

## PUBLIC

**THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY, 25 AUGUST 2017.**

---

### **REPATRIATION CENTRE REDEVELOPMENT PROGRAM**

**Mr MARK BALLARD**, PROJECT MANAGER, CAPITAL WORKS, ASSET MANAGEMENT SERVICES, **Mr GREG COOPER**, DIRECTOR, ASSET MANAGEMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, **Mr BRUCE EDWARDS**, GROUP MANAGER, COMPLEX CHRONIC AND COMMUNITY SERVICE, **Prof MICHAEL ASHBY**, CLINICAL DIRECTOR, TASMANIA HEALTH SERVICE - SOUTHERN REGION, **Ms MAIJA KUMPULAINEN**, CLINICAL NURSE CONSULTANT/IN-REACH REHABILITATION, TASMANIA HEALTH SERVICE - SOUTHERN REGION, **Mr PETER GAGGIN**, ARCHITECT/DIRECTOR, PHILPLIGHTON, ARCHITECTS WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

**CHAIR** (Ms Rylah) - Thank you for appearing before the committee. The committee is pleased to hear your evidence today.

Before you begin giving your evidence I would like to inform you of some of the important aspects of committee proceedings. The committee hearing is a proceeding in parliament. This means it receives the protection of parliamentary privilege. This 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 reported or referred to by you outside the confines of this parliamentary proceeding. This is a public hearing. Members of the public and journalists may be present and this means your evidence may be reported.

Do you understand?

**Messrs Ballard, Cooper, Edwards, Ashby, Kumpulainen and Gaggin** - Yes.

**CHAIR** - Would you like to make an opening statement? Thank you very much, Mark.

**Mr BALLARD** - I introduce myself as Mark Ballard, Project Manager, working with capital works in Asset Management Services, Department of Health and Human Services. We would like to present to the committee a project to provide an additional 22 bed capacity at the Repatriation Centre in the Peacock Building. The premises are at level one and currently consist of space that has been used for many years as office space. We have engaged Philip Lighton through Peter Gaggin to assist in the development of the redesign of the new ward.

In addition to the new ward, we are proposing to upgrade certain services and infrastructure at the site to complement the new ward. The air-conditioning system is the main focus because the air-conditioning system is 40 years old and is very energy inefficient. We can see an

**PUBLIC WORKS, HOBART 25/8/17 REPATRIATION CENTRE REDEVELOPMENT PROGRAM (BALLARD/COOPER/EDWARDS/ASHBY/KUMPULAINEN/GAGGIN)**

## PUBLIC

upgrading of this facility will enhance this floor at level one and also conditions that are relevant on other floors where they only have heating on some of the floors and have no cooling during hot summers. It is going to increase and improve the environment for all the users of the facility.

There are some other infrastructure improvements we are considering and reviewing at this time which includes upgrading the generator set, the access control system, and security. We present the plans which have undergone a detailed review and analysis by the Tasmanian Health Service to meet the requirement of their sub-acute board.

**Mr COOPER** - I would like to say thank you to the committee for meeting with us so quickly when we presented this. That is greatly appreciated, given the timeline we have on the project.

**Mr SHELTON** - After reading through the proposal I can say that it has to be done and it is a slam dunk. It does say under the recommendations 'the project control group and the project team'. I assume a number of you are on that. How many people were involved in the whole consultation process? We have the project control group and then a project team. In the parliament we look at these things as far as the money side of it. How many people have been involved in pulling it together? Can you give us an outline of that process?

**Mr BALLARD** - The project control group consists of senior members of the Department of Health and Human Services in THS, and Greg Cooper is a representative on that as well as Bruce Edwards and Maija. They are meant to be a guiding influence on the project in setting the broad parameters.

At the next level down, we have the people with more involvement, such as myself, in project manager. Maija is also a member of that group. Then we have Peter Gaggin and other sub-consultants in engineering who are participating in that process.

We access other skills, such as people within the department who specialise in infection control to assist with issues associated with doing a major upgrade in a building when there are patients present.

Basically that is the structure we work with. I have given the diagram which shows the responsibilities and the reporting processes. The project control group meets regularly to review the progress and status of the project, and signs off major milestones such as the overall design and other aspects.

**Mr SHELTON** - Thank you. Therefore it has been through those clinical processes of the design and so forth, and the recommendation is that your group says to us that you recommend this goes ahead. It makes my job all that much easier. I do not have to worry about it too much at all, bearing in mind it has had a microscope put over the whole the thing.

One question and it was raised quickly this morning and thank you for the tour up there. As a diesel fitter/motor mechanic, I presume the gen-set you are replacing is an old diesel operated generation set that was put in the building when it was first installed and however old the building is, that technology -

## PUBLIC

**Mr GAGGIN** - 1972.

**Mr SHELTON** - 1972, therefore the engines are more efficient, the gen sets are more efficient and so forth. It is commonsense to replace that at this time when you are going through a major refit. I have very few questions and objections.

**Mr COOPER** - It is also a capacity issue as well. There are more services, more intense use of electricity, so having a larger generator means that we can adequately respond.

**Mr SHELTON** - I can only assume that technology has moved on. Even though you need more generation capacity, in fact the unit you get to replace it would probably be smaller than the one that is there. That is neither here nor there, but that is one of the technological points that there are some great generators out there.

**Mr GAGGIN** - I might add that there will be a recovery cost if we dispose of the generator. It will come back to the project as a credit. It is not as if we are disposing of the unit that no longer has any worth. We expect that it would have a reasonable resale value and that could even be done as part of the acquisition process in terms of the trade-in scenario or public disposal.

**Mr FARRELL** - The submission is pretty detailed so it answers a lot of questions that would normally come up. I am curious to know what other options were looked at before it was decided to go ahead with this refurbishment which seems a perfectly sensible way to go. Were there other options available to the department?

**Mr COOPER** - I would say that options were pretty limited, given the timing expectations and available floor area and also the alignment with existing services.

Having two floors of sub-acute already in place, it would leave clinically a fairly natural alignment for then a third floor to be co-located in that way. That is probably the highest criteria that the team are trying to work with. Then it is on the site of the Repat, what is the most appropriate area? Whilst it is currently configured as an office-type space, you already have a lot of the infrastructure there that we can then do beds with.

**Mr FARRELL** - It does appear, when we toured through this morning, that it was originally designed as a ward set-up. It seems that all the plugs, services and outlets are there, but it has never been used as a ward set-up?

**Mr EDWARDS** - It is our understanding.

**Mr FARRELL** - If I could drill down a little bit into the clinical efficiencies that this will offer the staff -

**Mr LLEWELLYN** - I was going to ask a question about that too, so maybe you could take the two at the one time. My question was that there is a lot of pressure in the Royal Hobart Hospital for what is generically termed bed-blockers, but the general term bed-blockers is much deeper than that.

## PUBLIC

Professor, maybe you would like to tell us what sort of sub-acute patients will occupy that.

**Professor ASHBY** - Certainly. Answering the bigger question first, clearly this investment is about generating better patient outcomes and increasing our capacity to cope with the demand for inpatient beds of all sorts in Southern Tasmania. It is not in my portfolio but I do sit in the leadership group that has been struggling with this the last few years as you would be very well aware in Parliament. The real need was for more acute beds. Those who know the infrastructure of the Royal well from top to floor did put up options, some of which were taken up and most of which ultimately had to be rejected due to their disruptive nature, the small volume of beds, and the things that would then deprive the hospital of in order to have those additional beds.

The quickest, most efficient way to get a large pool of beds was to have them in the sub-acute sector at the Repatriation site. The main aim of the beds in operational terms is to make them medical transitional care beds in the sub-acute sector because it is very clear amongst my colleagues that we cannot replicate acute levels of care escalation at the Repat site as well as the Royal and that it would not be safe and sustainable to do so.

The types of patients, in direct answer to your question, that will be suitable for this unit are:

- frail aged people who are unsuitable or not ready for discharge yet;
- chronic diseases patients of all ages potentially, apart from children - what we call palliative care slow stream or slow hospice. At any one time there are a number of patients in the Royal, last week on one particular day my team advised it was six, who could not go home. Whittle Ward at that point was full, and their care needs were sub-acute but possibly not needing the full acute palliative care model in the Whittle Ward. That population of patients would be accommodated in the new unit.
- patients who are either awaiting or have failed rehabilitational targets - and there may be some capacity to deliver limited in-reach rehabilitation for people on the new unit, that is still under consideration.
- bariatric patients, those who have weight problems, obesity, that makes their care require special equipment and back up; and
- patients whose social or location of care issues prevent timely discharge or transfer.

In addition, it is important for any such unit in 2017 to be able to accommodate confusion and wandering behaviours. We are not suggesting that this will be a substitute for the higher intensity dementia management units and facilities that are run elsewhere in the health system, but we would be very foolish to not be able to have the level of security and environment that can accommodate those people because of the epidemiology with dementia now headed to be the number one contributing cause of death in Australia within the next few years, and the high prevalence in incident figures of that. That is the patient profile.

**Mr EDWARDS** - Can I add in analysing I suppose the need, we have a number of sub-acute services whether it be psycho-geriatrics out at Roy Fagan, our rehab aged care and

## PUBLIC

palliative care services, but while initially it was around where was the acute bed capacity the reality is even despite our sub-acute capacity there are still a reasonable number of people who no longer require acute care remaining in the Royal Hobart Hospital.

When we looked around, and as Michael has said in regard to trying to increase that acute care capacity at the Royal, it was not going to give the number of beds and would have been disruptive. Also, having another sub-acute area and moving out of that busy acute area into a better environment where we can provide better sub-acute care and better planning for this patient group was going to be a better option. Also, as Greg had mentioned, when you look around the real estate that we have for in-patient care is only the Royal, the Repat site and Roy Fagan, and we have a few areas for mental health that really are not for the managing of medical patients.

**Mr LLEWELLYN** - Can you make a comment about whether the new 22 bed sub-acute facility will accommodate most sub-acute people that are currently in the Royal Hobart Hospital? What efforts are going to be put to moving the people from the sub-acute unit at the Repat back into the community? That could become a blockage if we do not look at that question.

**Prof. ASHBY** - That is a very fair point. It is a little bit like in the country, where I come from, you build another motorway like the M25 where I live and then that becomes a traffic jam. The emphasis of care on the ward will be on a multidisciplinary team. The medical care will need to be of a high standard and adequate to cover the patient safety 24 hours a day. The model we are evolving with our colleagues is one where nurses, social workers, OTs and physios will have a prominent role in determining the pathways of care and the direction of care in order to get people to where they want to be and need to be in a timely fashion.

**Mr EDWARDS** - Having a critical mass of sub-acute patients at the Repat site allows for greater efficiencies in regard to that because there are a lot of needs around mobility and social issues that have to be managed for people who are in that sub-acute space. At the moment, many of those patients who still remain at the Royal Hobart Hospital site are dotted around multiple wards and they do not tend to have the concentration of allied health staff allocated. There will be some levels of efficiency when those patients are brought together at the Repat.

**Mr LLEWELLYN** - The situation in southern Tasmania has always been one where getting people back to a sub-acute facility in their own location is very difficult because we have New Norfolk, Bay Shore and that is about it. Whereas in Launceston you have a spoke and wheel effect where there are a lot of hospitals right around the Launceston General Hospital and they can provide that facility.

**Mr EDWARDS** - Yes. The north has about eight rural facilities and three in the north-west, whereas we only have New Norfolk and the Midlands and then we have contracted beds at a couple of the nursing homes but do not have the capacity the north has.

**CHAIR** - We are talking about a 22-bed ward but when I look at the map, my numbers only go up to 18. Tell me the difference.

**Mr LLEWELLYN** - The two big ones in the corner.

## PUBLIC

**CHAIR** - I counted that as 11 because is no 11.

**Ms KUMPULAINEN** - There are four two-bedded rooms on the top.

**CHAIR** - Okay, that gets us to 20 and there are four two-bedded rooms.

**Mr SHELTON** - My background, as a mechanic, I was involved in the building of a new building for Alanvale Automotive and the mechanical engineering that goes into this, we have a building that is built in the 1970s. It is not a hospital ward and the issue of gas was mentioned this morning. Someone might brief the committee on those later technologies and better, more efficient operation for nurses that were either not there or have to be upgraded.

**Mr BALLARD** - The medical gases is another one of the small items are under what we have termed project 2, which is the infrastructure for the site. We are aware the existing arrangement for gas bottles can cause occupational health and safety issues for our staff. That is another item that is being reviewed in conjunction with the air-conditioning and other issues. The expectation is, when the review is completed and we determine the capacity requirements, that we will end up with a fixed, larger capacity container that will serve the needs of the whole building.

**Mr GAGGIN** - When the building was built - 'future proofing' is a trendy word to use nowadays - but the building was actually future-proofed by two large services ducts that run up both ends of the building which is the size of a small room that are basically chimneys within a building, if you like.

With the redevelopment of the new air-conditioning plant from the top down, basically they will go down these service ducts which are already there. They are roughly three metre by five metre holes in the building. There is enormous capacity in those areas.

Other things which Maija has been heavily involved with is the security. Obviously now with digital technologies and those sorts of things, the nearest call systems are all hand-held on phones and these sorts of things now. All that technology is going into this redevelopment.

It is state-of-the-art linking into what is also used throughout the rest of the service. You have to factor all that in, what is compatible with the Royal and what is compatible with Launceston General, and what is compatible with the Repat so it all gels together. A lot of work has gone into that. As well as what Mark was saying answering Mr Shelton's question before about the groups, we have also been heavily dealing with the IT department, nursing, so there has been a fair level of involvement with those people to cover all those things.

**Mr COOPER** - Probably the local facilities team as well.

**Mr GAGGIN** - Yes, the local facilities team that do the day-to-day maintenance and operation.

**CHAIR** - On the plan we have here, are they the two plant rooms? Yes, okay.

**Mr GAGGIN** - Plant, yes.

## PUBLIC

**Mr COOPER** - The main plant room itself will be on the roof. It will do the central heating and cooling and that will be distributed through pipe work to plant on the actual floor.

**Mr GAGGIN** - The way the building works is concrete slabs, but there are quite large beams under those concrete slabs, and then there is quite a big gap under that before the ceiling so all the ducting goes under that. Part of this project - and it will be fed throughout the rest of it - is we are removing the ducting out of this floor to replace all with new. We have discovered a lot of the ducting has asbestos sealant which we talked about this morning. So we are actually removing it from this floor and progressively that will be part of the major redevelopment as we go on to the other floors.

**Mr SHELTON** - We walked across a sticky floor this morning. There has been a deal of trying to do it as efficiently as we can. I understand that those tiles that were lifted are going to be reused.

**Mr BALLARD** - Yes, that is correct. We understand that the tiles were only about six months old and were laid before this project came to fruition. As you can see the rest of the carpet there is pretty worn.

We do have the opportunity that in an adjacent building, what is called the McDougall Building on site, we happen to need some carpet so the carpet is being recycled after the carpet layers have confirmed it can be reused. That is probably a good outcome.

Another minor feature is that there was a lot of furniture that we were able to salvage and reissue to many of the areas across the department. You will see that there is very little that was left after we had our people move out.

As part of the decanting process we moved a number of people, for instance, to the Marine Board Building or 1 Franklin Wharf. We even reused and recycled furniture from this building which came from the Housing people who were upstairs.

What we have tried to do is retain all the best quality furniture we could and reuse and reallocate it.

**Mr SHELTON** - I am sure everybody in Tasmania appreciates that, particularly the taxpayers, doing things as efficiently as we can.

**CHAIR** - The diesel tank that you are talking about replacing. Can you explain for the benefit of the committee, the issue around the size of the tank, and how you are going to ensure that you have adequate supply of diesel for a prolonged outage?

**Mr BALLARD** - First of all the replacement of the diesel unit and the generator set is still at a very early stage of design. Our focus has been on the design of the 22-bed ward. We are aware that the diesel generator may not provide enough energy to operate the whole building. The engineers who provided the comments that were incorporated into the document have suggested that there may be no need to have 3000 litres but a smaller amount may be appropriate.

## PUBLIC

One of the problems with diesel, if it is not managed properly, is that it can be affected by bacteria and then make the diesel unusable unless you have an adequate process of checking and testing and then re-filtering. The diesel generator sets that we would expect to purchase today if we proceed to a new unit can be expected to be much more efficient and probably use less diesel.

The department also has contracts in place with our fuel suppliers that give us some level of priority and comfort about supply. We spoke with people in the Royal Hobart Hospital who take a similar view that this is the approach that they would adopt now rather than having the risk of having large amounts of diesel fuel because diesel fuel smells. Of course we do not like that necessarily in a hospital environment. It is obviously something that we would like to manage very carefully and our expectation is that the consultants will optimise the size of the diesel fuel tank to suit the application.

**Mr SHELTON** - As an automotive teacher I concur with those thoughts. Diesel does go off. It can go waxy. In any situation you would not want 3000 litres there anyway. In today's modern engines if they use 5 to 6 litres an hour you do not need 3000 litres. If you do the calculations it would be substantially less than that and less risk of other issues being raised.

**Mr COOPER** - I add that when we had the energy security issues 18 months ago, the department did a general review of all its acute sites with its generators. Part of that was where it flowed through into making sure there were agreements in place with suppliers that we would get the highest level of priority of delivery, and they would turn up with their fuel trucks and continue putting it into the tank if there was a circumstance where power was lost.

**CHAIR** - Very good. That is reassuring.

**Mr SHELTON** - With a larger tank if you only half fill it condensation happens in the top half. That also creates issues so the tank needs to be designed for an optimum period and therefore it does need to be a smaller tank so that it can be filled. As you say, the fuel delivery systems in Tasmania are good now. My brother-in-law has a fuel delivery business in Cressy. I can get them down fairly quickly, but there are other companies down here in the south.

**Mr LLEWELLYN** - I was going to say that I hope there is some regular plan on a weekly or two weekly basis to run the emergency generators for a couple of hours or whatever.

**Mr COOPER** - It is a challenge. It is not on that regular a basis. There is, I think, a requirement for six-monthly testing of generator systems in normal standards of acute hospitals as well. That is part of a contract in place to do regular maintenance and testing. The challenge with the hospitals is the acute nature of it at a time that it does not impact on the service delivery.

**Mr LLEWELLYN** - The modern systems have resynchronising arrangements and so on that enable them to flow off the mains and back on the mains without any interruptions.

**Mr COOPER** - Yes. It is not the case with some of the older systems that we have in place still.

**Mr LLEWELLYN** - No, but it is important to run the generators for a period of time. I think six months is a bit long.



## **PUBLIC**

**Mr BALLARD** - If I could add some comment on that, Mr Llewellyn. The present generator unit is always kept in the heated mode so that it has heaters in the cylinder heads or manifolds and hopefully that will provide a quick start-up. One of the problems in a hospital environment is testing it with a live load. In other words, what we call a drop dead test. You disconnect from the Royal supply and see what happens. That is something that has to be planned meticulously particularly with the stakeholders who are operating in the building and what we have there.

**Mr LLEWELLYN** - That is why you need a no-break system.

**Mr BALLARD** - Yes. The current system is using a bypass with a heat load bank that is part of the old air-conditioning system. It has heating elements in a big water tank on the roof. Part of the whole process of reviewing the infrastructure, not just one individual component, is to make sure that aspect of it still works. With any generator set there is more than one component, particularly the electrical side and the contactors, which have to be maintained. We expect, as part of the review of the infrastructure, that we will undertake a drop dead test to check all these aspects to make sure we have a system that will be effective and working when we need it.

**CHAIR** - Most unfortunate name.

**Mr BALLARD** - There are other terms used. Someone suggested black star test. There are different names. That is the term I used when I used to be the manager of Tasmania Police in 2000 and we had some issues with the generator set at that point, testing it. It was the term we used then.

**CHAIR** - Is the cost of the new generator part of these costs?

**Mr COOPER** - Yes.

**CHAIR** - In project 2?

**Mr COOPER** - Yes.

**CHAIR** - What I am hearing from that is, there is a fairly urgent need to update that, even though we do not have any life support, is that right?

**Ms KUMPULAINEN** - That is correct.

**CHAIR** - People on life support or intended to be in the Repat, but there is a clear need to be able to have, what did you call it, David?

**Mr LLEWELLYN** - A no-break system.

**CHAIR** - So that you can test it without having to go into weeks of planning.

**Mr BALLARD** - One of the features of the existing system is that it still serves systems up into what is called the Statton Building, which is an adjoining building. In the Statton

## **PUBLIC**

Building is one of the very old operating theatre sets, a dual operating theatre. We no longer use that facility and we no longer have a critic need with the statin building to supply emergency power because it is just an office at this point, we need to review the whole reticulation system that is present in both the Peacock and other parts of the Repat site.

**CHAIR** - Is that part of project 2?

**Mr BALLARD** - Yes. We are also installing energy meters which will assist in energy efficiency and monitoring as part of the upgrade to the chassis of the electrical switchboards. There is a lot to it.

**Mr LLEWELLYN** - I have 25 years background in electronic engineering and I understand that. We had some very complicated systems within the Telstra environment and the broadcasting area to try to achieve those outcomes you were talking about.

**CHAIR** - Do you want to make a closing statement?

**Mr BALLARD** - Only to thank the committee for their time and the interest you have shown in the project. We are hopeful we will be able to go for tender within a very short timeframe to have the works undertaken. We are targeting Tasmanian companies for the delivery of the project, which is always a good aspect. Thank you very much.

**CHAIR** - Our thanks to you all. I am sure you have all contributed to what sounds like a very complex and challenging two projects. We appreciate that and being able to talk to you to get some understanding albeit from a very high level. You have been very helpful, so thank you for that.

As I advised you at the commencement of your evidence, what you have said to us here today is protected by parliamentary privilege. Once you leave the table you need to be aware privilege does not attach to comments you may make to anyone including the media, even if you are repeating what you have said to us. Do you understand that?

**Witnesses** - Yes.

**CHAIR** - Thank you very much.

**THE WITNESSES WITHDREW.**