intention but it wasn't - the images are more for showing the intent of other things, rather than the colours and materials.

Ms RATTRAY - I quite like the brown and the blue, they're fine. I'm not sure about the bright green and the bright orange. I saw Dr Huckerby was nodding when I was talking about that.

Dr HUCKERBY - I am not an orange person. We are going to choose the colour scheme based on the best practice for geriatric patients. We will make sure that the colour scheme is something that is going to allow people to differentiate between doorways and walls and floors and have the best visibility characteristics. It will have some choices in it, but it will be done based on what is recognised as being best practice for those purposes.

CHAIR - It talks about accessibility at the bottom of page 9. While I understand that the helicopter service is not part of this reference, how will patient transfer happen from that service to this emergency facility if that is needed?

Dr HUCKERBY - For COVID-19 purposes?

CHAIR - No, just helicopter access. So, if anyone coming in who has fallen off a cliff in the south-west, they are brought in and straight into emergency. How close is the helicopter service to the emergency Department from the point when they land on the roof? Is that a torturous route?

Dr HUCKERBY - No, the travel has been quite fast. You call a lift and the lift goes straight down to the right floor and then you have clear access to the resuss cubicles from there. It is not a vast distance.

CHAIR - Weather wise, how do they protect patients coming in from helicopters from bad weather? If you are coming in the middle of storm or something.

Dr HUCKERBY - I haven't personally been on the roof but I believe there is a room on the roof - a receiving bay area. They just have to get in from the helicopter into that room before there is a problem, which I believe is a short distance. Trish has been up there.

Ms ALLEN - Yes. There is an area where they can hang their wet weather gear. Bear in mind that the helicopter often lands in inclement weather to pick up the patient. So, they can offload their wet weather gear in the helipad lobby before then going into the hospital.

CHAIR - Page 11: risk registers. Do you have a full risk register? How many items on your risk register?

Mr LEIS - We have the master register which sits with the redevelopment phase 2. Where we do get a specific item, we will raise that separately. They often sit underneath; they're not generic but they are broad and then go into the details. So, there is not a separate one for this project as such. We have not identified anything here different from the risks the broader program has as risks.

CHAIR - What project management model do you use?

Mr HARGRAVE - The project management framework that we use to manage our projects is based on PMBOK with some influence from PRINCE2 as well, as I understand.

Mr LEIS - In essence, it's a stage-gate approach through each of the major milestones.

CHAIR - Obviously your higher-level staff have an oversight through a steering committee?

Mr HARGRAVE - Yes, they do. All the projects at the Royal Hobart Hospital report through the Southern Capital Steering Committee.

CHAIR - Excellent.

Ms BUTLER - On the last line of page 11 there is an acronym, AHFG; what does that stand for?

Mr LEIS - Australasian Health Facility Guidelines, the one we talk to that guides us in all of our designs for health facilities.

Ms BUTLER - I should have known that.

Mr LEIS - That's all right.

Mr HARGRAVE - I might quickly add there, it more than just guides us. It actually forms the basis or a specification for all of our clinical spaces, so a departure from that is quite a big deal. It is a departure from, essentially, our specification. That requires, obviously, support from the relevant working group that includes the clinical staff but also the steering committee. There is an appropriate level of the governance that surrounds a departure from that specification, if I can call it that.

CHAIR - It would be a real chink in your armour.

Mr HARGRAVE - Correct.

CHAIR - Because that could risk your accreditations, I suppose.

Mr HARGRAVE - I would imagine so. I'd defer to Trish or Emma on that but, yes, it is a big deal for us to depart from the AusHFG.

Ms BUTLER - When it says, 'where applicable', what does that mean? It's a standard of sorts.

Mr HARGRAVE - Yes, it is. The AusHFG is very broad - and please jump in, Emma, if you know more about it than I do, or Trish. It is a very broad document and it deals very broadly with specific clinical spaces but it doesn't deal with everything for every space that you might have in a hospital. I think that's where the 'where applicable' bit is referenced.

Mr LEIS - I have a good example with the Peacock Centre, which I'm familiar with. There are only two rooms in there that the AHFG covers us on. The rest of the facility, our mental health facility, does not have specific requirements or specific specifications within the AHFG.

Dr HUCKERBY - In our short-stay unit I think it is the staffing areas that don't have much in the way of health facility guidelines around them, and the sizes and stuff, so we have to make the decisions about what we need without those rules behind it; whereas the actual patient bay, we need an oxygen outlet, we need a suction outlet, there are things that are really very clearly specified.

Ms BUTLER - Is there a compliance regime around that? Is it checked and monitored before you construct, based on the design phase? How does that work? I am probably going a little bit off here.

Mr LEIS - From our perspective the scope that we give to the architects must be met so we seek that comfort from them. It is not a full audit per se, just a comfort statement that we've met those requirements in tidying up the final designs.

Ms BUTLER - Thank you.

CHAIR - Moving over to page 12.

Ms RATTRAY - This is where the rubber hits the road, Chair.

CHAIR - Or not. Funding and budget estimates, always an interesting one. A question on the contingency here, 15 per cent. Most often you get 10 per cent contingency but more often than not we are seeing escalations in materials costs over the life of the project, and it may well be 20 per cent. Is that material cost elevation sitting in the contingency there, or where is that? It seems to me that there is only one - either that or it is in the construction cost.

Mr LEIS - We have allowed for that within the contingency at this stage, so the current amount allowed by the quantity surveyor is 12.5 per cent. That's once all the construction costs are done. We have added a little more to this one because we are seeing those material costs and building costs as high as 20 per cent above what is traditionally regarded, so 15 per cent is what we have here. We are hopeful we can still land it within that. The construction costs are generous as well, being in a working hospital environment.

CHAIR - That quantity surveyor allowance, 12.5 per cent, or the cap, is that something that is driven by government?

Mr HARGRAVE - Not that I'm aware. It is more their understanding of the market and the volatility that exists in the market at the time that they undertake the estimating. That is my understanding. It is really their projection or best estimate about the market conditions and volatility, or lack thereof. At the moment, certainly, there is volatility in the market.

CHAIR - You have that little extra because of the uplift in materials costs.

Secretary - Chair, can we hold it there for a minute? We are having a problem with the recording.

CHAIR - Okay. We will have a small break, if anyone is desperate to use facilities or get a drink.

The broadcast is going again. Sorry about that. To anyone who is watching online, we had a bit of an issue with the recording system but we are back to it.

We are looking at page 12 and the contingency amounts. Furniture and equipment. Is this all new equipment? Presumably, it is. How much equipment are we bringing in to this that is actually currently being used compared to new equipment? Do we have any understanding of that?

Mr LEIS - We haven't cut the schedules of that yet so it's an allowance. I will defer to Emma as to whether we are bringing any across but I'd suggest, being new beds -

Dr HUCKERBY - A lot of the trollies and beds and recliners we have as existing equipment. Some of the carts and things.

CHAIR - It's not another whole box and dice. You couldn't afford that?

Ms ALLEN - No.

CHAIR - Okay.

Ms BUTLER - You were saying this morning that some of the existing materials in the existing paediatrics area will be moved into that paediatric section. Can you run through that for us?

Dr HUCKERBY - When we first open the 28-bed area we will include a paediatrics section but when we do the full rebuild, the paediatric short-stay component will go into the paediatric precinct. That would future proof then to have another four adult spaces at that point. With the ultimate rebuild, the idea is to have the paediatric patient cohort visually and auditorily separate from adults for the whole patient journey through the emergency Department.

Ms BUTLER - Were you saying this morning that there's a Samek?

Dr HUCKERBY - There's a painting in the ambulance bay. Did you go out the ambulance bay? No, you didn't. There's a wonderful mural that was painted for the old ED, I think.

Mr LEIS - Yes, it was. Initially I thought it would be great if we just squared off the corner down there and used that all for the area. Then they said, 'Do you know what that is?' I said, 'Ah, right. Yes, I think I've seen that bloke before.' Obviously, he's moved on, so that will never be changed.

Ms BUTLER - It's very valuable.

Mr LEIS - Yes. The ambulance was out there this morning, and that sort of obscures it when that's out. It shows all the features of his artwork in there. One of his larger pieces, I believe.

CHAIR - He's got one at the Federation Concert Hall that's massive but yes, that would certainly be one of the larger ones.

Mr LEIS - We won't be touching that. We're looking after it.

CHAIR - Anything else on page 12? Completion of design development - December 2021. Has that happened?

Mr LEIS - Year 22, isn't it? This year.

CHAIR - No. The completion of the design development.

Mr LEIS - The floor plate that you see in the appendix, we approved; well, we got to a final state on that, and now we're into the detailed construction documentation.

CHAIR - Yes. It's DA exempt because it's largely an internal thing; is that right?

Mr LEIS - Yes. Again, we made very sure that we've kept to what we've got so that we don't trigger a few of those other longer processes.

CHAIR - Okay.

Ms RATTRAY - You haven't included the parliamentary approval process. Are you including that in the completion of the construction documentation?

Mr LEIS - I haven't, no. Correct. You haven't put that in there specifically.

CHAIR - PWC.

Mr LEIS - It's certainly not assumed.

Mr HARGRAVE - It's not in this project time line.

Ms RATTRAY - I wouldn't have thought you would ever do that.

CHAIR - She's just pointing out that it's not there.

Mr LEIS - My apologies.

Mr HARGRAVE - It's not noted in the report but is -

Ms RATTRAY - It's part of that completion.

Mr HARGRAVE - A broader part of the Gantt chart or schedule that we prepare for all of our projects. Parliamentary standing committee approval is a milestone.

CHAIR - Yes.

Ms BUTLER - Do you think, just for the record, that the commencement of operations - December 2022 - is a reliable date?

Mr LEIS - It's ambitious, yes. It's on track at the moment. We're hitting all of our markers. I'd like to start sooner but my director made it very clear that we need your approval before we do that.

CHAIR - Thank you. Anything on the conclusion? We've already been asked about phase 2. Okay. There's nothing else from me.

Before we finish these hearings there are a number of questions that we ask. I'm not sure who's going to be nominated to answer them?

Mr HARGRAVE - Usually me, yes.

CHAIR - We ask these questions at the end of the hearing prior to reading the closing statement, and they're very important.

Do the proposed works meet and identify need or needs or solve a recognised problem?

Mr HARGRAVE - Yes, it does.

CHAIR - Are the proposed works the best solution to meet identified needs or solve a recognised problem within the allocated budget?

Mr HARGRAVE - Yes, it is.

CHAIR - Are the proposed works fit for purpose?

Mr HARGRAVE - Yes.

CHAIR - Do the proposed works provide value for money?

Mr HARGRAVE - Yes, we believe it does.

CHAIR - Are the proposed works a good use of public funds?

Mr HARGRAVE - Again, yes, we believe it is a good use of public funds.

CHAIR - Thank you, it's important that we get that on the record from you.

As I advised you at the start of the hearing today, what you've said is protected by parliamentary privilege. Once you leave the table you need to be aware that privilege does not attach to comments you may make to anyone, including the media, even if you're just repeating what you said to us. Do you understand that?

WITNESSES - Yes.

CHAIR - Thank you very much, and thank you for coming along today to present.

THE WITNESSES WITHDREW.