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PARLIAMENT OF TASMANIA

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PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

# Royal Hobart Hospital Emergency Department Expansion Phase 2

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

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## MEMBERS OF THE COMMITTEE

Legislative Council

*Ms Rattray (Deputy Chair)*  
*Mr Valentine (Chair)*

House of Assembly

*Ms Butler*  
*Mr Tucker*  
*Mr Wood*

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## 1 INTRODUCTION

To Her Excellency the Honourable Barbara Baker AC, 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:-

### **Royal Hobart Hospital Emergency Department Expansion Phase 2**

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

## 2 BACKGROUND

- 2.1 This reference recommended the Committee approve the Royal Hobart Hospital Emergency Department Expansion Phase 2 project to meet the growing demand in Emergency Department presentations.
- 2.2 The existing Royal Hobart Hospital (RHH) Emergency Department (ED) was designed to accommodate approximately 45,000 presentations annually. However, the demand for emergency healthcare consistently surpasses this capacity. In the 2022-23 period alone, there were 75,258 presentations.
- 2.3 The ED currently faces difficulty providing adequate care to presenting patients. Facing high demand, the ED is often over-crowded, which consequently delays access to emergency care and lengthens waiting periods for inpatient beds.
- 2.4 The continuous increase in patient volume emphasises the urgent need for expanded healthcare infrastructure and additional resources. An analysis of clinical service activity projects a significant and sustained growth in both hospital admissions and ED presentations. Forecasts indicate that by 2035, ED presentations are expected to reach 135,000 per year, highlighting the urgency of addressing this escalating demand.
- 2.5 Together with the challenges of operating from a facility that continually exceeds its physical capacity, the ED is experiencing many issues with patient flow, resulting from an increase in demand for ED services. These issues include:
  - Delays in securing beds for inpatients (access block);
  - Prolonged waiting for ambulances to offload patients to the ED at peak periods of demand (i.e. ambulance ‘ramping’). Access block contributes significantly to this problem; and

- Extended patient wait times in the shared RHH ED waiting room, with mixed cohorts of patients (paediatric, adult, mental health, correctional) sharing the same waiting room.
- 2.6 In response, a multi-phase project has been initiated to create space and facilitate a staged expansion of the ED. Phase 1 of the ED expansion has seen relocation of the Paediatric Outpatient Department to 3D, and extensive renovations to the lower ground floor of H block, where a new fully contained ED Short Stay Unit (SSU) has been established, equipped with 28 points of care.
- 2.7 The ED Expansion Phase 2 project design has been guided by the Model of Care adopted for the overall ED expansion (Phase 1 and Phase 2). The Model of Care summarises the ways the ED will provide patient care across the different ED treatment streams to meet the projected increase in demand for ED services.
- 2.8 Based on the Model of Care, the ED Expansion Phase 2 will deliver a state-of-the-art ED across two levels, providing a total of 121 points of care in the ED when completed. It will also include a transition space so that ongoing emergency care can be provided to the community throughout the redevelopment project. The 121 points of care will be configured across the different ED treatment streams as shown in the table below:

Zone	Point of Care
Triage and Registration	n/a
Resuscitation	6
Acute Care	54 + Interview Room
Lower Acuity Adult	14
RITZ	6
Paediatric Short Stay + Acute	13 + 3 Assessment Rooms
Short Stay Unit (Completed)	28

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- 2.9 The Phase 2 Expansion will include the following features:
- An increased number of triage stations from five in the existing ED to nine including three dedicated ambulance triage stations. This will allow more timely access to triage and more rapid ambulance patient processing. Patients will then be directed to appropriate treatment areas or waiting areas.

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<sup>1</sup> *Emergency Department Expansion, Royal Hobart Hospital, Submission to the Parliamentary Standing Committee on Public Works, Department of Health, 28 November 2023, Page 11.*

- A dedicated paediatric waiting area which complies with contemporary child safety recommendations.
- A Rapid Intervention and Treatment Zone (RITZ) waiting area where rapid assessment and initiation of treatment will occur.
- A dedicated medical imaging waiting area which will improve the processing of patients.
- A new resuscitation zone with increased capacity to care for the most severely ill or injured patients presenting to the emergency department. Each resuscitation bay will have its own x-ray machine and there will be a dedicated CT scanner for the resuscitation area to allow for rapid access to imaging for the most critical patients. The resuscitation area will include a larger treatment space specifically for trauma patients and a negative pressure room for those patients requiring respiratory isolation for highly infectious diseases.
- A rapid intervention and treatment zone (RITZ), which is a new concept for the RHH ED. This area will allow for the rapid assessment of patients immediately after triage and sort patients into appropriate areas for ongoing treatment if necessary. Treatment can also be initiated in the RITZ for patients who are likely to remain ambulatory with the aim to increase early patient departure. This will improve the patient experience by reducing wait times and length of stay in the ED. This model has been successfully adopted on the mainland and has proven benefit for early diagnosis and treatment which not only improves patient experiences but also increases efficiency of processing.
- An acute care zone, specifically designed to meet requirements for care of older patients. Tasmania has the oldest population in Australia and it is well recognised that these patients are high users of emergency hospital facilities.
  - A section of the acute care zone has been designed to meet the specific care needs of Mental Health patients so that when they seek care this can be provided in a purpose built area. To maximise efficiency this area is designed as multi-purpose, so when there is low demand from Mental Health patients it can also be utilised for patients requiring care for other conditions. Increased privacy in this area will offer better quality care to vulnerable patients. The mental health zone has been designed with streamlined access, which allows mental health patients to transit directly to the low stimulus area.
  - Within the rest of the acute zone, all the treatment spaces will be single rooms - some with glass sliding doors and some open bays. There will also be several isolation rooms with ensuites to provide emergency care

to patients with complex infection control requirements. In preparation for future pandemic events, the acute care zone has been designed to have two stand-alone zones, each having a dedicated ventilation system in order to safely isolate airborne pathogens.

- A greater number of acute (lie-down) treatment spaces to cater for the increasing percentage of unwell older persons with increasingly complex illnesses anticipated to present to the hospital over the coming years. A large percentage of these patients require lie-down treatment spaces and subsequent admission to hospital. Additional spaces will not only improve ambulance offload KPIs but will provide a better quality of care to the Tasmanian public.
- A new low acuity adult area, configured with four procedure rooms, including one specifically for the assessment of eyes. The increase in procedure rooms will allow common emergency procedures to occur more efficiently, such as fracture reduction and wound repair, which often require intravenous sedation.
- A medical imaging area with two x-ray machines, a CT scanner and ultrasound room. This is in addition to the medical imaging facilities in the resuscitation zone. This will improve patient flow through the ED, as there will be reduced waiting time for medical imaging. A dedicated medical imaging waiting area will improve efficiency in patient processing.
- A new paediatric area that is physically separated from other areas of the ED, including a dedicated paediatric waiting room and procedure room. A dedicated paediatric area where children are separated from adult patients is a requirement of the new Safeguarding of Children and Young People regulations.

2.10 The RHH ED needs to continue to function throughout the build process. The greatest risk to patient safety is disruption to resuscitation and acute care areas, which must continue to run during the works. Therefore, a transition space will be provided so that ongoing emergency care can be delivered to the community throughout the redevelopment project. The completion of Phase 1 of the Short Stay Unit in LG H Block will facilitate the capacity required to complete the major component of the ED Expansion in Phase 2 of the project. The Emergency Department will temporarily be relocated to H Block to allow for the main building works to progress.

### 3 PROJECT COSTS

- 3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work is \$105 million.

A funding allocation to the amount of \$149 million has been provided by the Tasmanian Government for the entire Emergency Department Expansion Phase 2 project from the RHH Redevelopment Stage 2 budget of \$201 million.

The following table details the preliminary cost estimate for Phase 2:

Phase 2 Budget	Cost Estimate
Construction Costs	\$95,739,700
Contingencies (Design, Construction, Escalation and Market) *	\$34,665,000
Post Occupancy Allowance	\$855,900
Professional Fees and Authority Fees	\$8,300,000
Information and Communication Technology Infrastructure	\$2,000,000
Tasmanian Art Scheme	\$80,000
Furniture and Equipment	\$7,500,000
<b>PHASE 2 TOTAL</b>	<b>\$149,140,600</b>

\* Contingencies are significant at this stage given the design stage and current economic issues surrounding escalated building costs. It is anticipated value management activities and resolution of uncertainties will support a reduced estimated project cost in the pre-tender phase.<sup>2</sup>

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<sup>2</sup> *Emergency Department Expansion, Royal Hobart Hospital, Submission to the Parliamentary Standing Committee on Public Works, Department of Health, 28 November 2023, Page 27*

## 4 EVIDENCE

4.1 The Committee commenced its inquiry on Tuesday 28 November last with an inspection of the site of the proposed works. The Committee then returned to Parliament House, whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Brendan Docherty, Deputy Secretary Hospitals and Primary Care, Department of Health
- Andrew Hargrave, Deputy Secretary Infrastructure Services, Department of Health
- Hanz Lee, Director, JAWS Architects;
- Mark Leis, Project Manager, Programming and Delivery, Infrastructure Services, Department of Health; and
- Dr Paul Scott, Acting Director Emergency Department, Royal Hobart Hospital.

The following Committee Members were present:

- Mr Valentine (Chair);
- Ms Butler;
- Ms Rattray; and
- Mr Wood.

### Overview

4.2 Mr Hargrave, Dr Scott and Mr Lee provided a background to and an overview of the proposed works:

**Mr HARGRAVE** - ... In 2019, the Tasmanian Government committed funding for stage 2 of the Royal Hobart Hospital [RHH] Redevelopment. At the time it was estimated to cost \$91 million. In the 2021-22 Budget, an additional \$110 million was announced for the RHH Stage 2 which included the redevelopment of A Block to provide a new roof and facade, and ward upgrades.

The RHH Redevelopment Stage 2 is well progressed and has already delivered 28 additional treatment points by the ED [Emergency Department] Phase 1 Expansion Project, which you would have probably seen today.

... We've also delivered major upgrades and expansions to the ICU and major upgrades to Cardiology, Sleep Studies, Endoscopy Unit, Trauma and Acute Surgical Unit and the Rapid Assessment Unit.

Obviously, today we're here to talk to the Parliamentary Standing Committee about Phase 2 of the ED redevelopment. Phase 2 will deliver a modern, contemporary Australian Health Facilities Guidelines (AusHFG)-compliant ED across two levels, providing, ultimately, 121 treatment points.

...

**Dr SCOTT** - The Royal Hobart Hospital is the only public hospital in the southern part of Tasmania. As such, it sees all public presentations. The existing Emergency Department was built in 2007 for a planned occupancy of 45 000 patients a year. In 2010, we already exceeded 45 000 a year and, over the last three years, we've been seeing around 75 000 patients a year.



The predicted growth in Emergency Department presentations is quite alarming in that the population of Tasmania is predicted to age, with a dramatic increase in people moving to Tasmania in the age group of over 65 - 50 000 out to 2050; and with an 85 per cent increase in people over the age of 85 between now and 2035. That means that the demand on the Emergency Department is predicted to increase significantly. We've worked with Kelly Shaw and the government Treasury and Finance figures to anticipate how many points of care we will need to provide to future-proof emergency department care out to 2035.

That's where the basis of the footprint size of the Emergency Department has come from, requiring 118 points of care. We think we can deliver 121 out of the existing footprint. That is bearing in mind the ageing population with increased need for lay-down bed spaces and to have an older person-friendly emergency footprint.

It's also bearing in mind particular groups who will use the Emergency Department, such as the paediatric population needing to be seen and treated in separate areas from adults, as well as other groups such as mental health and other patients who have specific needs. We have tried to address all those needs with the footprint that is proposed. To gain the size of the department we needed a two-storey build, requiring a significant footprint which runs from Campbell Street across to Argyle Street. That is thought to be able to deliver care out to 2035 with what we expect to be the predicted increase in population growth from the current data modelling.

...

**Mr LEE** - ... We recognise that this Emergency Department is just not a healthcare facility, but also a place where lives are impacted and healing begins. Our approach works closely with the key stakeholders and our health planning experts, to plan a layout for an efficient flow of patients, staff, and emergency vehicles. Our design aligns with all AusHFG guidelines, the model of care, and adhering to the fundamental principles outlined by the health planning unit, also as outlined by AusHFG. We endeavour to implement the best practice in health planning and emergency department design.

Patient comfort lies at the centre of our consideration when it comes to designing the new emergency department. We believe that a hospital environment should be a place of comfort. To enhance the patient experience we are cautiously choosing materials that not only meet the highest standard in durability, infection control requirements, but also create warm and welcoming feelings. Soft colours, wood finishes, and comfortable furniture are centre in our consideration.

Clear signage and way-finding systems are important in emergency department design. We have thoughtfully integrated it to guide visitors through the space, prioritise the functionality and efficiency, reducing stress during critical moments for both patients and their loved ones.

As you witnessed this morning, in the subterranean space where access to natural light is limited and challenging, we placed strong emphasis on selections to maximise the use of available light. Our strategies include integration of artificial lighting and care for design of interior spaces, ensuring a well-lit, inviting environment, even in areas where access to natural daylight is so limited.

Recognising the wellbeing of the staff is vital to the success of running the facility. We work closely with the stakeholders, incorporating spaces and amenities dedicated to staff for relaxation, respite, and collaboration. Well-supported and comfortable staff contribute not only to a positive work environment, but also overall quality of care provided.

The new emergency department entrance is designed to prioritise the functionality and efficiency. The layout ensures the smooth flow of patients, staff, and emergency vehicles. The design for the emergency department entrance considers the surrounding urban fabric, aiming for seamless integration of the surrounding environment. The architectural expressions and materials chosen for the entrance harmonise with the surrounding context instead of competing with it, ensuring a cohesive appearance. Consideration is given to the

scale, mass and proportion of the entrance, enhancing overall visual appeal of the urban landscape.

We also respect the indigenous culture of nipaluna/Hobart. Our design incorporates elements inspired by culture, stories, inclusivity and the natural environment such as artwork. In collaboration with the representatives of the Tasmanian Aboriginal Centre, these cultural elements are considered and will be built into the functional aspects of the entrance, the interior design and the material selection.

In conclusion, I think the design for the Royal Hobart Hospital Emergency Department combines functionality, cultural sensitivity and adherence to the highest standard of health planning principles.

### **Will Emergency Department Capacity Meet Future Needs?**

4.3 The Committee sought further information from the witnesses regarding the capacity of the ED to meet the expected future demand once the expansion was completed:

**Ms RATTRAY** - ... In regard to the proposed 28 points-of-care that are going to be extended, is that enough to future-proof, or is there no other opportunity to provide any more space at this point in time?

**Dr SCOTT** - I will clarify, we have already completed phase one of the development, and that has delivered an additional 28 points-of-care. We have that already and that has been a fabulous improvement in the care standard that we have been able to provide to the Tasmanian public.

**Ms RATTRAY** - What are the extra ones now?

**Dr SCOTT** - The actual end product of the proposed rebuild essentially doubles our existing points-of-care. Prior to this project we had 61 points-of-care. We have gained some through the additional 28, as Andrew has mentioned. By the end of the rebuild we will have 121, essentially doubling the existing footprint.

**Ms RATTRAY** - Given that somebody mentioned that the existing model was opened in 2007 and had already reached capacity in 2010, and we are in 2023, how much future-proofing would this capacity deliver?

**Dr SCOTT** - The rebuild that was done separate to this project back in 2007 planned on 45 000 per year. That was reached in 2010. Back in 2017, planning occurred for this rebuild with a proposal coming away in 2021, and that was an entire new build. Currently, we are essentially in the old footprint, the old build, and this proposal is aimed at addressing need out to 2035, provided we have other improvements in patient processing in terms of access to sub-acute beds, district hospitals, NDIS funding, hospital avoidance programs and other things that address access-block.

**Ms RATTRAY** - There are still quite a few other arms to go into the whole structure to possibly meet future demand?

**Dr SCOTT** - A bigger emergency department alone will not fix the health needs of the Tasmanian public. They need ways of avoiding coming to the hospital in the first place. We have multiple initiatives currently under way to address those. Among those include telehealth, urgent care centres, increased primary care support, increased hospital in the home beds, geriatric in the home and mental health in the home. All these initiatives are looking at keeping people away from hospital or supporting people who would otherwise

need to come to hospital out in the community. That addresses some of the flow coming into the hospital.

There is the emergency department that is the front door to the hospital, if you like, but we also need efficient means of having people leave the hospital and that traditionally in Tasmania has been very difficult, with the older population needing access to sub-acute beds, nursing home care, rehab beds and district hospital beds. Without fixing that exit or draining from the hospital, the larger ED will fill up.

### **Continued Operation of the Emergency Department During the Redevelopment**

4.4 The Committee was keen to understand how the Emergency Department would continue to operate during the redevelopment, including how patient care could be delivered safely and effectively during transition:

**Mr WOOD** - ... Obviously, there is going to be a major upheaval to what is an incredibly busy and essential department in the hospital. What will be done to ensure patient comfort during that period? There is going to be a lot of noise, a lot of people moving around. What things are being organised to mitigate and ensure patient and, of course, staff care during the two-year project?

**Dr SCOTT** - ... We acknowledge that this is going to be a very complex process to move through. We have been well aware of its complexity now for several years. Since I have taken on the role in the last 15 months, we are having multiple stakeholder meetings to future-plan for the best way to deliver emergency care to the Tasmanian public between now and the end of the rebuild. Involved in that are significant communication strategies.

There is also careful selection of where we place patients. We are doing our best to place the older, more vulnerable patients away from noisy building work such as jackhammering concrete and other things. People who have a shorter stay in the emergency department, such as a minor limb injury, will be closer to the building works at times. That seemed to be a reasonable stratification of the disruption and the impact of the noise, in particular.

For staff, it's going to be very challenging. We will require our staff to work across four different levels in the hospital. With our staffing model that has been supported by the Department of Health, we've planned ahead to get more orderlies, security guards and other staff members that will facilitate patient movements across those different areas.

Overall, moving forward from here, meeting with manager groups but also key stakeholder groups, looking at what the actual model of care delivery looks like in those different phases through the rebuild. Also, planning to deliver responses to events like mass casualty or major incidents during those things, maintain fire evacuation pathways and processes for patients in different areas. These are all things that occupy a great deal of my thought process and will continue to for quite a while. But we are actively doing our best to get ahead of that and make a workable plan that will allow us to deliver high-quality care during the rebuild.

**Ms RATTRAY** - Supplementary question: is it fair to say that patient safety is the greatest risk that this project will have to face?

**Dr SCOTT** - It's a compromise. Patient safety already is significantly compromised by the ED we're working out of. It's not fit for purpose. Staff safety is compromised.

**CHAIR** - I think everyone would agree with that.

**Dr SCOTT** - Whilst we have challenges over the next few years while we move towards a much better solution, I think we'll manage. The challenges won't be any worse than they are currently, working out of the existing footprint.

**Mr DOCHERTY** - If I might just add, one part of the equation, of course, is safety. The other half is quality. The whole new build is focused on the quality, which is the outcome of clinical

care for our patients. We can manage and mitigate the risk, absolutely, as we've described. But now the ... benefit and return on investment would be around the quality of care being optimised and improved.

**Ms RATTRAY** - From where I come from, it's short-term pain for long-term gain.

...

**Dr SCOTT** - I'll just add in. I think there are some building design considerations that we'll do to protect patients from noise, dust ingress and infection control principles that we need to adhere to. That may involve building double walls, putting towers around dust-generating procedures, maintaining highest infection control measures that are needed in a hospital environment. That is all part of our planning as well.

**Mr LEE** - If I may, we will have the highest acoustic performance of the temporary construction hoarding. Dr Scott covered a lot about the coordination from the hospital side. I think one of the key aspects is also to maintain transparent and open communication with the contractors working on site, educating them that this is a live and operating hospital, making them aware of this as well.

**CHAIR** - Is it fair to say that this particular project, this upgrade, would be as complex as it comes for a hospital or not?

...

**Mr HARGRAVE** - It would be up there. Redevelopment of working hospitals is always complicated. It's not something that's unique to Tasmania. ... the reason it has taken us so long to get to where we are is the consideration of the staging and identification of the risk, and mitigating that risk through the build. How we plan that out and execute it is really important to the safe operation and maintenance of patient safety during the build.

...Dr Scott has indicated the sorts of conversations and consultation that we've been having, not just in the hospital but with council and other consumers and those sorts of things. There's a lot of thinking and a lot of planning that goes into this project before you even start a procurement to build.

...

**CHAIR** - Another aspect ... is the EMU - the emergency medical unit: Is anything further being done to that, or is that as it is at the moment? ...What's going to change in its physical nature, for the record?

**Mr LEIS** - As part of phase one, we have set that up so it can accommodate when the ED in J Block pivots across to H Block. It's been set up ready for that. There are a few minor changes that need to be tweaked - provide drug room storage and a few other aspects to accommodate the transition plan - and then after the transition has occurred, there are a few minor tweaks to have that back to an EMU.

**CHAIR** - The separated airflow and the no-touch doors, they're already there?

**Mr LEIS** - Correct, and that's the way we designed that to get the uplift in capacity for a start, and then be able to maintain and pivot through this transition period. I think the best way to describe the transition period, ... is it's a combination of Tetris and Jenga, which we've been enjoying across the last period.

**CHAIR** - ....The period of transition is just a matter of couple of days, you were saying, to go from one site to the other?

**Mr LEIS** - Yes, that's the actual transfer of care, which Dr Scott's team will handle. The planning that goes into the back end of that, we've got numerous spreadsheets that have mapped out a period of months to execute that couple-of-day transition-

...

**Mr LEIS** - We had a good practice at that with phase one as an easier run-in; this one will be quite a bit more complex. What you don't see in there is actually how much data and ICT goes into the back of that, which I've been quite surprised at..

**Mr LEIS** - We're working through the next level of detail on our spreadsheets of how both the ICT, the build ability as well as then the operational aspect, is going. That will continue to be the case and we'll literally get down to minutes at the end of the day when we do that transition so that we're comfortable with any security-

**CHAIR** - Was there any thought of the dummy run of any sort to make sure it's all going to work?

**Dr SCOTT** - ....The commissioning of the 28 point-of-care EMU in January this year was, in fact, a dummy run. We set in place strategies ahead of that. Many of those strategies required multiple months lead-in time, which included creation of IT-based map systems for patient tracking - these things take a long time; communication with hospital-wide care teams who may need to come to the emergency department to see patients; as well as communication with the public in terms of how to access both the emergency department and other areas.

We didn't get it perfectly right in January, but we've learnt from essentially operationalising that area in January. That will make us better, more capable to open the other areas.

## **Consultation**

4.5 The Committee sought an assurance from the witnesses that appropriate consultation had been conducted, such that it would ensure the works were fit for purpose:

**CHAIR** - Okay, project budget stakeholder consultation program.

**Mr LEIS** - I may just speak to the consultation side of things. We have RPS [RPS Consulting] on board now, a national stakeholder specialist consulting group.

**Mr LEIS** - ....We've had them on other projects and they are helping us complete a stakeholder and community consultation program. We've already done a large level of consultation both within the department and within the areas that need to work in this project. But we are certainly taking that to the next level as we move through this project because, obviously, we will impact the way the community will need to interact with the site, especially through the transition period. And then, ultimately, to how they use the site afterwards. That will be a key piece that we are working on at the moment to make sure that we absolutely get it right.

...

**CHAIR** - ... So, we are not going to hear after the event that there is a major part that has gone wrong here because someone did not consult?

**Mr HARGRAVE** - Mark mentioned what we call the SCEP, or the stakeholder communication engagement plan. We do these for all of our projects now; we have stakeholder engagement as a key part of the project team. What we find is that the model of engaging early and often actually helps inform the design and project's success because you are identifying and consulting and listening to those people who are your key stakeholders. It works.

## **Staffing needs**

4.6 The Committee recognised that increased ED capacity would require appropriate staffing levels to support service delivery. The Committee sought further information on the staffing and recruitment challenges this presented:

**CHAIR** - I imagine staffing is an issue as well. What are we talking about and what increase in staffing would be needed to be able to cater for the new structure that you are building now to make it fully functional?

**Dr SCOTT** - ... staffing is a problem across medical, allied health and nursing workforce in the health sphere nationally. I'm proud to say that we've achieved significant improvements in staffing. We had assistance from the Department of Health a year ago realising that the extra points-of-care were coming on board. We've doubled our registrars, which is the main workforce cohort, to 54 FTE next year up from 26 this year. We're full in the intern space and in the SRMO [Senior Resident Medical Officer] space. I'm actively recruiting specialists to act at the supervisor level. In nursing staffing, we've been benchmarked against increased presentations and we're fully recruited from a nursing perspective.

**CHAIR** - Who do you benchmark with?

**Dr SCOTT** - It's a national process. I'd probably take that on notice, but they look at how many presentations occur through the department per year and then allocate staffing based on the presentations, so we've gone through one of those cycles a few months ago and been able to recruit to those spaces based on 75 000 presentations per year. We are undergoing active training and you would have seen on our tour ... a dedicated training space to bring those nurses and medical staff up to speed in terms of operating in more remote areas across the dual-storey ED staffing procedure rooms, resuscitation rooms -

**CHAIR** - So, you're fairly confident that once the build is complete that you will be able to make it fully functional with staff?

**Dr SCOTT** - Staffing remains challenging in the health sector. It is a difficult place to work and it's challenging for staff who work here. We are better off compared to many places on the mainland with our staffing next year and we propose to open 103 beds initially and then open further beds from the rebuild as the demand becomes apparent. That will allow us, with further releases of funds from the department, to actively recruit extra members as the need becomes apparent.

### **Impacts on Patient Flow and Access Block**

4.7 The Committee noted the increase in Emergency Department capacity may have consequences for patient flow and access block. The Committee questioned the witnesses to understand what these issues might be and how they could be managed:

**Ms BUTLER** - ... when you're talking about opening beds are you talking about opening beds within the hospital itself or within the ED?

**Dr SCOTT** - I'm sorry for the confusion. A simpler term would be a point-of-care, which is a treatment space. It may be a bed. It may be a reclining chair and that is where we can deliver care. There are certain requirements of that point-of-care. It needs to have oxygen nearby, power, medical suction.

So when I'm talking about opening beds, I'm talking from an ED perspective and I'm talking about a point-of-care. We do need extra beds in the hospital, but we also need efficient drainage from the hospital's subacute sector.

...

**Ms BUTLER** - That goes to my next question. Once this project is complete, you will have double the capacity when it comes to those point-of-care sections. How do you envisage tackling what you do with people from that ED as they are transitioned into the hospital? Otherwise you could end up with just an ED overflowing with people.

**Dr SCOTT** - Yes. Absolutely. That is a problem that is faced Australia-wide, where we have trouble accessing inpatient beds. We work collaboratively and closely with the integrated

operation centre, so the 'patient flow' people. We're aware of the pressures. We have meetings of the senior decision-makers across the hospital every morning, who are fully aware of the pressures on ED and working as hard as they can to improve flow out of the ED.

As mentioned previously, the main problem, the one thing to fix, would be the subacute beds, the nursing home beds, the rehab beds, and that would then create extra bed capacity within the hospital which would then allow those access-blocked patients who you saw ... who were stuck in ED and they couldn't move to the hospital, have the care delivered over a six-day admission, whatever it might be, and then move on out. So, it's collaboration. We're well aware of the problem. We're trying to work ahead of it and we're trying to not only invest in initiatives that avoid people needing to come to hospital in the first place, but also improve the back end of processing to give people a safe place to go once their acute care episode is over.

...

**CHAIR** - ...After you get all of this, you've got an amazingly efficient operating area for emergency management; but if the rest of the hospital is not prepared to take your patients, you've still got that capacity to fill up, what do you have in terms of 'plan B'?

**Dr SCOTT** - There are multiple reviews that you are probably aware of. There is an Emergency Department review ...; it's a whole-of-system review.

...

**Dr SCOTT** - ... We've heard from the review people that it is looking at the entire system, not just the Emergency Department. You are looking at the inflow into emergency - hospital avoidance; increased community support; you are looking at the outflow. We are close to getting some recommendations from that review. There's also the transfer-of-care review that is occurring at the moment, looking at ambulance off-load delay, and the reviews from that will be important as well. There's now widespread recognition that this isn't about emergency departments; it's about the systems and processes set up before you get to hospital, and while you are in hospital, and while you are out of hospital.

**CHAIR** - Preventative health.

**Dr SCOTT** - Correct. The appetite across the Department of Health is the recognition that it is not about just building a bigger Emergency Department - it is addressing all those other areas of need. I am extremely hopeful I do not need a 'plan B'.

### **Triage and Waiting Area Improvements**

4.8 The Committee noted the planned increase in triage stations and changes to the waiting room model being employed in the ED, post expansion. The Committee questioned the witnesses on the triage process and changed waiting rooms to understand how this would improve patient flow and treatment:

**Ms BUTLER** - I have a question about the triage bays - how many will there be, and what there is currently, and how this will improve that? Because that is the most high-risk area isn't it, as people are coming in: how are they triaged and how they will be triaged? You went through that with us in the tour and I found that was an important change to how the emergency department will operate. It would be good to have that on the record.

**Dr SCOTT** - The triage event is where a patient arrives at the emergency department and has a brief interaction with a triage-trained nurse, who within two or three minutes decides what treatment category they should receive. In addition to that, they have an interaction with a clerical staff member who checks their identification and lodges their details appropriately.

At the moment, we have two nurse desks, two triage desks and one separate ambulance triage desk. The new rebuild will have nine desks total - six desks facing the walk-in members of public and three specific for ambulance, but cross-capability between those. So, if ambulances

weren't there we could have up to 9 triage stations which could be used by either the nurses or the clerical staff members to deal with walk-in people. It's essentially a doubling of capability, and our projections would be that would be adequate out to 2035, given the projected increase in ED demand.

**Ms BUTLER** - And the different areas, if you could run through for the record, that the triage nurse can direct patients to, with the new system, or the proposed system?

**Dr SCOTT** - Our current system has a mixed waiting room model, which places challenges on people having to wait in the waiting room. There's a mix of paediatric and adult mental health, forensic, and other people in that waiting room. The new model has a variety of streams within the one department, and many of those streams have their own sub-wait area. For example, patients would have a triage and clerical event; there is a small waiting area if there was extra need for seats while people were queuing to be triaged.

From there, they would then go to a particular stream. We have a rapid intervention treatment zone, which has six dedicated bays, and our intention is to staff that with senior decision-makers to allow early provisions of pain-relief; early assessment; early review of ECG; and early test ordering. That rapid intervention treatment zone has its own waiting room, so people could be directed through there and assessed early and start their treatment and assessment protocol.

Alternatively, people may go straight to the resuscitation area; they may go straight to the acute cubicle area; they may, if they require a mental health bed or zone, they may go directly there; they may go directly to a paediatric area or a clinic area. It's basically a streaming and a sub-wait and that will avoid having children and adults share the same space. So, we'll be in line with the new safeguarding children and young people guidelines that we're required to abide by, as well as being more respectful and offering greater privacy for people in particular need - such as patients under forensic orders or people under mental health orders.

### **Improved Resuscitation Bays**

4.9 The Committee noted the planned improvements to resuscitation bays, and sought further information on what would be provided:

**CHAIR** - So, the resuscitation bays, you were saying at the moment are very small compared to what they're supposed to be, and so in the new builds we're talking an extra metre or two?

**Dr SCOTT** - Near on an extra metre in x and y axes for both rooms, so that would add another eight square metres or so, or 10 square metres, roughly. We also have a larger trauma resuscitation bay that allows us to accommodate large pieces of equipment such as portable special X-ray machines, rapid blood transfusion, that's a 36 square metre bay which will allow attendance of large trauma teams for critically injured people and would be in line with other resuscitation bays on the mainland.

### **Mitigating the Impact of Water Ingress from Flooding and Leakage**

4.10 The Committee was aware of flooding and water leakage issues within some areas of the RHH. The Committee sought to understand what measures had been included in the design to mitigate this:

**Ms BUTLER** - A question about the design... the current hospital layout or building is prone to leaks and sometimes flooding. Can you talk through how this design would ensure that doesn't happen?

**Mr LEE** - This design has acknowledged this ongoing leaking issue within a subterranean ED. Part of the contributing leaking problem is the ground floor space subject to weather. We are in-filling the ground-floor space, becoming internal spaces, as part of the build, and the slab



design will have a better waterproofing technique and mitigation strategies to prevent that happening.

Another thing is, consciously, we are in-filling quite close to the retaining wall on Liverpool Street on the lower ground floor. These are responses to create a service corridor again, rather than build very close to it. The construction of that wall is a double-wall system. We also consulted the leading waterproofing contractor nationally to select the appropriate waterproofing system for that new wall. In front of that new wall there is a 2-metre-wide corridor that is not a patient care area, so in the event of any catastrophic failure there is a bit of a buffer to protect the Emergency Department.

## **Caring For Mental Health Patients**

4.11 The Committee recognised mental health patients are likely to present to the ED, and sought to understand how their treatment would be managed:

**Ms BUTLER** - What would the new process look like to a person who has mental ill health and they present at the ED?

**Dr SCOTT** - Patients may be brought in by a variety of means - maybe walk-in unaccompanied; they may be accompanied by a guardian or loved one; they may be brought in by a community mental health service; they may be brought in by police; or brought in by ambulance. Regardless of how they're brought in, they would have a triage interaction, either at the ambulance end of the triage area, or at the walk-in end of the triage area. A rapid clinical assessment would be made, patient identification would be confirmed because it is important to know we are dealing with the right patient. Then, for someone who is perhaps acutely agitated or very anxious, there would be a very easy pathway to get them to a quiet and private space - a matter of walking maybe 15 metres around a corridor from the triage area, not through a public space, into a lift, swiping the back end of the lift, and walking straight into a space designed to be appropriate for people with mental health issues such as anxiety, depression or agitation. That journey is specific to that patient group. People perhaps with pneumonia or other illness like that would take a different path out of the elevator. That way, we minimise the exposure for an agitated mental health person to other members of the public.

**CHAIR** - When the St John's Park facility is completed, ... would ambulances be simply taking them there? Or would it still mean that they would end up at the Royal?

**Dr SCOTT** - Again, the Royal footprint is flexible. We have an area that is appropriate for mental health patients but those cubicles could be used for acute patients. Experience from the mainland shows that when you have a centrally located large hospital, you will always have people attending requiring mental health treatment. It may be appropriate that those people can be managed either at the Peacock or perhaps St John's Park. However, the more unwell a mental health person is the more likely it is that they will be managed through the hospital environment. We are certainly planning for that in terms of security, in terms of mental health safe space, in terms of clean admission pathways through to the mental health inpatient services that will still be on site.

...

**Dr SCOTT** - And we still need to manage acutely unwell mental health patients, which will be better done through the Emergency Department, so we are planning for that.

**Mr DOCHERTY** - There will also still be that group of patients who have got either biophysical or biochemical challenges which might exacerbate the mental health condition or might be causing it. Therefore, there will always be a hybrid patient who will always come to the Royal Hobart ED because the other mental health facilities won't deal with biophysical care, and such.

## **ED Access and Traffic Management Issues**

4.12 The Committee was interested to understand how traffic flows around the hospital site would be managed given the proposed changes to ED access:

**Ms RATTRAY** - ... It would be interesting to put on the record around the changes in the traffic management for the entrance.

...

**Mr LEIS** - ... We've had GHD on board as specific consultants addressing the traffic flow around the site as well as how it will impact the site. So, I think we would have gone through at least half a dozen designs with the team and with Ambulance Tasmania to determine the best way to exit the site. GHD's experience with the Geelong site that has been recently done whereby ambulances can essentially trigger a change in the lights, that's the current proposed solution. We have yet to fully consult with DSG on that, Department State Growth. We obviously need to move through the Hobart City Council for a start. They're considering that as we speak. There are other aspects of it in the transition as well that we've worked on with our design as well as internal surveys of understanding how people use the site. Our design has accommodated that within it.

**Ms RATTRAY** - So, if there's an issue being able to receive the appropriate compliance, I guess, with the Department of State Growth and the Hobart City Council, does that impede the project in any way if there is a 'no' or a pushback or - I'm just interested in what happens, particularly when it's talking about the entry to the emergency department.

**CHAIR** - Is it a show stopper in other words?

...

**Mr HARGRAVE** - ... We would work with the planning authority to understand their concerns. There might need to be some modifications to the design or how it operates but that's consistent with projects that we work on with our partners both in council and other state government agencies. I wouldn't envisage that it would be a 'show stopper'. It might just be that we need to work through some concerns with whoever it is, whether it's State Growth or with council or both, to resolve them and incorporate those changes into the design. I wouldn't foresee that it would be a show stopper.

**Ms RATTRAY** - But the issue is, once that the design goes out to tender, and then if you are still trying to negotiate with Hobart City Council, would you do that before you put this out?

**Mr HARGRAVE** - A development application would need to be submitted and approved well before. Ideally, we would have done that well before we went to tender. It doesn't always happen that way but that's what we'd seek to do.

...

**Mr LEIS** - Certainly, within this one and what we've allowed for within the time lines allows for that consultation and DA period with council as well as DSG and we wouldn't go to tender without those key stakeholders on board - in this case because it is a critical aspect of how it works.

...

**Ms BUTLER** - Further to that, for the record, could you run through what that traffic management plan will be for Liverpool Street and Campbell Street? There are traffic lights there and on Liverpool Street and Argyle Street. The traffic flow around those areas. There's also the pedestrian access points, ambulance access and exit points and also the passenger drop-off section as well. There's a lot in that.

**Mr LEIS** - Each of those aspects has been done within the plan. Starting from the Campbell Street side, Campbell and Liverpool Street. If we look at delivery of the ambulances in from there, as we experienced today, the lights go on if they need to urgently cross into the current

subterranean space. In the future, they will be at street level and have access to their area there.

Public can drive along there as well but we will look at a number of different aspects of signage and wayfinding to assist people with navigating that area, because there is drop-off in that area for the Holman Clinic and less-able people.

...

**Mr Leis** - There is one main entry on the design as it is at the moment. Both the ambulance as well as public drop-off will be going along the front parallel with Liverpool Street.

**CHAIR** - They are separate entrances for ambulance and for public?

...

**Dr SCOTT** - ...There is one vehicular access point which is used by both ambulance and members of the public. There are separate entrances for ambulance patients and walk-in general public entrance into the building.

**Mr HARGRAVE** - Page 15 of the report gives a schematic render of what it would look like.

**Mr LEIS** - Vehicular access will not be dissimilar to what it is currently, in that public go down underground as well. That will be the same up at ground level and it will be easier to see. We are working on better signage for it to make it very clear where you have to go.

**CHAIR** - When ambulances are backing in to their space, because that is what they are going to do - do they go anywhere near the footpath that is out the front or is that quite a distance?

**Mr LEIS** - Quite a distance for the footpath. The footpath as you currently see on the side here is up against the buildings. It will be effectively out on the street where the current row of trees is.

...

**Mr Leis** - There's actually a hump in Liverpool Street - it is about 400 millimetres high to what the flat level will be across on the ED at the moment. It's caused us a few challenges in engineering but that clearly creates a delineation between what will be vehicular space and what is pedestrian; and then the new bike lane that will go in and the remaining two lanes of traffic for Liverpool Street.

**Ms BUTLER** - So, pedestrian access and pedestrian crossing - what will that look like?

**Mr LEIS** - I will take you from the other angle where most of the pedestrian traffic comes from, which is obviously closer in to the city and the mall area and where the carparks are on Argyle Street. That will come along Liverpool Street, and then there is a pedestrian crossing of the traffic to get back into the hospital. But we will be working through a communication plan for anybody who is a visitor using the Campbell Street access, which is the front access to the hospital.

## **Project Costs**

4.13 The Committee noted the contingency allowance in the project budget, and questioned the witnesses as to the reasons it was relatively high:

**CHAIR** - ... In the contingencies you have design, construction, escalation and market. ... It is 36.2 per cent. Usually for a contingency we would see 10 per cent or maybe 15 per cent, but this includes escalation and you are putting in 36.2 per cent. Is this because it is over a two-year period, therefore, a lot is going to happen in that period of time? How have you arrived at that 36.2 per cent?

**Mr HARGRAVE** - ... it is significant at the moment and a lot of that is to do with where we are in the development of the design. We've got a concept design at the moment and that design and this estimate - and I note that the contingencies are high - informs our business case to

our project sponsor .... As we move into subsequent stages of the design, we should be able to firm up or remove risk that we've priced or made allowance for in the contingency. As we move through that there's hopefully an opportunity to get a better feel or reduction of that contingency.

...

You're right, the contingency is a bit higher than you'd normally allow and there is a bit of uncertainty in the market as well. We've seen a lot of cost escalation. We've been seeing it in our project and we've also been observing it -

**CHAIR** - Because of a glut of work?

**Mr HARGRAVE** - Yes, demand is high. There are still some supply chain issues as a result of COVID-19, so logistics remain a problem, but mainly because everybody's busy. If you're lucky, you get someone who has a gap in their workbook and they really want the work. If you're not so lucky, you get one tenderer only and they know they're the one tenderer. We have to try to work through that.

...

**Mr LEE** - If I may add, chair, the contingency was developed in consultation with a professional quantity surveyor. I think we lean on his expertise. He's not only involved in one sector of work but also across multiple sectors, for instance education, health care, major infrastructure and private development as well...

- 4.14 The Committee noted that many projects it had inquired into had seen significant increases in cost when put out to tender or once completed. The Committee was keen to understand the implications, if any, if very high tender bids were received:

**CHAIR** - You've got to understand that we see all of those types of projects and we see schools. We always use this of late: the Brighton High School, which was \$39 million and then ended up being \$70-something million. Quantity surveyors were involved in all cases. That's probably about that same distance out when it first commenced construction I think. So, I'm thinking to myself 'are we going to see this end up at \$300 million rather than \$149 million?' If it did, by the time you got to putting a spade in the ground or putting a crowbar into a wall, would this be, sorry we can't do this? Is there room to pull this project if it's way overpriced or not?

**Mr HARGRAVE** - Yes, absolutely, part of the tender evaluation process is this value-for-money test that we have to put over the tender evaluation.

...

**Mr HARGRAVE** - ... If we received tender prices or a tendered price that was significantly above, double, as you've indicated, we would have to withdraw the tender. It would be very hard to demonstrate value for money, I think, if you received a tender at \$300 million.

...

**Dr SCOTT** - Yes, well I'm sure Andrew and I would have some conversations because we've got a department that's not serving the needs of the Tasmanian public currently and the alternative is many years away if this project didn't get up. But I completely understand we need realistic costs. If you go back to a drawing board greenfield site, we are looking at 10 - 15 years before we deliver a product rather than two, and we are already struggling.

### **Industry Capacity to Complete the project**

- 4.15 The Committee recognised the impact construction industry capacity could have on costs and ability to complete the project in a timely manner. The Committee questioned the witnesses to understand their expectations on the industry's capacity to undertake the ED expansion:

**Ms RATTRAY** - Do you see any issues with workforce availability? Not for the hospital itself but for undertaking the works, given that you have got so many balls in the air?

**Mr HARGRAVE** - It is a good question. There is an ongoing shortage of capacity. If I go back a step, the Tasmanian building and construction industry is small. There is a small number of players that would take on this sort of work or have the capability to take on this kind of work. That's the first thing. Secondly, nationwide there is a shortage of specialist trades -whether they be carpenters and joiners, electricians, plumbers, plasterers. We are seeing all of that in Tasmania but more broadly across the country, we are seeing those sorts of shortages as well. Yes, it is a consideration. When we approach the market, it is often something, particularly in relation to pricing, that lead contractors are very keen to secure a contract because their subcontractors are only prepared to provide pricing for 30 days - our tender validity periods are normally 90 days - because of that shortage. There are often concerns that their subtrades will -

**Ms RATTRAY** - Go off and do something else.

**Mr HARGRAVE** - Exactly.

...

**Mr HARGRAVE** - We try not to hit the market all at once, for that reason as well.

...

**Ms BUTLER** - ... There would be a level of expertise within some of those building firms, I assume, with some of the work that has already been undertaken around the state with different hospitals and medical facilities. So, is that expertise here in the state already to be able to tender for some of these jobs?

...

**Mr HARGRAVE** - ... absolutely. And we have seen that with the stages of the RHH - stage 2 of that we have already delivered. Not just the RHH, also work that we have done in Launceston General Hospital, work we are doing at the Mersey Community Hospital.

...

**Mr HARGRAVE** - ... There are a number of key players that are focused in particular provision of health building construction services, and I can say without reservation, the quality of their work is excellent. Local companies too.

...

**CHAIR** - Also desirable in the sense that some of those firms will be able to gain experience in that area, so you should get some reasonable quotes.

**Mr HARGRAVE** - To add there, chair, they see a lot of benefit in it as well, particularly from a training and development of their staff and apprenticeships. There are lots of benefits. They are all very busy, as we have indicated, but they are also very much targeting health projects.

**Ms BUTLER** - I imagine it would make it so much easier being project manager with a building firm that already understands the culture, already understands that specialist nature of trying to rebuild in a project in a hospital site -

**Mr HARGRAVE** - In a brownfield site.

**Ms BUTLER** - Yes, in that setting where it has to be quietly and methodically done and the project has to be very streamlined to fit in with such a busy ED area. That won't be an easy fit.

**Mr HARGRAVE** - No, and the hospital build is esoteric in its nature and it's very different to building a set of apartment blocks or a commercial development. So, the contractors that deliver this work for us do have a specialist skill and they particularly understand the infection prevention control side of working in a hospital.

## **Does the Project Meet the Requirements of the Public Works Committee Act?**

4.16 In assessing any proposed public work, the Committee seeks an assurance that each project meets the criteria detailed in Clause 15(2) of the Public Works Committee Act 1914. Broadly, and in simple terms, these relate to the purpose of the works, the need for and advisability of undertaking the works, and whether the works are a good use of public funds and provide value for money to the community. The Committee questioned the witnesses who provided the following confirmation:

**CHAIR** - ... does the proposed works meet an identified need or needs or solve a recognised problem?

**Dr SCOTT** - I would say it absolutely does. I feel that we are struggling to provide the care that the Tasmanian public deserves, at the moment, due to not only a reduced footprint but also the pressures on the system as a whole. The larger ED will provide a bigger footprint and be a temporising measure to allow other systems and processes, both pre-hospital and within the community, to spring up and provide a solution to access block. So, yes.

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

**Dr SCOTT** - Again, to provide that level of care capacity at an alternate site would cost billions, because an ED does not run alone. It needs surgical unit; medical unit; imaging; pathology; clinical services; cleaning; food services - a whole heap of things. You're not just building an ED; you are building an entire hospital somewhere else to provide something that can deliver care to the Tasmanian public. So, whilst the proposed works are expensive it's the best available use of the remaining space on that city block footprint and it will deliver care out to 2035.

**CHAIR** - And that's a tad over \$149 million on the budget. Is that right?

**Dr SCOTT** - That's correct.

**CHAIR** - So, that's a yes?

**Dr SCOTT** - In my opinion, yes.

**CHAIR** - Are the proposed works fit for purpose?

**Dr SCOTT** - Yes, I would say they are; I think the level of architecture and planning input as well as the AustHFG .... The Australasian Health Facility Guidelines. We're building to the nationally recognised, and Australasian, recognised health standard. We've had expert level input from our architectural colleagues; and consultation with a wide variety of groups who are required to use that space. The product - while challenging to deliver on that brownfield site - is the best available use of that space, in my opinion.

**CHAIR** - And we're not going to get to the end of it and find a critical component which stops it getting its accreditation?

**Mr HARGRAVE** - No. Lots of planning, lots of interaction with health facility planners, specialist architects. That's their key role - to make sure this facility is safe, contemporary and functional.

**CHAIR** - Okay. At over \$149 million, do the proposed works provide value for money?

**Mr HARGRAVE** - Yes, and in line with current market expectations.

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

**Mr HARGRAVE** - I believe they are, yes.

## 5 DOCUMENTS TAKEN INTO EVIDENCE

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

- *Emergency Department Expansion, Royal Hobart Hospital, Submission to the Parliamentary Standing Committee on Public Works, Department of Health, 28 November 2023.*

## **6 CONCLUSION AND RECOMMENDATION**

- 6.1 The Committee is satisfied the need for the proposed works has been established. Once completed, the Royal Hobart Hospital Emergency Department Expansion Phase 2 will provide a state-of-the-art ED, with the capacity expected to be needed to meet the continued growth in Emergency Department presentations through to 2035.
- 6.2 The proposed works will deliver a total of 121 points of care in the ED, approximately double the capacity prior to the commencement of the staged ED expansion. It will also deliver an increased number of triage stations (from five to nine) including three ambulance triage stations, a new separate paediatric area with a dedicated child safety compliant paediatric waiting room and procedure room, a Rapid Intervention and Treatment Zone (RITZ) with waiting area, a medical imaging area with waiting area, a new resuscitation zone with increased capacity, an acute care zone with an increased number of acute treatment spaces and a new low-acuity adult treatment area.
- 6.3 Accordingly, the Committee recommends the Royal Hobart Hospital Emergency Department Expansion Phase 2, at an estimated cost of \$149,140,600, in accordance with the documentation submitted.

**Parliament House  
Hobart  
8 February 2024**

**Hon Rob Valentine MLC  
Chair**



