THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT THE KING ISLAND COUNCIL CHAMBERS, CURRIE, KING ISLAND, ON WEDNESDAY, 15 DECEMBER 2010.

KING ISLAND HOSPITAL AND HEALTH CENTRE

Ms SARINA LAIDLER, HEALTH PROMOTIONS AND COMMUNITY DEVELOPMENT OFFICER. KING ISLAND HOSPITAL AND HEALTH FACILITY; **Ms NANCY GROGAN**, ACTING DIRECTOR OF NURSING, KING ISLAND HOSPITAL AND HEALTH FACILITY; **Ms ROSEMARY AYTON**, NURSE UNIT MANAGER, KING ISLAND HOSPITAL AND HEALTH FACILITY; **Mr SCOTT CURRAN**, DIRECTOR, ARTAS ARCHITECTS; **Mr MATTHEW GREEN,** PROJECT COORDINATOR, ARTAS ARCHITECTS; **Mr GREG COOPER,** MANAGER, MAJOR PROJECTS, ASSET MANAGEMENT SERVICES, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

DEPUTY CHAIR (Mr Hall) - I welcome everybody to this hearing. In particular, I recognise Mayor Charles Arnol, who is sitting in the back box to see how a Public Works hearing is conducted. Thank you for coming along, Charles. We have two apologies today - one from Mr Harriss, who is normally the Chair of the committee, and one from Ms White.

I note that you have a PowerPoint presentation, but we have had a very good look around this morning, so I think you can keep most of your presentation pretty succinct. If you wouldn't mind being reasonably brief, it will allow committee members the appropriate time for their questioning. Who will lead off?

Mr COOPER - I will lead the presentation. Today's project is the redevelopment of the King Island Hospital, so I will touch on the existing deficiencies in the project, the project time lines and budget, and how we will resolve the issues in the existing centre.

Mr BOOTH - Is this presentation the same as this PowerPoint document that we have?

Mr COOPER - It is a bit of a summary, showing some of the specific issues that need resolution and describing how that will -

Mr BOOTH - Information not included in this document?

Mr COOPER - Most of it is in that document. There is some additional information in this presentation.

The project is that we have $5.3 million to spend on the existing building, which consists of a six-bed acute wing, a 14-bed aged care area, community health, doctors and specialists, and then general administration. So within the centre, as you will have noted when you walked around today, there are a number of deficiencies. We have consult rooms, which are crowded and poorly configured. The nurses' station has inadequate hand-over space and there is no space there for doctors and nurses to do their write-ups.

There is poor configuration to manage visitors to patients and there is also poor storage and filing space in all those areas.

We have issues with the wards: they share common toilets; there are poor finishes; and the lighting is poor. They are generally in okay condition, but they really do need a general tidy up in the amenity spaces, as you saw, because of the age and condition of the fittings and fixtures. They are also too confined to allow lifting of the patients on to the amenities.

When we went up into the aged care area, you saw the sunroom and you saw an example of the conditions that exist as soon as it gets reasonably warm. The area just becomes a big hothouse and most of the time it is an unusable space. In winter it becomes really cold. That is part of the aged-care area that we certainly need to refurbish.

We also have an ambulance entry at the moment that is adjacent to the main entry, so that creates issues for ambulant access, dropping off of the patients in a private and discrete manner - that is difficult. In the waiting area where there is ambulatory access there is no visible control of that space from the nurses' station. It is well away, so there is no management of residents and friends who may be coming along. At the moment the Tasmanian Ambulance Service is not co-located on the site, so this project is going to co-locate Tas Ambulance. There is also lack of storage.

A lot of the background is in the report you have. The main hospital was constructed in 1973 and has not seen much redevelopment since. The aged-care extensions were in the early 1990s. It is a very cohesive hospital that operates on a whole range of areas, from the acute to aged care through to its own GP space and all the primary health areas that we need.

The four areas on which we will concentrate include high and low care, the acute wing, relocating the GP clinics, providing space for Tas Ambulance, and changes to the mortuary. Then we have community health, the administration and a relocated kitchen. From the site plan you can see the different areas that we are looking to update. We walked through the aged-care wing today. We have the low-care area, which consists of six beds. We are not doing a lot of work in that space. It works reasonably well for the clients. There is some need to provide improved access, so we are widening the doors. We are also providing some support functions with their own disability toilet and some additional storage space for equipment in that area. We are upgrading the general patient dining areas. At the moment there are three separate rooms. We are combining them into a single, larger space, which will improve lifting and allow more patients to be in the one space rather than in three separate areas which created problems in staffing.

We are creating a specific dementia wing as part of the high-care redevelopment. That will assist in preventing dementia clients wandering throughout the hospital. We are a providing their own dementia garden and will better manage the dementia clients. We have six other high-care, aged-care beds, all of which are to be fitted with their own ensuites, which meets contemporary health standards and aged-care certification. The benefits from redevelopment of the aged-care area are increased compliance with aged-care standards through the individual ensuites, improved patient lifting ability as well as additional space around the beds with larger bedrooms. We are providing lifting beams over the top of each bed to assist the staff. We are also going to improve security for

staff and residents by having that specific dementia space, whereas at the moment dementia patients wander throughout the whole centre.

At the moment the acute wing has six beds and a treatment area. We are redeveloping that space to provide individual ensuites for each of the single-bed acute bedrooms. That will provide some flexibility should we have increased need to accommodate aged-care residents. It has the capability to accommodate them because it is set up for that need. We will provide a new separate covered access for the ambulance, so there is more discrete and private drop-off for patients into the treatment area. They go straight into the treatment space when they are dropped off, a slight improvement on the current arrangement, which is through a few corridors. We have X-ray immediately adjacent. We are improving the nurses' station for a better view up to the aged-care wing and into the acute. We are providing an adjacent hand-over space, which now gives us the write-up space for doctors and nurses, and a larger drug storage area. It will also improve our after-hours access and it will be easier to monitor visitors. The benefits are improved compliance with modern standards. We will improve patient lifting ability through having lifting beams over beds. The new configuration of bedrooms will allow lifting gear to move around the beds. It provides improved security for staff and residents. We can close off the acute and operate it as a stand-alone wing in future, rather than needing to open up the whole space. There will be improved access and privacy for ambulance patients.

The next areas we are redeveloping are the GP clinics, the morgue, and providing a space for Tas Ambulance. At the moment the GP rooms are located in the community health area and the GPs regularly need to go into the acute space, so they are located relatively poorly to the acute wing and treatment area. The new location will provide discrete access for the GP patients who don't need to be in the general departmental space. They are also almost co-located within our treatment area to provide quick access and assistance. We have also improved their space because they are currently constrained in it - there are only two GP rooms. We will provide a specific space for specialist services that attend the island, and a nurses' clinic area.

There are improvements to the morgue. For some time the community has complained that the viewing room was just a single room. Other family members and friends had to stay outside of the viewing area through poor weather. We have managed to configure the space better now that we have a waiting area adjacent to the viewing area, so visitors can be sheltered from the weather. We are also constructing, adjacent to that services area and the morgue, a new covered ambulance bay so we can co-locate Tas Ambulance services onto the hospital site.

The final area of the redevelopment is the community wing, which is the traditional primary health area of the department's services - community nursing, health promotions, physiotherapy, community consultation, and our dental and child health. That is all being reconfigured. It is quite a crowded space at the moment, with people sharing the same consultation rooms and so we are able to provide more specific spaces that suit each of those service groups. The physio will have its own space now rather than using shared space and the dental area gets an upgrade to modern standards. We are also relocating the kitchen into this space. Where it currently sits is where the acute treatment wing is going and so we had to relocate the kitchen to improve the patient flow in that area. The kitchen is now located in a more central location so we can feed

to the aged care and the acute wing quite easily and also provide services into our community day room which may have large groups of people and functions. We are also providing a larger telehealth training area, which will be a shared service with Tas Ambulance so it will also be a training room for staff - an improved staffroom. We are also relocating the reception area to better manage the community care area and improve filing and storage and resource-sharing areas for them.

That covers pretty much the areas that we are redeveloping. Our program is that we are hoping to go to tender in early January. With our documentation we are still working through some consultation on some finer details but we are getting very close to resolution of the drawings and then we are hoping to have contractors on site at the end of March/early April. Then construction will go through to about April or May in 2012 through six stages of construction. I will show you the plan. We are beginning with stage 1, the low-care aged care and construction of the dementia and redevelopment of the dining areas. We are then moving into construction of the main acute aged-care space. Stage 3 is the acute wing and the acute treatment area that we are developing.

Mr BROOKS - Regarding the tender that you just mentioned, will that be a tender for the whole construction or for each stage?

Mr COOPER - That will be for a whole project and these stages will break it down.

I am sorry, I missed a stage there. Stage 2 is redevelopment of the central reception area and creation of the new kitchen so that we can then go into the acute wing and redevelop that and create the treatment bay. Then we move into finalising the GP area so that the GPs can move out of where they are. Finally we redevelop the community health area.

In terms of budget, we have $5 million in the capital investment program which is allocated out to 2012. Tas Ambulance have contributed a further $100 000 and we have some additional funding from the North West Area Health Service of $200 000, giving us $5.3 million. Our current capital works estimate is nearly $3.8 million. On top of that we have a remote area allowance of $600 000. An allowance to accommodate builders and for travel issues is an unknown at the moment and that is what we will need to find out at tender time. We have $160 000 in a construction contingency allowance; $480 000-odd for professional fees. We have an art in public buildings requirement of $80 000 and then we have equipment escalation of just over $200 000, and that also includes some redevelopment of the existing accommodation block for the nurses. We are looking at doing some early works and once it is completed we hope to have constructed three single-bedroom units which will be available for the builders in the construction period to reduce that $600 000 accommodation allowance.

DEPUTY CHAIR - Thank you. Mr Curran, we have had a good look at the plans at the hospital and we have them here with us. There were a couple of small amendments, I think. Is there anything else that you need to say, Scott?

Mr CURRAN - No, Mr Chairman, I think it has all been covered off, thank you.

DEPUTY CHAIR - Going back to the project cost, Greg, we are talking about a $600 000 contingency for construction. Then you have a fees contingency of $40 000 on top of

that and an escalation cost. If we already have a contingency in there, I am wondering about the escalation costs.

Mr COOPER - The escalation is essentially that the QSs develop their budgets at this moment in time and so, given that there is going to be another three or four months, maybe longer, before we go to tender and a contractor starts, then there is an escalation that we just leave in our budgets internally until we come to the pre-tender estimate.

DEPUTY CHAIR - At the front of the report you talked about the BER funding slowing down, of course, because a lot of that stuff has been done out of the Federal stimulus package. You talked about increased competitiveness for the project. Are you still confident that that will occur?

Mr COOPER - Yes. The department tendered a few projects 12 months ago and we would only get one price. Recently we have been tendering some works at the Mersey and the North West Regional Hospital and we have received seven or eight tenders so we are seeing more interest from the builders in pricing, which is good for ourselves. We also have the unknown, though, of the island and how many builders are going to be attracted to coming over to the island if there is adequate work on mainland Tasmania.

CHAIR - What would you anticipate - five or six tenders?

Mr COOPER - Maybe less. We are hoping that we might get five or six but I suspect that it is probably mainly going to be the big three or four builders - Fairbrother, Vos, maybe Hazell Brothers, maybe one or two others.

Mr BROOKS - You have put a 20 per cent contingency in for remote location, and that is understandable. You have a fairly specific amount here of $4 367 132. How did you come up with that figure? How much fat is in there, on top of the 20 per cent?

Mr COOPER - I will hand that over to Scott, whose sub-consultant, a quantity surveyor, came up with that estimate.

Mr CURRAN - Initially they start off with a square metre rate. We start off with our schematic design and then they will put a base square metre rate, based on their experience working within the industry. Then as we progress the drawings and we get more and more detail onto the drawings, the quantity surveyor is able to refine his estimate. We are at a stage where we are probably 75 per cent to 80 per cent complete with documentation, so he has been able to refine his estimate down. There are still some unknowns as we continue to tinker with the design and what is in some of the rooms, but essentially that is the process that we have been following and we are very much guided by the information that he provides to us.

Mr BROOKS - Okay. What capability or opportunity will there be for local King Island resources to be used?

Mr COOPER - Essentially there is every opportunity. It is a public-let tender process.

Mr BROOKS - If they're on the preferred tender list.

Mr COOPER - The head contractor needs to be on that preferred tender list and they will need to be pre-qualified up to the level of the project. The construction value is about $4 million so they will need to be pre-qualified at that level. In terms of local tradespeople, they will all have the opportunity to provide quotes to each of the major contractors. There might be some pre-qualification requirements for mechanical and electrical contractors which may make it difficult for local contractors if they are not already pre-qualified, but certainly in terms of, say, a carpenter, plumber or bricklayer, they could all put quotes to the main builders.

Mr BROOKS - The selection process of the tender once tenders are submitted - who will decide that?

Mr COOPER - The department will set up a tender assessment panel. That will consist of myself as the department's project manager on the construction site. It will involve Scott as the architect and we will have another representative from the department, which could be a local representative, and we also have representatives from the North West Area Health Service.

Mr BROOKS - Would the committee consider a preference of using local subcontractors where possible?

Mr COOPER - Yes, certainly, and we have done so before with Bruny Island - another recent project where as part of the tender assessment we asked them to provide details of any local labour that they were going to incorporate, and we can include that in the tender documents that we go to the market with.

Mr BOOTH - Greg, I am interested to know how you adduced the design criteria for the project. Was it a funding-based thing or was it an age-based thing? How did you get to the point where you decided that this what was needed?

Mr COOPER - I think it was about two years ago. Prior to that there seemed to be a need to redevelop a number of remote acute health centres, what we call Tier 2 health centres. The department saw this site, Flinders and a few others that needed redevelopment and we at that time did an assessment, including a condition assessment - Scott was involved in this site - identifying what all the deficiencies were and from that we came up with a budget which was put up for Cabinet approval, and that occurred about two years ago. Since then we have been going through the planning process.

Mr BOOTH - How was the brief prepared on that basis? Did Scott, ARTAS, develop the project scope?

Mr COOPER - Scott, in conjunction with the site manager, would have gone around the hospital and identified the different aspects we are upgrading now as items that needed to be fixed up.

Mr BOOTH - Is that work part of the design fee? I notice that professional fees are nearly 10 per cent of the billed cost? Can you give us a breakdown of those fees?

Mr CURRAN - The initial work that we did was not part of the engagement that we have now, that was a separate engagement to do the investigation on the hospital. We then

went through a process where we had to tender for the work and we were successful with that tender. The fees that we have are broken down into a number of different sub-consultants that we use. As the architects, we are the lead consultants and it is our responsibility to coordinate the other consultants. I do not have the breakdown of the fees with me but I can provide that to you, but included within our range of sub-consultants we have mechanical, electrical, fire, communications, quantity surveyor, building surveyor and a number of other different consultants that we use to enable us to produce documents to tender for this project.

Mr BOOTH - So then the design part of the project was put to tender?

Mr COOPER - Yes.

Mr BOOTH - What other tenders did you get? How did you sort out the tender for the design, and what were the other prices for the design?

Mr COOPER - I couldn't tell you here but I can find it out and make it available.

Mr BOOTH - Ten per cent seems an extraordinarily high fee for architect and design fees, it seems to be a lot of money.

Mr COOPER - That is a very traditional figure - on most construction projects it is a broad rule of thumb. If you are getting up to a $30 million project it might be less than 10 per cent, it might be 7 or 8 per cent. The other issue - the same as the builders - is the travel requirements. For the consultant team to come over here they need to go through the existing building with fine toothcomb and that takes time and effort to look at all the issues, go through ceilings, look at walls and plumbing and then to prepare the documents and go through the consultation phase with staff and management, and then go back and forth with the designers. We come up with estimates and we might find that we are over budgets and we need to prune areas and see where we can get savings. So it is a very typical-type rule of thumb - the 10 per cent-type figure.

Mr BOOTH - With regard to the ultimate design, which at this time isn't finalised because there are some changes taking place - and I want to talk about some of those issues at a later time - how did you go about determining the needs of the site, was it something that you discussed with the managers and sought their advice with regard to that?

Mr CURRAN - Initially we get a brief, which is what we prepare our submission on, and then we will take the brief and start our consultation. So we sit down with the managers and start to discuss the brief to determine whether parts of that brief are still relevant or whether things need to be added into it. From there we progress through a number of stages. We have a schematic design stage where we then start to put some of these thoughts onto paper, then come back and have consultation, talk about the impact of what we are doing on the building, on the design and on the functionality of the hospital. As we work through those stages we move into a stage of further schematic design where we continue to resolve some of these issues in more detail to a point where we ask for it to be signed off. So that issues of functionality, placement of rooms, size of rooms, all of those things, are signed off at an initial phase, and then we would start our documentation, which is when we start to zero in on rooms and see what bits of furniture

and equipment are needed, locations of power points, fire detectors, lights, conditions of ceilings and all those sorts of things, and through that we were able to tender the job.

Mr BOOTH - I direct my question to Rosemary, Nancy or Sarina - and remember, this is your one chance to say it, and it is very important that we get an answer you are happy with - in your professional opinion is what is currently proposed - bearing in mind that there will be some changes made, and I will talk about them later - adequate to cater for the needs of the King Island community into the foreseeable future?

Ms LAIDLER - I believe it meets quite a lot of our needs for the foreseeable future - it depends on how far into the future you are looking. It certainly will bring about some great improvements on what we currently have.

Mr BOOTH - You said that it meets 'quite a lot' of your needs. What about the ones it doesn't meet?

Ms LAIDLER - I think some of the needs around storage - it's just some basic stuff to sort out overall.

Mr BOOTH - There are issues with regard to storage and lack of a sterilisation room and things like that being smaller design things, but the general concept, as far as capacity is concerned - is that adequate?

Ms AYTON - Yes. I concur with Sarina - it meets our needs at present and for quite a few years ahead, I would say.

Mr BOOTH - Just to clarify that - if this project is approved, can we be sure that in 12 months or two years' time it will not prove inadequate for the community's needs? Could we find that the design doesn't meet proper occupational health and safety requirements and so forth?

Ms AYTON - No. I think it meets the needs.

Mr COOPER - I might add, Kim, that one of the other aspects that the department did was a health snapshot of the island, looking at projections of health issues, so in terms of the numbers of beds and that sort of thing, that was reviewed at that time and it was confirmed that having six acute beds was adequate moving forward - it may even be a little more than we need. Similarly, in terms of the 14 aged-care beds, it was felt that that was adequate for current and future needs.

Mr BROOKS - I have one more question on the project costs. It has $80 000 allocated for art in public building. Can you just explain how that figure came about and what it is actually for?

Mr COOPER - It is a statutory requirement that all projects have a 2 per cent contribution of the budget up to a maximum cap of $80 000, and if we had had the 2 per cent for this project, the amount would have been about $100 000-plus, but with the $80 000 cap, that is where we are at.

Mr BROOKS - Is that 2 per cent of the total project or 2 per cent of the construction costs?

Mr COOPER - It is the total project budget.

DEPUTY CHAIR - So just returning to Mr Booth's line of questioning, are you saying that we are perhaps creating a facility that has some overcapacity, given future demographics?

Mr COOPER - I would like to say that it has flexibility in that there is the occasional instance where the acute wing might be used as a bit of a respite area. We have that flexibility there and we should retain that.

DEPUTY CHAIR - We all recognise that there is an increasing ageing population, but as far as the demographics of population go for the island, has that been taken into account in future projections?

Mr COOPER - That is my understanding.

DEPUTY CHAIR - So what are the projections? Can you answer that?

Mr COOPER - I couldn't tell you what those are - that is a separate report. I can make that report available to you as well, if you wish.

Mr BOOTH - I think we would need that. I would just like to make the point - and I don't have an opinion on it either way, but it is my job to scrutinise public expenditure - that it is important that we get full answers to all these matters. I think we would need that information because it is not simply good enough to just think that that demographic study has been done. It is important that the committee should see it and take note of it.

Mr BROOKS - You currently have a 20-bed capacity, and the project will finish with a 20-bed capacity after we have spent $5 million on it. We need to make sure that that will suit the 20-year plan.

Mr COOPER - Yes.

DEPUTY CHAIR - Any more questions on the development budget? If not, we will move into the nitty-gritty, nuts-and-bolts, if you like.

Mr BROOKS - Just a quick one on the budget again - air conditioning and heating. Are these adequately designed for the full project and included in the construction costs?

Mr COOPER - It is within the construction costs. The system at the moment is a centralised hot water boiler that reticulates to radiators. I might let Scott tell you what is happening in each of the wards.

Mr CURRAN - We have a split system air conditioning in each of those rooms and we are also looking to air condition the kitchen as well. The other areas will have a combination of natural ventilation and ceiling panels utilising the existing boiler.

Mr BOOTH - In terms of the carbon footprint of this building, its insulation qualities, double-glazing et cetera - I wonder whether those things are incorporated so it will be low energy use building.

Mr CURRAN - Certainly all the new areas that we are providing will have all those design items, such as double-glazing and insulation. In existing areas where we are adding new linings we will be looking to do that, but areas that are just being refurbished will remain pretty much as they are at the moment. They will just be getting new carpet and new paint finishes. Where new lights are required, they will go back to low-energy light fittings; they will go on to things like sensors. Any new fittings that we replace in terms of hand basins or toilets will have the appropriate energy rating on them. We are doing as much as we can within the budget and within what is practical in the building that we have.

Mr BOOTH - Are there constraints in the budget with regard to making it energy-efficient, which might mean a greater cost in the long run in not putting in proper energy-saving measures?

Mr CURRAN - I don't believe so because, based on previous experience, the payback periods that we are looking at on a building such as this are just not able to stack up against the amount of work that you would have to do the basically retrofit it. If we were building a new building it would be a totally different conversation but, given the infrastructure and the construction that we have, I don't believe that it would be efficient to retrofit that.

Mr BOOTH - And the cost of a new facility would be way over $5 million, I presume.

Mr CURRAN - It certainly would, yes.

Mr BOOTH - Do you have a rough estimate of what it would cost to replicate the whole thing with a modern new building?

Mr COOPER - How many square metres have we got?

Mr GREEN - Approximately 3 000 square metres.

Mr COOPER - In Hobart the cost would be about $3 500 per square metre, so if you are adding 20 per cent to that, then you are looking at $4 000 per square metre so we are talking about a $12 million project. It is substantially more.

Mr BOOTH - How much more would you get out of a $12 million project, given that this is only refurbishing part of the facility?

Mr CURRAN - That 3 000 square metres is the overall footprint that we have at the moment, so if we were to replace the whole footprint I believe about $12 million would be fairly close to what the cost would be.

Mr BOOTH - How much of the footprint are you actually rebuilding, refurbishing or dealing with? It may be difficult for you to give me a figure out of your head, and I appreciate that, but some sort of general guide. Forget about the rooms that are just having carpet

and a repaint, but where you are moving walls, substantially altering the building, how much are we getting for that as opposed to biting the bullet and demolishing it and putting up a new one?

Mr CURRAN - We are essentially rebuilding eight rooms in the aged-care area, we are building a new kitchen, some ancillary stores and services through the low-care area and we are doing a fairly substantial reconfiguration through the doctors' and specialists' area, so I guess that is probably about a quarter, as an estimate.

Mr BOOTH - So will the other three quarters require similar capital expenditure over the foreseeable future - in the next 10 or 20 years? Is the rest of it going to have the same treatment?

Mr CURRAN - No. The acute area, for example, after we have done that, there will be new floor coverings, new fittings and new lighting, so the areas we are refurbishing get a fairly substantial upgrading.

Mr BOOTH - Could I ask Rosemary and Sarina to comment on that? Presumably if you had a choice you would prefer a brand new custom-designed facility?

Ms AYTON - Of course.

Laughter.

Mr BOOTH - It is a quite a complex, multifunctional centre, you have a lot of different disciplines there and obviously some inadequacies in design; the work that has been done is to fit in things that you need into what you have and there are obviously some limitations. Were this to be built, refurbished in this way, as a health facility, how deficient would it be compared to a modern, contemporary design with perhaps different separations between areas.

Ms LAIDLER - I think the design is very good and works well and that you wouldn't be making any great changes to the configuration because a lot of work has been put into that aspect of the design.

Ms AYTON - Yes, I would agree.

Mr BOOTH - So if you built it new, the configuration would be similar to what you have, you have achieved efficiencies in the design?

Ms AYTON - Yes.

Ms LAIDLER - You have the acute, aged care, community health -

Ms AYTON - Emergency.

Mr CURRAN - If I could expand on that, Mr Booth, we are also doing Flinders Island as well, which is basically a demolish and new build.

Mr BOOTH - Okay.

Mr CURRAN - A lot of the concept behind the new build actually follows a lot of lines that are very similar to this where you have an entry with the GP area, with a separate entry off to the side. Then you have the community centre, all the community services, and then through the building into the emergency and treatment room and the aged care on the back. Even though it is a new build and there are constraints on the site, in terms of configuration it is fairly similar to the configuration that we have been able to get here. I think we have been fairly fortunate with the configuration that we inherited that we were able to do some minor alterations and reposition some things to get the layout that we got.

Mr COOPER - I might add that Flinders Island is another project that we are redeveloping and the analysis of that project was that we were better off to spend the dollars on a whole new construction because the existing facility was not suited to reconfiguring and getting the optimum configuration. So there we have had to begin from scratch, whereas here we have a good basic structure that we can redevelop 100 per cent and provide some minor additions to overcome the shortcomings.

Mr BROOKS - Was that taken into consideration at the initial planning stage of this project?

Mr COOPER - I suspect it was. The decision was pretty much made at that time, that this building was quite suitable for redevelopment whereas Flinders wasn't, and so the budgets were set correspondingly.

Mr BOOTH - There are some deficiencies that we have noted on our walk through, things like no sterilisation room. I think there was an equipment storage issue and drug storage - are they the only three areas that are outstanding at the moment?

Ms AYTON - I don't think it was the drug storage because there has been adequate provision for that. I was just highlighting that the current drug storage in the aged-care area is totally inadequate and that has been improved on.

Mr CURRAN - Yes, that has been addressed.

Mr BOOTH - What about the sterilisation room?

Mr AYTON - We need to get together and re-talk about that.

Mr BOOTH - Scott, do you see a problem in providing enough space? You only have the rooms you've got; you don't have a sterilisation room and I think the equipment storage was another issue. Is there capacity within the design, or are you constrained by the building to adequately cater for those deficiencies?

Mr CURRAN - We are constrained by the building but there are a number of opportunities underneath the building to provide an ancillary equipment store. I think it is a matter of going back and addressing some of the issues with the equipment to see where they need to be placed around the facility. There have been some comments back that some areas we have, such as the linen store, may be able to be decreased and some other storage put into there. I think now that we have this in more detail, it is a matter of sitting down and discussing where those things will be located.

Mr BOOTH - And the issue of the sterilisation room will be dealt with? There seems to be conflict at the moment in terms of the advice; one advice is that you don't need it, the other advice is that you do and it seems from a health professional point of view the advice is that you do need it.

Mr COOPER - I think there are two professional views about sterilisation. One professional view is that you go with disposable systems rather than sterilisation. But working through the local issues, I think that onsite sterilisation is a more suitable solution for King Island. The disposal option just doesn't work well for King Island. Would that be a correct summary, Rosemary, or are there other clinical aspects?

Ms AYTON - I think some of the issues that we can address probably need to be discussed more with clinical nurses. You couldn't possibly provide enough pre-packaged sterilised equipment to be available. On the day they run a podiatry clinic, for example, I don't think it would be possible to have 50 pre-packaged sets for podiatry, it is just not realistic.

Mr BROOKS - Or economically viable.

Ms AYTON - No, it's not realistic.

Mr BOOTH - I am very interested in your advice as a health professional, because this committee has to make decisions about the whole building in the sense that it will be adequate for the community. Is your opinion then that you need a sterilisation room and that you need to be able to sterilise?

Ms AYTON - We certainly need an area that will accommodate a benchtop steriliser, a crimper, a machine that seals packages. We can buy packages that don't all need a sealer, but we need a sealer. We need a storage area for all the equipment that is needed and I don't think logistically you could work in a hospital on King Island without some sort of sterilisation available.

Mr BROOKS - I am not sure whether we are getting into the nitty-gritty bit now, but I have one question on a minor detail and wanted to get the opinion and the idea of the community. If we look at the drug store layout compared to the sterile store, the entry points are in opposite directions. For example, if you are looking for a centralised location, the sterile store is from all the treatment rooms but then not available from the other side where the nurses' station and drug store are. The drug store entrance is from the nurses' station, I presume for security reasons -

Ms LAIDLER - Yes.

Mr BROOKS - because you cannot have everyone going in there and out there. Is that, in your opinion, the best layout, is that the way it should operate?

Ms LAIDLER - Mr Brooks, I would have to really look at these plans in much more detail and discuss with my colleagues.

Mr BROOKS - I see us here to make sure that the public's money is protected and spent wisely and invested in an appropriate manner. This is also about scrutinising the project and seeing if we can make some more adjustments or suggest to the architects or those involved that they make some amendments to get it right so that we do not have to knock a hole in the wall six months later.

Mr COOPER - That is really what we are still working through with the design process. The original program was trying to go out to tender by about now but we recognise that we still need to do a bit more detailed consultation with the staff and so we are still working through that. These minor details are certainly important details but they are relatively minor in the overall scheme of the project and that is what we are still working through, that is what the final 10 per cent of the design does for us; it finetunes those elements and, as you say, we do not need to knock out walls in six months' time after they have moved in.

Mr BROOKS - Whilst I am the newest member here, I do not believe that this committee has the job to say, 'No, you need to change that doorway' or things like that; I am sure the working group and the experts can work all that out. But I think we should bring it up if we see it.

Mr BOOTH - Moving on from the infrastructure part, I have some questions as to some of the cross-jurisdictional issues that you touched on walking around the building. There is potential conflict, I imagine, given that you have different funding streams, different areas from aged care. A funeral director, I think, works out of here, private doctors' practices, specialist services coming into the aged-care facility, the Tasmanian Ambulance Service, and dental practitioners. Are they through the Health department or are they private practice?

Ms LAIDLER - There is a mixture. We have private and public dental services.

Mr BOOTH - How do you deal with issues where you have a mixture of liability, occupational health and safety issues, resources that are paid for by the public and used by a private practitioner who is running a private business? It is a very eclectic mix of services here under the one roof in the one building using the same electricity supply and presumably the same staffrooms, kitchens, toilets, cleaning facilities, parking. Who is responsible for trying to make that work?

Ms LAIDLER - Certainly we have a complex mix of funding, and it is even broader than what you have just mentioned. I think that is one of the key roles of the site manager and Director of Nursing, to manage all those issues. We have a lot of fairly clear lease arrangements with our private practitioners generally - things like the chiropractor. We have to have very clear guidelines around that. One of the big issues on King Island - as an example I always use our chiropractor - is that we as a community have an advisory committee attached to the hospital and they recognised the need for a chiropractor. So we have quite a lot of give and take because we need to have a chiropractor within the community and that helps with people's long-term health and wellbeing. I am not saying that we provide him with all his facilities, he pays for his rooms and so on, but we do have really clear guidelines and arrangements around those providers that use the facilities.

Mr BOOTH - If a private doctor who has a practice there needs a practice nurse, does he just grab one in the corridor if one is wandering past or what does he do?

Ms GROGAN - Really they should be employing their own practice nurses but, as the girls alluded to before, there are those challenges when they cannot get their practice nurses and our staff are available, so I think it is important that that is discussed in the agreement with the contractor, the new agreement that is going to be retendered or whatever with Gemini or whoever gets that tender. I think locally on the ground it is all about that communication; I think it is really important that we have regular meetings with the GPs. That has not happened recently but we are going to reinstitute those meetings so that we can sit down and address the issues and talk through them and see how we can get an outcome that is agreeable for everyone. Obviously, as Sarina says, it is all about those clear guidelines to start with but I think it is also about maintaining that ongoing communication with people so that you are addressing the issues as they come up and not letting things fester and go on. It is a challenge.

Mr BOOTH - It is not really for this committee to be concerned about how you staff a building, it is about whether the building meets the needs. With everyone all under the one roof and with a whole lot of different chains of command and jurisdictions, and with the need for private insurance, with liability issues and so on, I can take it from what you are saying that you do not see that as being an impediment to the design, rather than having a separate GP clinic 20 feet away, for example, that is totally under the control and responsibility of a private practitioner? In a public hospital or a public facility normally all the people are employed by one head employer. It seems to me to be quite extraordinary, and good on you for being able to do it and I understand that you have to do different things in rural areas perhaps because of the critical mass. I wonder whether there will be ongoing conflict. Will you have a look at that in the future in terms of the liability issues?

Mr COOPER - I think it becomes a discussion point, though, that the department is enhancing the ability to get doctors onto the island. If there was an expectation that to avoid some of these liability issues a GP was to come across, build their own facility and work and provide the services from that facility, the island would not have a doctor's service. That is why the department provides the facility within the building and then leases those buildings under commercial leasing arrangements. There are service agreements in terms of the output that the doctors are expected to provide to ensure that the island has GPs available.

Mr BOOTH - Obviously you are doing it for the best reasons but if there are unforeseen consequences or difficulties in terms of spending $5 million or something, you then find you may have to separate into discrete areas - you are saying that you lease the rooms to the doctors, are you?

Mr COOPER - That is correct. This redevelopment makes that easier because now we have a specific GP area which has a separate specialist clinic room as well so a lot of the visiting specialists have a space to come into rather than trying to share a podiatrist's room or whatever else used to happen historically.

DEPUTY CHAIR - I take on board the line of questioning that Mr Booth has put but I suppose that throughout Australia there are many different models like this that operate

even in Tasmania and in regional and remote communities it is a matter of management - micromanagement - as to how those processes are sorted out. In that case it is certainly not unusual. I think really what Mr Booth is asking is whether with this new model the infrastructure will suit what is going to happen. It seems to be that the answer that you are giving to the committee is yes.

Ms LAIDLER - Yes.

Mr BROOKS - We briefly discussed the reformatting of single-bed rooms. We are spending $5 million improving this facility. We currently have 20 beds and are retaining 20. Are you looking at including the infrastructure, pre-wiring or pre-work, to increase the number if the demand were there? Are you confident that the demand will not be there in the foreseeable future - say out to 20 years?

Mr COOPER - The health modelling we did before shows that the number of beds we have is adequate. Constructing a room with the ability to have two beds was going to require significantly more structural cost. To limit our costs we worked within existing structural walls, which limited the opportunity to put in double beds.

Mr BROOKS - So it wouldn't make any difference other than to cost a lot more with no benefit if you were to pre-wire. If you needed more beds you would have to extend it anyway.

Mr COOPER - That is correct. The other aspect of the island is that, whilst it is an acute ward, severely injured people are flown off to the North West Regional, so there is that spare capacity anyway.

Mr BROOKS - I just didn't want to see you say in five years that you would need more beds, are turning people away and can't cope. It is this committee's job to make sure that is taken into account.

Mr BOOTH - Are the proposed works in this tender all State government-funded or is there a federal component for the aged-care facility? Is there a Federal government responsibility to fund some of those works?

Mr COOPER - No. It is all State government-funded. I couldn't tell you if there was a responsibility for the Commonwealth to fund any of the aged-care beds. In the same way that a private nursing home would invest its own capital funds, that is what they would do. If you can leverage some Commonwealth funds then you aim to do that as well. When we put up our capital bid to Cabinet it included redevelopment of the aged-care facility. From what I understand of Commonwealth bids, the process is a bit like roulette, so getting a submission up and funded was probably unlikely given that there would probably be an expectation that the State should fund its own.

DEPUTY CHAIR - We seem to be going outside the square in discussing responsibility for funding.

Mr COOPER - Yes. It is because King Island is a special case. You are not going to get a private provider of aged-care facilities. This is one of only two facilities in which the

State provides aged care. It is because of the specific nature of King and Flinders islands.

Mr BOOTH - It does seem to be a fantastic facility, with all of those things together. I wonder if the Government might have driven the dollar a bit further by getting a Federal contribution. I understand that is a Federal responsibility.

Mr COOPER - Yes. The Commonwealth fund provision of treatment - the operating costs. They will fund some infrastructure. A lot of private organisations still need to fund construction works themselves. They cannot rely on the Commonwealth to provide infrastructure funding.

Mr BROOKS - Regarding fire suppression and bringing the whole building up to modern fire standards, has that been included within this scope, including asbestos removal and bringing the whole building into compliance with modern needs?

Mr CURRAN - Yes. We are putting in a new fire detection system and upgrading areas where fire needs to be detected. Asbestos will be removed. It has been identified in the eaves, the gables, lagging around some pipes and in some floor tiles. It will all be removed as part of this project.

Mr BOOTH - Across the whole facility?

Mr CURRAN - Yes.

Mr BROOKS - Will this require an increase in the maintenance budget?

Mr COOPER - I don't believe so. We are not adding extra bells and whistles.

Mr BROOKS - We are increasing the air conditioning across the board. I'm not sure if you are spending more on maintaining the older systems than bringing in a new preventive maintenance regime of quarterly, six-monthly or yearly inspections and so on.

Mr CURRAN - The current system will be removed - those big stacks over the top of the old surgery area. We are looking to refine that system and make it a lot more efficient. Regarding the exterior of the building, we are going for low maintenance materials - such as brick. A lot of the finishes will be as they are currently. Areas where we are required to upgrade downpipes and so on will be done as part of this process. We have tried to keep the construction on a cottage scale so if things need to be fixed in the future they can be sourced locally without needing specialist tradesmen to do that work. That is part of the philosophy behind the construction.

Mr BROOKS - Mr Booth touched on the energy rating and efficiency of the new building. You have a very energy efficient power system on the island - wind and solar. Has that been taken into account for energy generation on site?

Mr COOPER - In the budget at the moment we cannot accommodate our own on-site generation. We want to do so, therefore the electrical system has been designed to allow future external connections. When the department, through its whole-of-agency energy

efficiency upgrades, can afford a wind turbine, we will look to install one and connect it to the system.

Mr BROOKS - A hospital requires a back-up energy supply. Is that being upgraded as part of the project?

Mr COOPER - No. We have a generator on site, which is adequate. It is probably over-designed for what you would reduce a building to in an emergency. The scale of the generator will allow us to maintain probably 70 per cent of this site.

Mr BROOKS - So it's not a 30-year-old diesel that puffs out smoke?

Mr COOPER - No. It has quite a reasonable life left in it. Should it fail in the future then we will have those other funds to upgrade that facility.

Mr BROOKS - I was just thinking that if you are spending a significant amount then it should be included in the project if it needed to be updated.

Mr COOPER - Yes, but it doesn't.

DEPUTY CHAIR - Just a quick question on water. On page 22 you talk about the water supplies - 'Town water is utilised for fire-fighting and laundry. Potable water is also town water, which goes through a water-softening system'. And then you say, 'Reserve capacity is available in existing underground tanks which have not been utilised for some time, but will be reinstated under this project'.

I would assume that the town water supply is adequate here. I just wonder why you are spending money reinstating these old reserve tanks? Is it because it is a health facility? Is it a requirement to have reserve capacity there?

Mr CURRAN - My understanding is that the water goes through s softening process and that is why we are storing the water - so that we have an adequate reserve of this softened water.

DEPUTY CHAIR - Okay, but I presume that you would be using normal reticulated water that goes into the system at the moment.

Mr CURRAN - Yes, but it comes in and then it travels right down to the bottom of the site, it gets softened, and then it comes right back up around to the top and back into the supply. What we are looking to do is to bring it in, soften it in the areas where it comes in and then have adequate storage of it on site. I don't believe it has the capacity to constantly keep producing itself - that it my understanding, but I could seek some further information for you.

Mr COOPER - I think the peak water flows are above the instantaneous ability of the water softener. Would that be correct?

Mr CURRAN - Yes, I think that is a good way to describe it.

Mr BOOTH - I think the point Greg was making was, what is wrong with the reticulated supply that is coming to the site? Is it a requirement that with every hospital you have to soften the water?

Mr COOPER - No, I think we soften the water -

Ms LAIDLER - The Currie water does need softening. It contains a lot of iron. It needs a lot of work done to it before its useable.

Mr COOPER - That is for the laundry-type functions -

Ms LAIDLER - That's for maintenance of all the equipment that water is running through.

DEPUTY CHAIR - But you have gotten away with it for some time without using those reserve tanks - that is the point I am trying to make.

Ms LAIDLER - We have had ongoing issues around that.

Ms AYTON - No water, frequently.

Mr BOOTH - No water?

Ms AYTON - Yes.

DEPUTY CHAIR - That answers my question.

Mr CURRAN - It is an issue that needs to be addressed.

Mr BOOTH - Is there any proposal to upgrade the whole reticulated supply? These softening procedures would then be unnecessary, were you getting a proper, safe, potable supply.

Ms AYTON - I cannot answer any technical questions, but as a resident I have to say that King Island water isn't nice. If you are able to have either tank water or softened water, that is the way to go. But perhaps the gentleman at the back could comment on that!

DEPUTY CHAIR -We cannot do that. People have to be sworn in before they can do that.

Ms AYTON - I am sorry.

DEPUTY CHAIR - We could invite the Mayor or his deputy to make a comment, if they would like to be sworn in - if they feel it is necessary to answer that question.

Mr CHARLES ARNOL, MAYOR, KING ISLAND, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

DEPUTY CHAIR - I welcome you a second time, Mr Mayor! If you wouldn't mind, could you answer that question about the water.

Mr ARNOL - The water contains a high calcium content because it is obtained through the sand aquifer, and it is a requirement to reduce that so that it doesn't put a coating on or otherwise affect the equipment that it is going through. Basically it is potable, as far as the medical side is concerned. It is tested every week or fortnight, but it does play up with machinery and particularly hot water systems where it calcifies. That is where the difference is.

Mr BOOTH - Is there a proposal to upgrade the island's water supply to soften it all or remove that calcium from it?

Mr ARNOL - It is highly impractical to do that. It was looked at but it was found to be totally impractical to soften it at the source because basically we would be putting softened water through for agricultural or horticultural purposes and it is a cost that we can't stem, the same as electricity costs. If you would like to bat for us we'd be happy with that too.

Laughter.

Mr BOOTH - I have a question, but perhaps not to you Charles, with regard to electricity costs. It is an issue I was going to ask with regard to the current facility - you have boiler, I presume, for heating up hot water -

Mr COOPER - Correct.

Mr BOOTH - What drives that?

Mr COOPER - That uses bottled LPG.

Mr BOOTH - Are there plumbing upgrades in the reconstruction?

Mr CURRAN - Yes, some of the systems need to be upgraded as we move through those areas.

Mr BOOTH - I imagine LPG would be pretty expensive here - it is all shipped in in bottles, I presume?

Mr COOPER - That is correct. As I understand it, there was an analysis of the different types of fuels done a few years ago which at that time showed that using LPG was a more economical solution than having an electric boiler.

Mr BOOTH - I am wondering why you haven't included solar hot water in this upgrade and then whether anything that is being done now would be a waste of money were you to upgrade to solar, or whether the design precludes putting solar in. You have a huge

heating burden here for hot water, given that you run the stuff right around to heat the rooms as well.

Mr COOPER - I think solar hot water is again one of those nice things that we would really like to achieve but we have the service requirements of the space that we are concentrating putting our dollars into. We could quite easily add a solar hot water system that could preheat the boilers, and then save money. Ultimately, we really need to wait until the tenders come in and we see certain aspects, such as the remote area allowance and how realistic those figures are, and should we end up in a fortunate situation where we are $300 000 under budget, then we might be able to put in a wind turbine and solar hot water. They are certainly high-priority items that we would like to put in but the focus needs to be on providing the solution for the people who use the space.

Mr BOOTH - So, Scott, what plumbing works are being done would not pre-empt solar heating. Do you have any electric hot water units in the building, for example, or is it all from that central LPG boiler?

Mr CURRAN - I believe it is all off that boiler.

Mr BOOTH - Do you have any centralised airconditioning ducting through this place?

Mr CURRAN - There is a centralised duct that runs through the acute area at the moment.

Mr BOOTH - Which is the one that is fed by that old stack you were talking about?

Mr CURRAN - That's right, and it is delivering air into those rooms at the moment, and that is the one we are looking to take out and replace.

Mr BOOTH - Do you have any issues with golden staph in this hospital, or legionnaires?

Ms AYTON - Not to date.

Mr COOPER - No, that's more an issue if you have a cooling tower as well, and we don't have that type of system on the island.

Mr BOOTH - And you haven't had any issues with staph in the ducts? I know that some of the places golden staph likes to live is in an airconditioning duct.

Mr COOPER - I don't think there has ever been an incident.

Mr CURRAN - I don't think the air is airconditioned, I think it is just drawn in and put straight into the room without any conditioning.

Mr BROOKS - But you are looking at the split systems?

Mr CURRAN - Yes.

Mr COOPER - You touched on the issue of maintenance earlier. Having that central airconditioning system is one of the items that we struggle to maintain because of the

skillsets required. Going to smaller split units will overcome some of the maintenance issues we have.

Mr BROOKS - Is it more cost-effective to puts splits in? Are they cheaper or more expensive to install?

Mr CURRAN - They are a lot cheaper.

Mr COOPER - It will also be more cost-effective because the heating at the moment is probably just direct electric, whereas a heat pump has 200 per cent efficiency.

Mr BROOKS - And then you do not have two people arguing over the temperature of their room.

Mr COOPER - Correct. You have individual control, so that is another benefit.

Mr HALL - Thank you all for your evidence today.

THE WITNESSES WITHDREW.