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PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

Royal Hobart Hospital Paediatric Enhancement Project

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

MEMBERS OF THE COMMITTEE

Legislative Council	House of Assembly
Mr *Harriss* (Chairman)	Mr *Best*
Mr *Hall*	Mr *Green*
	Mrs *Napier*

By Authority: Government Printer, Tasmania

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INTRODUCTION

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

MAY IT PLEASE YOUR EXCELLENCY

The Committee has investigated the following proposal: -

Royal Hobart Hospital Paediatric Enhancement Project

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

BACKGROUND

The Royal Hobart Hospital (RHH) is the principal tertiary referral hospital for Tasmania and a major teaching and research hospital linked to the University of Tasmania. The RHH provides a range of services to its local community as well as complex tertiary service in medicine, surgery, critical care, aged care, rehabilitation, mental health, obstetrics and paediatrics.

In addition to providing services to the south the RHH is also the state referral centre for Paediatric Services. The service also provides care for adolescents up to the age of 18 where other jurisdictions accommodate patients over 16 in the adult services area.

There are increased demands on paediatric services and increasing the capacity to meet these demands had been restricted by staffing resources and the physical limitations of the current accommodation. Staffing issues are progressively being resolved however; restrictions with current facilities continue to be a limiting factor.

$2.625M of CIP funding has been made available to undertake a project to develop adequate facilities to accommodate service enhancements to paediatric services. A program of works will be undertaken to provide additional space of a contemporary standard for paediatric clinic and ambulatory care and other associated services.

The objective of the project is to undertake a program of works to develop a contemporary and functional facility for the delivery of Paediatric Services.

Undertaking this project has also provided an opportunity to relocate and upgrade facilities for Audiology and provide a dedicated consulting room and office space for the Cystic Fibrosis' service. The Audiology unit delivers a number of services but importantly this expansion provides enhanced facilities for delivery of the Infant Hearing Screening program and the Cochlear Implant Outreach Program.

In addition Oral Health Services is planning to develop dental units within each of the major tertiary hospitals. These units will be comprised of two dental treatment surgeries with supporting functional areas. The purpose of these units is to provide access to dental services for clients with medically complex conditions. Inclusion of the Oral Health Services initiative within the scope of the project is highly relevant as the intended location is within an area adjacent to Paediatric Services and as such the design and construction can be undertaken as a component of the paediatrics project. Oral Health Services are contributing $200,000 to the project budget.

GENERAL SCOPE

The project will require construction works to be undertaken in two distinct areas within the RHH: On level 3 C Block (above the Liverpool Street forecourt) and on the site of the previous Department of Emergency Medicine lower ground floor H Block (Argyle Street).

Site Details

The C Block was constructed in 1938 and has been subjected to a range of alterations and additions since then. The C block is heritage listed but the listing is relative to the façade of the building so internal changes relative to this project will not require the involvement of the Heritage Council. The Paediatric clinics currently occupy approx 120m2 on the eastern or Campbell Street end of the building. This area will be available for development of a 4 bed short stay unit and existing consulting rooms for Women's and Children's Services will be upgraded.

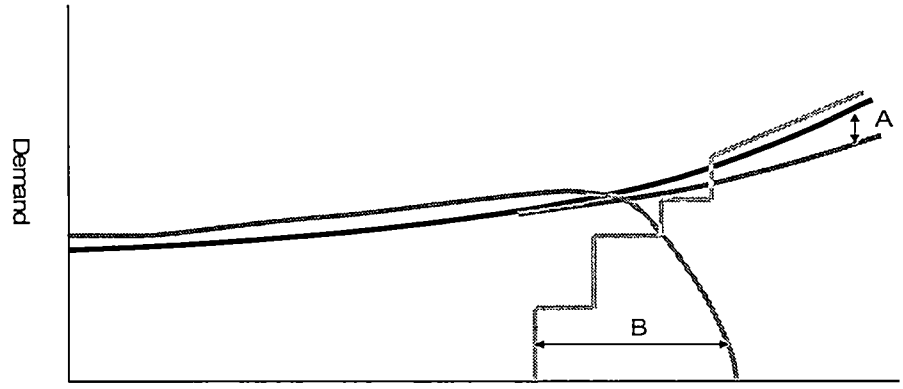
The Level 3 C Block redevelopment works will also need to include the upgrading of Level 3 building services compatible with the remainder of the building and in compliance with contemporary standards and building codes.

The H Block was constructed in 1963 and relative to its proximity to the Argyle street car park and pedestrian routes to the CBD the H block entry provides a major entrance point to the RHH. This entrance needs to be maintained and if possible within the available budget enhanced. The floor plate of the old DEM is 824m2. It is estimated that approx 650m2 of this floor area will be required for Paeds and Oral Health services.

The H Block redevelopment works will also need to include the upgrading of building services to ensure they are compatible with the remainder of the building and in compliance with contemporary standards and current building codes.

Investment in the Existing RHH

Although the Government has announced the probable construction of a new hospital, continued investment is required in the existing Royal Hobart Hospital. The following diagram (figure 1) illustrates the interrelationship between demand, the RHH, the New Royal and DHHS ability to influence these relationships through the establishment and support for primary health services.



Predicted demand for acute services
Demand for acute services adjusted for improved integration with Primary Health
Capacity of new hospital
Planned capacity of existing campus
"A" discretionary and to be determined
"B" dual campus to be minimised

Notes:
Demand for acute services is represented by the black line. DHHS has the capacity to influence this by the extent to which it invests in primary health, including satellite facilities. This change is shown by the letter "A".

The New hospital will probably be commissioned with some staging – the green line. At this point it is necessary to decommission the existing RHH as quickly as possible to minimise the cost of operating two campuses; the distance "B".

Despite this, the existing RHH must continue to meet interim demand which is growing at the rate predicted in Tasmania's Health Plan. The red line shows the planned capacity of the existing RHH in this environment.

Demand planning shows that an incremental increase in services is required until the new hospital is completed. The need to provide high quality, safe services is not diminished by the promised redevelopment.

The existing Royal must also maintain accreditation and provide an environment which provides an acceptable level of amenity to patients and retains the ability to attract and retain high quality staff.

Additionally, service change to provide more efficient services is a continual process and cannot be delayed until the new facility opens its doors. Staff moving to the new hospital must take with them contemporary work practices and familiarity with modern design and its interaction with people.

It is incumbent on DHHS to manage this investment intelligently such that there is no over-investment. This is the subject of the Royal Hobart Hospital Interim Strategic Asset Management Plan which identifies key "pressure points" in existing service

delivery and provides cost-effective solutions which include service change, off-site investment and targeted management of existing infrastructure.

Because capital investment in the existing RHH will be constrained by the limited period for return on investment, maintenance costs will rise; as it becomes less cost-effective to replace equipment, the existing equipment will need to be maintained more intensively to ensure reliability and continuity of service.
Similarly, there are core functions which must stay within the hospital, due to their interdependence with other acute services. Expansion and modernisation of these core services will be accomplished by the displacement of less acute functions such that the existing hospital can continue to provide a core of necessary functions while other functions may be successfully re-established in satellite facilities, such as Integrated Care Centres which are closer to clients, less expensive to establish and will remain viable for a longer period.

Paediatric services have been identified as a key service which is currently under pressure in respect of size and amenity, which it is necessary to maintain and support in the acute setting and which must be addressed before 2015 – the earliest scheduled date for commissioning of an alternative facility.

NEED FOR THE PROJECT

The Paediatric Clinics and Ambulatory Care Unit

The Service

Clinic Name	Number of Rooms Required	Frequency	Comments
RHH Clinics			
General Paediatric Clinics	2	20 per month	Consultant / Registrar
Paediatric Surgery Clinics	2	8 per month	Consultant / Registrar
Paediatric Intensivist Follow Up	2 -3	8 per month	Consultant / Registrar / RN
Neonatology Follow Up	2- 4	8 per month	Consultant / Registrar / RN / Allied Health
Continence Clinic	5	4 per month	Consultant / Registrar / RN / Allied Health
Diabetes Clinics	4 - 5	4 per month	Consultant / Registrar / Diabetes Educator / Allied Health
Oncology Clinics	4	4 per month	Consultant / Registrar / RN / Allied Health
Haematology Clinics	2	2 per month	Consultant / Registrar
Allergy Clinics	1	2 per month	RN

Cystic Fibrosis Clinics	5 - 6	4 per month	Consultant / Registrar / RN / Allied Health
Eating Disorders Clinics	4 - 5	1 per month	Consultant / Registrar / RN / Allied Health
Out of Home Care	3	1 per month	Consultant / Registrar / RN / Child Protection
Cardiology	1	1 per month	Consultant
Visiting Clinics from RCH			
Cardiology Clinic	2	8 per year	Consultant / Technician
Endocrinology Clinic	1	6 per year	Consultant
Neurology Clinic	1	4 per year	Consultant
Genetics Clinic	2 - 3	6 per year	Consults / Allied Health

In addition to the services above, clinics in the near future for Rheumatology and Gastroenterology will be conducted by visiting specialists from Melbourne.

One consult room is also needed full time for emergencies.

In 2005 Women's and Children's Services outpatient clinics (both Paediatric and Women's Health) undertook 31 347 instances of patient care. This number decreased to 31,011 in 2006 which coincided with a decrease in the number of available medical staff and hence clinics were reduced. In 2007 the number rose to 32 655 with an expected increase in 2008 to 33 180 (based on first half year data).

This data does not include instances of "do not attend", however, the time and space still had to be scheduled for the occurrence.

Existing Facility

Paediatric outpatient clinics and the ambulatory care unit are physically confined to 3 consulting rooms, one treatment room, and one overcrowded office for the PACU nurse, oncology nurse co-ordinator, assistant oncology nurse and the PACU registrar. There is also one multipurpose staff office and a small area where children can sit while receiving infusions or chemotherapy.

Many specialist clinics are multidisciplinary involving 2 to 3 allied health and nursing staff, in addition to consultants, registrars and medical students.

Waiting times

At present the waiting time for an appointment for paediatric clinics is approximately 10 – 14 weeks for general paediatric clinics and 4 – 7 weeks for paediatric surgery clinics.

When visiting specialists come from RCH Melbourne to provide clinics the RHH is forced to close some of these clinics as there are not enough rooms to allow for the existing clinics to operate along side the visiting clinics.

Not cancelling local clinics would make a significant impact on the waiting list and we believe that there is potential to increase the number of general clinics if additional space is available.

The aim would be to get the waiting time down to under 4 weeks.

Current medical staff numbers would allow an increase in the number of clinics and reduce the waiting lists but this will only be possible with an increase in the total number of consulting rooms. This additional space would also improve the services by allowing other staff (dieticians, physiotherapy, diabetic educator etc.) to play a greater role in the clinic service.

New Functionality

Office Space

The new design has incorporated office space for the CNC Paediatric Outpatient Services, Paediatric Ambulatory Care staff, Paediatric Oncology / Haematology Staff, Paediatric Cystic Fibrosis staff, Paediatric General Clinics Staff and Paediatric Home Care Service staff.

Consult Rooms

4 standard size consult rooms have been provided as well as 2 larger consult rooms. In the larger consult rooms there will be seating and room to accommodate parents, stroller (sometimes a double stroller if the child has a disability or there are twins) and 2 therapists. Sometimes there are also siblings attending with the parents and an extra therapist.

Assessment items range from a beam (measurement rule), small bike, balls, doll and small blocks, pegs, books etc. All these items need to be stored safely as they are not items for play or general use but for assessment. Storage is provided for handout booklets, scoring papers, clean linen used for the floor mat and the baby rugs, towels.

The therapists use a small table and chairs for the children for seating. They also have an activity mat that goes on the floor to assess the children. The children are asked to do a variety of tasks and they need to have room to allow them to be carried out and assessed.

These rooms are multi purpose and are often used by other staff that have an examination couch and other medical equipment in the room.

Procedure Rooms

1 procedure room will be used by Paediatric Ambulatory Care and 1 by Paediatric Oncology / Haematology. 2 are required as often the patients using the Oncology procedure room are neutropenic as they have been receiving chemotherapy. We need to separate neutropenic patients from patients who may be potentially infectious.
Procedure rooms are used as a place where patients have such procedures as blood taking, needling of ports, injections and receive sedation for procedures. Best practice

for paediatrics is that procedures such as those described are done in a procedure room and not at the bedside, it allows the patients to feel safe and secure in their environment and 'nasty' procedures such as blood taking etc are taken in a separate area.

It also allows for optimal handling of patients taking into account OH&S needs and allows for better lighting and access to equipment required for the procedures. It is also more conducive to an aseptic environment.

Both of these rooms are quite large however there needs to be enough space to fit a trolley for the patient to lay on, seat(s) for parent(s), space to fit a pram or a wheelchair for children with disabilities. There also needs to be desk space and a computer for the staff to use to write up notes, adequate storage of needles, syringes and space for diversional therapy equipment such as toys, books etc.

There needs to be adequate space for a doctor and sometimes 2 or 3 nursing staff to assist in the insertion of intravenous cannula or needling of ports. Often children need restraining for these procedures and there needs to be adequate space to allow for the extra staff required to assist with this.

Therapy Rooms
The 2 single day Therapy Rooms are used as a place where patients receive their treatment. They will have recliners or recliners and trolleys for patients to receive such treatment as chemotherapy or infusions. They will accommodate same day patients.

1 room will be used for oncology patients receiving chemotherapy who are most likely neutropenic and need to be separated from potentially infectious patients.

1 room will be used for patients who require infusions or who have undergone a procedure under sedation such as an EEG or Nuclear medicine scan.

Again both will have adequate space to accommodate a parent or both parents and siblings, some of which are in prams and need to have space for wheelchairs for children with disabilities.

The Paediatric Ward

The Current Service
The 25 Bed Paediatric Unit accommodates babies, children and adolescents from birth to 18 years of age. It caters for a wide variety of medical, surgical and psychological conditions. It is the tertiary referral centre for Paediatric Services in Tasmania and is the only dedicated Paediatric Unit in Southern Tasmania. The unit has a 4 Bed High Dependency Unit, a Nursery and Isolation facilities and provides a high standard of Paediatric Care. Typical patients include Oncology, Cystic Fibrosis, Diabetes, Eating Disorders, Surgical conditions, Trauma and common medical conditions such as asthma, bronchiolitis and gastroenteritis. The Paediatric Unit has a Philosophy based on family centred care.

Services offered on the unit includes 2 Play Specialists and a Teacher (during normal school terms). The unit has a bright playroom, school room and an adolescent recreation room. The unit strongly believes in a multidisciplinary team approach and members of this team include a Physiotherapist, Dietician, Occupational Therapist, Pharmacist, Speech Pathologist and Social Worker.

Historical Changes
The Launceston General Hospital has a 22 bed paediatric ward, which includes a 4 bed adolescent unit, for a considerably smaller population. The North-West Regional Hospital has 14 beds. Hobart, the State referral centre for patients presenting with complex conditions, has only 25 beds in the paediatric ward.

In 1997 when the Government of the day leased the building that housed the Queen Alexandra Maternity Hospital which is now The Hobart Private Hospital, the two Children's Wards Ward 1A (which catered for children from 6 to 18 years) and Ward 2A (which catered for children from 0 to 6 years) amalgamated to become the Paediatric Unit. Both wards had previously 20 beds each and the new unit was to become a 24 bed unit. This was later renovated to increase the capacity to 25 beds. The only other paediatric ward (private) in St Johns Hospital ceased operations some 3-4 years ago forcing the private paediatricians to admit to the Royal Hobart Hospital thereby increasing the load on the Public paediatric system.

Change in Service needs
A change in the acuity and complexity of paediatric patients has meant that services that were previously provided by transferring patients to the Royal Children's Hospital in Melbourne are now provided at the Royal Hobart Hospital.

This includes such services as:

- Tracheostomies and home ventilation
- Oncology and Haematology services
- Increase in the number of surviving neonates with complex conditions
- More complex paediatric surgery
- Child and Adolescent Mental Health services.

Obesity and other health factors have meant that there has been a dramatic increase in the number of newly diagnosed diabetics which has caused increased pressure of both inpatient and especially outpatient diabetes services and diabetes education services.

Existing Facility
With the relatively remote geographical situation of Hobart and the absence of another Hospital offering the same level of tertiary referral care in Tasmania, it is imperative that the Paediatric Service be able to cope with peak demand. The current service within the RHH is unable to do this and due to the bed shortages children are now regularly being admitted to adult wards, spending long periods in DEM awaiting admission or having surgery cancelled.

Placing children in wards with adults is not acceptable as this is often not a suitable environment for a child. Putting a child in a ward with adult patients creates issues about child safety with children potentially being with adults who may have mental

health, aggression or drug and alcohol problems. In a recent press release from the RACP the following statement was made:

"Children need to be cared for by professionals that are fully trained in paediatric services and also in a safe environment that is designed specifically with children in mind. Whenever a child is hospitalised it is a major issue for them and children's wards help a child cope with what is often quite a traumatic occasion".

New functionality
The long term solution to the problem of inadequate inpatient facilities for children is to ensure that this is corrected in the planning of the new Royal Hobart Hospital.

The proposed new facility will not be available within the next 8 to 10 years and we therefore need a solution for the interim period. We recognize that space within the current Royal Hobart Hospital campus is in very short supply but the area currently housing the paediatric clinics will become available when (if) the clinics are redeveloped in the old DEM space. We propose that some of this area be used to create a four bed short stay paediatric inpatient facility (which will be in very close proximity to the main paediatric ward) and the balance be used to provide additional space for the overcrowded women's clinics which are adjacent to the existing paediatric clinics

Paediatric Audiology Services

The Service
A paediatric Audiologist was employed to provide a state wide service in 2005. Previous to this there had been no paediatric Audiology service at RHH. The number of referrals has been steadily increasing and to date over 60 patients are referred per month. We would expect this number to continue to increase.

In 2006 the Tasmanian cochlear implant outreach services began providing assessment and rehabilitation to severely hearing impaired adults and children. Currently 30 implantees receive rehabilitation at RHH and an additional 20 patients per year are being referred for assessment. The increasing numbers of referrals will inevitably lead to a significant increase in the number of implantees needing long term rehabilitation

Universal new born hearing screening was introduced at the RHH in March 2008. It is expected that up to 200 babies per year will require some form of follow up.

Existing Facility
There are currently no paediatric Audiology testing facilities at RHH. A very limited service is provided from a converted ward on level 5. In order to cope with the lack of appropriate facilities children are being seen in the speech pathology department as well as at Australian Hearing in Battery point.

Staff currently share an office that is also used for storage of equipment.

Waiting Times
The lack of appropriate facilities means that children are waiting up to 3 months for an assessment. In order to cope with the limited facilities a regular clinic has been arranged at Australian Hearing in Battery point. However this is not a long term solution.

New Functionality
The new design incorporates sound proof testing facilities that meet international standards. This includes a sound treated paediatric testing suite, a paediatric cochlear implant treatment room as well as an infant electrophysiological testing room.

Office and reception space is also included and storage will be made available in one of the testing rooms.

Women's Health Clinics

The Service
Current clinics undertaken by Women's Health include;

- Gynae Oncology - 1 per week.
- Antenatal High Risk – 1 per week
- Obstetric Endocrinology – 1 per week
- Gynaecology Endocrinology - 1 per week
- Antenatal Early Pregnancy - 5 clinics per week conducted 0815-0900 every weekday morning.
- Antenatal Teenage Clinic - 1 per week
- Gynaecology – 4 clinics per week
- Urogynaecology – 2 per week
- Antenatal – Complex care and drug dependant clients – 1 per week
- Colposcopy – 5 per fortnight
- Midwives clinics – 3 per week
- Antenatal booking in clinic – 9 per week
- General Antenatal Clinic – 13 per week

In addition to the above clinics the interview rooms are used on a Friday morning by lactation consultants for clinics and on Monday afternoons by the Diabetic educators.

Existing Facility
There are currently 6 consult rooms and 2 interview rooms. The current rooms are small and struggle to accommodate staff, patient, support person(s) and visiting personnel such as medical or midwifery students.

Due to the lack of number of clinic rooms the Antenatal teenage clinic is currently undertaken in the physio department.

The waiting area space is inadequate to accommodate pregnant women that often bring in a support person, their other children and prams. This often necessitates long periods of standing for some and congestion within the corridors for the duration of the clinic.

Lack of appropriate space to conduct interviews requires midwives to discuss issues such as urine tests and GBS swab taking in corridors which is potentially embarrassing for all concerned. Also due to the current layout conversations held in one area can easily be heard throughout adjoining consulting rooms. Given this area is at times used by staff to consult women suffering from a serious gynaecological disease, this is hardly appropriate but represents the only available option at this time.

There are also currently 3 clinic rooms that do not have patient trolley access. In the event of an emergency this could pose a serious risk to patient safety.

Change in Service Needs
In 1999 Women's and Children's Services moved from the Queen Alexandra hospital to the RHH. Of the above clinics the Gynae Oncology, Early Pregnancy, Teenage and Urogynaecology are all in addition to what was originally offered at the Queen Alexandra site.

In October this year due to a change in models of practice an additional midwife clinic will need to be implemented as expectant mothers will have an additional visit at 26 weeks.

Also due to changing demand a Bariatric Clinic for obese women in pregnancy will soon be added to the high risk clinics. These women will require multidisciplinary care and are not eligible to share care.

Waiting times
Current waiting times for clinics do vary. Some Gynaecology clinics are out to 15 weeks, colposcopy clinics vary between 12-8 weeks and Antenatal Midwife clinics at 6-4 weeks. Doctors and Midwife High risk and Emergency patients are generally seen within 1 week in the clinics.

With the need to find space and time for clinics to meet the ever increasing demand, as evidenced by clinics starting at 08.15, the flow on effect throughout the day of any minor delay leads to increasing wait times for all the other clinics.

Within the main work area, midwifery and medical staff negotiate constantly for access to computer terminals, telephones and chairs, which further slows clinic movement and interferes with the ability of all staff to work efficiently and professionally. Without suitable work areas the noise levels are increased which reduces the ability of staff to maintain privacy and confidentiality.

New Functionality
Whilst not all the problems highlighted above are resolved by the additional space being made available to Women's Health from the move of paediatric clinics out to the old DEM, it will provide significant increases in functionality and efficiency for the service. With some minor works staff access to office equipment can be improved thus resulting in more efficient use of time. Patient flow can be greatly improved as can the waiting areas.

Cystic Fibrosis

Cystic fibrosis is the most common lethal genetically inherited condition in our population. In more than 90% of cases it is diagnosed on screening shortly after birth. The management of children with cystic fibrosis involves an intensive multidisciplinary approach from the time of diagnosis. A pre-emptive strategy is used in order to keep children well as long as possible, rather than waiting for them to get unwell and being reactive. This has resulted in the care of such children becoming more intense with the pay off that they have an ever increasing life expectancy if they receive this care. As well as there being a decrease in their need for unplanned inpatient admissions.

Currently in the south of the state RHH looks after 25 to 30 children with cystic fibrosis. Their care is vitally dependent on the involvement of paediatricians, a cystic fibrosis nurse, physiotherapy, dieticians and social workers. Children are seen at least every 3 months for a general team clinic review, but more frequently when they are very young, (less than one year old) or unwell. They often also need more frequent review buy one of the team members such as medical or physiotherapy.

A dedicated office is vital to effectively coordinate their care. This is made even more necessary by the planned move to state-wide paediatric cystic fibrosis services as outlined in the state health plan. This will almost double the number of children who have there care coordinated through this service.

Oral Health

Purpose

The Government was gave a commitment to Oral Health Services in the Better Dental Care Package 2006-2010 which allows some capital funding to develop general dental surgeries at each of the acute hospital facilities. It has been of long standing concern that there is currently no appropriate setting for the treatment of clients who are medically unwell and in need of dental care.

Oral Health Services Tasmania (OHST) is proposing to develop dental units within each of the major Hospitals Royal Hobart, Launceston General and North West Regional Hospitals. These units will be comprised of two dental surgeries. The purpose of these units is to improve access to dental services for clients with medically complex conditions. These clients will include hospital department patients and community dental service clients that require treatment in a supported acute setting. These units will also provide a facility for dental workforce development through education and training.

The broad range of functions that could be performed in the hospitals would increase the quality and safety of services currently offered to the client group and would be a major step in rebuilding an appropriate seamless pathway between the acute sector and community settings for designated oral health services.

Current research supports the concept of "medically necessary dentistry" being (a) dentistry performed to assist, support and complement the treatment of certain medical conditions and (b) dentistry performed as a result of an adverse outcome of medical conditions. This concept is one of three client treatment categories

underpinning the initiative. The others being the client group whose medical condition deem dental treatment unsafe and unsuitable to be performed in a community setting and those clients requiring a level of invasive and extensive dental treatment unsuitable for the community setting.

Potential client groups

- Organ transplant care clients
- Management of pre and post bisphosphonate therapy clients
- Oncology clients
- Clients requiring pre-treatment hyperbaric therapy
- Bone marrow transplant clients
- Clients with confirmed anaphylactoid reactions to dental drugs and materials.
- Inpatient emergencies
- Extensive local anaesthesia/sedation minor oral surgical procedures on paediatric/adult clients with no co-morbidity
- Pre, intra and post head and neck radiation clients
- Unstable cardiovascular disease clients
- Type I diabetic clients
- Post-stroke management
- Anti-coagulated clients
- Pre, intra and post chemotherapy clients

CONSULTATION AND GOVERNANCE

Preliminary Consultation

The original project brief was prepared in 2005 when Women and Children's Services put forward and initiative to expand Women's Health Clinics and Paediatric Services. Funding for the initiative was provided in 2006/07. In the interim period the project brief has been refined by the key stakeholders and options for the location of expanded services investigated by the RHH. The current project concept was agreed and approved in August 2007 and the project has been actively progressed from this point.

Project Control Group

Detailed stakeholder consultation commenced immediately following appointment of the Project Architect Crawford Padas Shurman (Architects Designhaus).

The Project Control Group and Project team have been meeting on a regular basis to enable the project to evolve in line with the project timeline, the aim being to enable an adequate consultation phase while still allowing sufficient periods for documentation and procurement of the project. The Project Control Group oversees the progress of the project. The Project Manager and Project Team report to the PCG to enable the PCG to track progress, provide guidance and issue formal approvals at key milestone points of the project.

This approach was identified during the initial consultation phase to maintain the project momentum to effect tendering of the project in the third quarter 2008. The tender date is based on working back from the desired completion date of mid 2009.

Consultation with Onsite Stakeholders
Consultation has occurred with all key services groups, other internal stakeholders and other associated services. Additionally privately donated funds have been made available to apply to the project (as agreed between RHH and the Donors) and the donor groups have been kept informed of progress.

Design Approval
The Project Control Group (PCG) at its meeting of the 19th May endorsed the project schematic design and cost estimate report. At this meeting all desired project outcomes where tabled, discussed and then reviewed for compliance with the endorsed project brief. Participants tested for adequacy in planning, design and budget and maximising value by improving the relationship between various services and related functions. While the review was undertaken on a value management basis and the outputs assigned a relative priority the cost plan indicates that all outputs within the project brief will be able to be delivered. It was also established that additional minor upgrades to the Women and Children's consulting rooms on level 3 C Block can also be undertaken within the available funding.

This consultative approach has resulted in a design that allows all of the desired outcomes to be resolved and provides sufficient flexibility for future expansion.

ADDRESSING THE NEED

Design Philosophy
The proposed redevelopment can be described in two portions:

Portion A - Paediatric Clinic ground level (Argyle Street) H Block.

This area was formerly the Department of Emergency Medicine. As the existing room layout is quite unsuitable for the new Paediatric Clinic, internal walls have been largely demolished leaving only the structural columns - this has allowed the flexibility to design an efficient, new floor plan.

In order to keep costs down, the locations of new plumbing fittings have been generally kept as close as possible to existing fittings.

Entry into this department has been maintained at both existing locations (i.e. directly from Argyle Street and from the existing lift location between C Block and H Block.

Design decisions have been founded on:

Incorporating current best practice from knowledge of contemporary health planning issues and hospital operation procedures, established through extensive consultation with PCG members and other RHH staff from each department.

Retaining the existing building services as much as possible in order to provide cost effectiveness.

Provide best value for money by balancing functionality and design through cost effective construction/materials generally, with higher design impact in certain areas only.

Works to this area consist of the creation of a new four bed short stay ward for Paediatrics, and a range of minor items (such as widening of existing narrow doors, new joinery etc) throughout part of the WACS facility.

Design decisions have been founded on providing good value for money solutions to improve patient and staff amenity, and at the same time addressing various compliance issues. Careful consideration of construction staging will form part of the Contract Documentation, to minimise disruption to the ongoing use of this facility.

Planning

As the Paediatric clinic houses a number of different services, these are treated as a series of well defined clusters, planned around a passage that forms a 'loop' through the facility. This provides easily followed and efficient circulation from Reception/Waiting areas to any required destination.

While there are two entrances into the Clinic, the main entry is via Argyle Street. Reception is easily identifiable and set amongst a series of smaller waiting areas, which will have a 'kinder' scale than one larger area. The Audiology and Oral Health services are located close to Reception and having their own Waiting areas, patients can be directed there without the chance of confusion.

In the centre of this clinic is a children's Play Area, with the waiting areas adjacent offering good supervision of this space. Patients waiting to go to the Consulting Rooms, Cystic Fibrosis, Oncology or PACU, will be met by staff at this location and chaperoned to their destination.

As patients in the Oncology and PACU Therapy rooms may have lengthier stays, a Kitchenette and WC are conveniently located nearby. The Oncology and PACU Services require efficient access to the lifts and so are located at the end of the 'loop', with a secure door into the lift lobby.

In the interests of cost efficiency, an existing Staff Room currently used by Centrepath will also be available to Paediatrics staff. Toilets are retained at existing locations (refurbished) and Utilities Rooms located at existing plumbing locations.

Architecture & Interiors

Due to the limited life span of the current campus, the design team's approach has been to conceive a redevelopment that provides good value for money, is extremely functional, and provides a certain level of delight. The idea of delight is, the team submitted, necessary to 'de-institutionalise' the clinic.

By engaging the minds of young patients, the team hopes to bring some relief and joy to both them and their carers: this would be achieved with cost effective applications; paint, vinyl film etc and with simple interactive installations. Bright colours and playful themes would be incorporated into the wall, floor and ceiling finishes.

Materials are being selected that comply with Infection Control's requirements, and are required to be durable and attractive. Importantly, materials must also satisfy principles of Environmentally Sustainable Design and will be selected to achieve the lowest possible emissions and toxicity ratings.

Furniture will be selected on the basis of durability, appropriateness, comfort and finally aesthetics.

The layout of each and every space has been designed following close consultation (and sign-off) by the pertinent stakeholders for that Service, with a view to maximising staff and patient amenity.

Building Services

Generally
As a general comment, it should be noted that H Block is generally poorly serviced, which much of the engineering services infrastructure dating back to the original building construction in 1960. The previous DEM area was redeveloped, largely using existing infrastructure in late 1980's. Hence, the engineering services are generally aged, and much of it is past its service life expectancy. Access to inspect the condition of services is difficult, and accurate documentation is limited. As a result, there are a number of unknowns and risk areas to be dealt with as part of this redevelopment process. RHH has confirmed that the main heating and cooling plants serving the area is in good operational condition with a number of years life remaining.

Mechanical
Block H:
Generally existing air conditioning, mechanical ventilation, exhaust and medical gas systems shall remain and be modified to suit revised floor layouts.

Provision of new exhaust systems to PACU WC, Dirty Utility and Disabled Access WC.

Extension of medical gas systems to new stations in the Oral Health surgeries.

Block C:
Existing air conditioning, mechanical ventilation and exhaust systems shall remain and be modified to suit revised floor layouts.

New wall mounted split air conditioning systems to COLP Proceed 1 & 2 and NS Station.

Provision of new exhaust system to Dirty Utility.

Electrical
Block H:
The existing power, lighting and communications installations are unsuitable for re-use and become redundant.

New power, lighting, communications, and security systems will be designed to suit final floor layouts and functional requirements.

Liaison with the RHH/DHHS IT personnel and other relevant specialists.

The lighting layout will meet with the energy efficiency requirements of the BCA and compliance with the Australian Standards with T5 lamp technology, electronic control gear and lighting control. Consideration will be given to reducing the artificially lit environment where there is adequate daylight contribution.

Feature lighting is proposed for key areas.

The security installation shall meet with the requirements of the Room Data Sheets and interface with existing infrastructure.

The new electrical distribution will be cabled back to the existing Distribution board. The existing Distribution board will require further evaluation and possible rationalisation.

Block C:
The existing installations will be re-used where practical.
New power, data communications, security and lighting will be interfaced with the existing installation.

Communications
Block H:
The existing Nurse Call installation will be removed – new services will be upgraded to current technology and interface with the existing installations on this site as far as practicable.

Block C:
Additional Nurse Call points will be provided – further assessment of existing system required.

Hydraulics
A design check of the existing floor slab for trench cutting will be required to determine if existing footings, beams or slab thickenings may affect new drainage to fixtures or that existing drains are of sufficient depth to connect into.

A design check of the existing floor slab for trench cutting will be required to determine if existing footings, beams or slab thickenings may affect new drainage to fixtures or that existing drains are of sufficient depth to connect into.

Existing copper hot and cold water and flusher service pipework within the ceiling space will be extended and modified as required to suit the proposed fixture layout.

The retention or total replacement of all existing galvanised cold water and waste/vent pipework, which are well beyond their service life, will need to be considered as part of this project.

Existing sewer, stormwater and water services pipework within vertical service shafts are to be retained unless architectural design requires their relocation.

Fire

Block H:

The fire detection will be designed to suit the final floor layouts and in accordance with the requirements of the current Australian Standards and the Tasmanian Fire Service. The new fire detection layout will interface with the current installation for this building.

Block C:

The existing fire detection will be altered to suit the revisions to the existing design layout with relocations of existing detectors and additions as required.

PROJECT COSTS

The approved CIP funding for the redevelopment is $2,825,000, $2,625,000 from RHH Capital and $200,000 from Oral Health Services. The cost of the redevelopment is currently advised at:

Description	Sum
Construction Preliminaries	$229 000
Building Works	$691 500
Mechanical/electrical works	$655 500
Fitments	$277 500
Site Works (Argyle Street & entry)	$100 000
Subtotal of Construction Works	$1 953 500
Art in Public Buildings	$52 500
Professional Fees & other fees	$220 000
Loose Furniture and Equipment	$300 000
Construction & Design Development Contingencies	$120 000
Construction Contingencies	$179 000
Site	
TOTAL	**$2 825 000**

The current project costs are provided by the project Quantity Surveyor and based on reasonable allowances for the complexity of the job, current market conditions and the ability of the contractor to engage subcontractors in a busy market. In addition to the advised CIP funds the $100 000 anonymous donation specifically gifted for improvements to audiology will be utilised to purchase the specialised audiology booths.

EVIDENCE

The Committee commenced its inquiry on Thursday, 31 July last. Accompanied by Officers of the Department Health and Human Services and the consultants, the

Committee was conducted on a site inspection of the relevant areas of the Royal Hobart Hospital.

Following the site inspection the Committee reconvened in Committee Room 2, Parliament House. The following witnesses were called, made the Statutory Declaration and examined by the Committee in public:-

- Peter Alexander Director, Facilities Management
- Assoc. Prof. John Daubenton, Director Paediatrics (also acting Medical Co-director Women and Children's Services)
- Julie Viecieli, Nursing Co-Director Women and Children's Services
- Michele Trobbiani, Nurse Unit Manager, Women's Health O/patients
- John Padas, Project Architect, Architects designhaus (Crawford Padas Shurman)
- Bill Cochrane, Manager Major Projects, Facilities Management
- Larraine Millar, Director Clinical Support Services

Background

Dr Daubenton provided the following submission in support of the project:-

> *The purpose of my presentation is to make the case for why we need this project. The Royal Australasian College of Physicians, the Paediatric Division, brought out a document, a statement of principles for paediatric services in Australia ... I have highlighted just a few of the points that they make in it. First, that high-quality services need to be available and accessible and appropriate to the needs of Australian children, and this is fundamental to ensuring their optimal physical, psychological, emotional and social development. Australians value highly the health of children and families and health policy resource allocation and funding methodologies should be consistent with that priority. It is recognised that children's health and wellbeing provide the platform for life-long health, and I think this is important because if you get it right as children, you probably have less expenditure on adults.*
>
> *Accommodation and facilities must be separate from those provided for health care of adults and facilities and equipment must be designed, provided and maintained to ensure children's safety, emotional wellbeing, sense of belonging and optimal development. I think these are very important principles. There is an expectation that these will, in the near future, become part of the accreditation process for hospitals and, rather than just principles, become a requirement for places to be accredited.*
>
> *The paediatric enhancement project deserves just a little bit of history so we understand where it has come from. During the 1980s there were two paediatric wards in the Royal Hobart Hospital, 20 beds in each ward, which gave a total of 40 beds. The outpatients was a combined area with adults with, I think, one or two rooms available and some of the specialist*

clinics were actually run from the ward area rather than from an outpatient area.

In 1997 the Queen Alexandra Maternity Hospital was given over to become the Hobart Private Hospital and at that stage paediatrics was reduced to one 25-bed ward and the small clinic with three consulting rooms and a treatment area, that you saw this morning.

In addition, there was the closure of the St Johns Private Hospital paediatric ward which means that the ward at the Royal is the only facility for inpatient care of children in southern Tasmania, and I think that is very important. The end result is that there are 25 beds in southern Tasmania compared with 30 in the northern part of Tasmania. One has to remember that the Royal Hobart Hospital is the statewide referral centre for a number of services of which my own special service, the paediatric oncology, is one of them. I think the number of beds in the north of the State is appropriate and I think there is a shortage in the south of the State, and that is evidenced by the overcrowding that we have.

As we got into the twenty-first century, there was a growing recognition of the inadequate service facilities for children at the Royal Hobart Hospital. That has already resulted in some significant improvements. We have had an improvement in staffing. I am one of those people. It took a number of years to fill the position that I am currently in but I came here just over three years ago. We have also had the neonatal and paediatric intensive care unit which has made a very big difference to critically ill children and newborns.

It is also important to note that there have been changes in practice. The first thing is that there has been improved survival of patients, so there are more children requiring health care who have survived serious illness. There are now far fewer transfers interstate to hospitals in Melbourne or Sydney. A good example of that I can quote from my own experience is that before I came here as the sole paediatric oncologist, most of the children requiring treatment for cancers were sent to Melbourne for at least part, if not all, of their treatment. Since I have been in the State and been able to provide a service with the skills that I brought, we have had 53 new children with cancer and of those, only 17 have required any time in Melbourne. The rest have been treated completely within Tasmania, with the assistance of not just my work but that of doctors both in Launceston and Burnie who co-manage patients with me so that they can get appropriate treatment close to home. That has made a big difference to the costs of sending patients interstate but it has placed far greater demands on the services within the Royal Hobart Hospital.

There has clearly been a move towards outpatient care, and that is appropriate, so the outpatient area has become more and more important and obviously has become too confined. I have mentioned the paediatric oncology service. We have had an increase in the load of juvenile diabetes. Tasmania currently has the highest percentage increase of

juvenile diabetes in the whole of Australia and the reasons for that are being researched but are not entirely clear yet.

We have had a new service where children now with serious illness are being provided with the opportunity to have ventilatory support at home. Five years ago this did not exist. Simon Parsons, one of our intensive care specialists, introduced this and although it is a small number, obviously having them out of the hospital makes a big difference. This service requires a home and we hope to have that in the new outpatient area.

We have also opened an eating disorders clinic. Unfortunately this is a growing area with the psychological problems that many teenagers get.

The funding for the paediatric enhancement project was applied for in early 2006 through the normal processes and a decision was made to approve just over $2.6 million of capital improvement funds to make an improvement to the paediatric facilities. The reason that has not been spent yet is that there was a delay in finding an appropriate space in the crowded confines of the current Royal Hobart Hospital but eventually with the completion of the new emergency medicine department it became evident that that area was available for some further redevelopment. We then went through a process of identifying within the hospital the highest priority and the paediatric area was identified as the highest priority by the hospital administration.

The paediatric enhancement project also comes with recurrent funding for staffing and this is a list of the various staff people that we will be getting on board in addition to those that we already have. This will allow for a proper functioning of what will be a larger area, requiring some more staff to run it.

The whole project encompasses these five areas: the outpatient facility, the inpatient area, an audiology area, women's clinics and the dental facility. I am going to touch on each independently.

The outpatient facility has a large number of things that it is responsible for. Firstly, there are the general outpatients, patients that are referred by general practitioners or others. There is the ambulatory care unit which is designed to provide procedures, infusions and care for children who do not require admission to hospital but require this to be done in hospital. As you saw, that current area is not adequate for that.

The paediatric oncology and haemotology service includes the cancer service, a significant service for children with haemophilia and some other blood disorders. That area is currently shared with ambulatory care and in the new plan it will be much better to have that as a dedicated area. An amount of $100 000 has been donated by Camp Quality towards that improvement.

Regarding diabetic clinics, we have mentioned the increase in diabetics. We have specialised clinics for patients with cystic fibrosis, eating disorders, and there is a continence clinic. There are a lot of children with bed-wetting problems who need help.

Regarding the newborn follow-up clinic, we have seen the nice new facility. The graduates from that facility, the newborns from that facility, often are complex patients who need follow up and they need to be seen in a clinic area.

We have visiting specialist clinics currently in cardiology, neurology - genetics I have highlighted there because they used to come to that area. We have not been able to accommodate them this year and we are hoping to re-establish them in the paediatric area when we have more space. Endocrinology clinics come as well.

I have mentioned the home care service, children getting high-level care in the home. This is very appropriate but the people running that service need a home and we hope to have an office for them as part of the new clinic. The surgical clinics is another significant area, and those will be increasing because we will be getting a second paediatric surgeon. The service cannot cope with only one surgeon.

Regarding the future needs, I have mentioned the paediatric surgeon. Child and adolescent mental health services are an incredibly difficult area at the moment. Effectively there are no acute child and adolescent mental health services because there are no child and adolescent psychiatrists on the staff at the Royal. That is busy being addressed and we hope to have one in the near future with money from the paediatric enhancement project. But they will require an area to deliver their outpatient services.

We need an increase in certain areas in the visiting specialists, including areas such as rheumatology and gastroentestinal diseases, all of these being highly specialised fields where we get specialists over two or three times a year to see difficult patients and to give us advice on their management. It is far more cost effective to bring one specialist down here than sending dozens of patients over to Melbourne, but we need space for that.

I have mentioned the genetics. We would be able to increase the number of general clinics with our existing staff, and we spoke about the waiting lists.

Regarding the present situation, you have seen that there are three consulting rooms, two offices - one actually houses four staff members in it - there is a 12-week waiting period for the general clinics at the moment and there is a seven-to-eight-week waiting period for the surgical clinics.

Each room has two sessions a day, morning and afternoon, and if you multiply that by, say, four weeks, you get 120 sessions available in the clinic area that we currently have. The table on page 8 details all the clinics that we should be running and if you work it out on the basis of those personnel and clinics, we currently would need 190 sessions to accommodate all of that properly, so we are obviously not able to do that at the moment. So 190 sessions would need an increase of at least two consulting room over the current three. We also need a consulting room available for when we have emergencies coming in. There is nothing worse than getting a new patient with a serious problem and having sub-optimal circumstances under which they have their first interview or consultation. So we need one consulting room for that, and that is why we have asked for six new consulting rooms in this facility and that will meet our current and probably our expected needs. Of those 120 sessions, four of them in every four weeks are used up by the visiting interstate specialists, and I have mentioned the problem with the urgent cases.

You have seen our waiting area. On a typical busy clinic day you can see some of the parents standing in the corridor because there is not space for them to sit down. This is the treatment area. The little girl on the left has leukaemia, the little boy in the car has a kidney tumour and the little boy in the pram also has leukaemia.

So the proposal is to have six consulting rooms, one that will be available most of the time for urgent consultations. There will be a separate area for the ambulatory care service - and, as I mentioned in our walk-around, that will allow us to deal with some of the patients, who currently get admitted for certain day services, in the outpatient area and take some of the pressure of the overcrowded ward.

We will have a separate area for the oncology haematology service with three rooms which will include an office, a treatment area and a therapy area where they can receive their chemotherapy and infusions.

We will have appropriate office space for the clinic nursing staff, the ambulatory care staff, the oncology staff, the cystic fibrosis clinic staff and the home care service, plus the support services such as the reception, waiting areas, toilets and things like that.

With this we will have a child-friendly environment on the lower ground floor with easy access off the street, particularly for people being dropped off with prams or children in wheelchairs. We will be able to offer a much improved service in a far better work environment, and I think we must not underestimate the effect of the work environment. The current work environment is challenging for staff and in a situation where the recruitment and retention of staff is difficult in Tasmania, we need to have facilities that do not make people want to leave. We need to make them want to work there. As I said earlier, we hope with these improvements to be able to, within the existing staff complement, bring down the waiting times to less than four weeks. This will be done by a combination of not

cancelling clinics when we have visiting specialists and by increasing the number of general clinics within our existing staff, which is entirely possible.

The next area is the paediatric inpatient space. As we have said, this is a 25-bed ward now. It is the only admitting facility in southern Tasmania. The only alternative for the more complex patients is transfer interstate and if you have a sick patient with complex problems that you are sending interstate, that requires air ambulance evacuation. That is very expensive so anything that we can do to lessen that cost will be put to better use for patient care in Tasmania.

Children not infrequently have to be housed in adult wards and we all know the sort of pressure the adult wards are under so even the adult wards will benefit if we have more space because we will not be occupying any of their space, or certainly less of it. We will be able to get by with cancelling much less of the surgical cases if we have appropriate bed spaces to house them afterwards. The project aims to create an additional four inpatient beds, as I showed you in the area where the clinic currently is down the end close to the paediatric ward and this will help the situation tremendously.

The next area is audiology. I am not an expert in this but this was given to me by the chief audiologist. The paediatric audiology gets over 60 referrals a month from various sources. They also run the Tasmanian cochlea implant outreach services. There are 30 patients who have had implants and about 20 a year are being referred for assessment. They have also started something which is a really good innovation, which is a universal newborn screening. This allows you to pick up early babies who are deaf to take appropriate steps to improve their hearing so that you do not end up with a two-year-old that cannot talk because he cannot hear what is being said to him. This screening service will result in around about 200 babies who do not pass the screen requiring a more formal audiological assessment and this will be done in the new facility that we hope to create. At present the audiology services are a mixture of things all over the place - a converted ward on level 5, a little space in the speech pathology department, Australian Hearing in Battery Point and a consulting room in the ear, nose and throat department. Sometimes the children have to have multiple appointments to get the different services. We hope to be able to have that all in one; good service in the same area as the paediatric area where you have properly sound-tested testing suites, the cochlea implant treatment room, the infant testing room and the office and reception. There has been an anonymous donation of $100 000 towards the purchase of the audiology booth which will go in there, so that is in addition to the funding already available that the health service has agreed to.

I am not an expert on women's clinics, I do not work in that area, but we do know that as with paediatrics, the space that they have been allocated has been very inadequate since the move of the women's services from the

Queen Alexandra hospital to the present site. Women's clinics will benefit by taking up some of the space that is vacated by the paediatric clinic and by a refurbishment and rearranging of some of their services on that floor. We believe that this can be done within the existing budget so that women's services will also benefit from the paediatric enhancement project.

The reason the dental facility is being placed there is that this was the only remaining area in the hospital that was open for redevelopment and they needed to have a proper dental facility in particular for difficult complex patients, such as people with heart disease, people with cancer requiring dental services where this is difficult to deliver in a distant clinic where you may need the support of the hospital and the specialists in the hospital in order to make decisions about whether their dental care can take place at this time and if they need any help. If they have problems while they are having their dental care then the hospital facilities are available. I believe this is a much-needed facility but it is being funded independently by the oral health service. But it will be co-located in that area.

Design

The consultant architect, Mr Padas, provided the Committee with the following explanation of how the design meets the service needs:-

You will see from the floor plans that it is a very functional layout. We have attempted to provide a solution which is a very good value-for-money solution in that it is highly functional and no excess money is spent on superfluous design elements.

We intend to use materials that are very cost-effective, durable, functional and satisfactory to the infection control department. We intend to spend a bit of money on providing a bit of delight to the children's play area, which is something that will perhaps distract and engage them while they are there and relieve them from any undue stress that they may be feeling at that time.

The existing structure, which is basically a grid of columns, is going to remain as is so that once again we do not use any money that we do not need to be spending. We have had to demolish some existing walls because the current layout that you would have seen - those of you who have been down there - did not suit the needs of this facility. So basically the partitions are all new but the columns are existing and are remaining intact.

We have retained the existing location off Argyle Street and put a bit of money into providing an airlock for climate control at the entry. As you can see, it is again a pretty simple layout but we believe quite functional.

One of the areas where some costs might have been used up was in carving up the existing slab to provide plumbing fittings. We started by

trying to locate new plumbing fittings as close as possible to existing ones, once again to avoid spending unnecessary money.

You will also see a floor plan for level 3 C block, which is the short-stay ward in women's services. This has recently been the subject of some review and we are just getting sign-off on that at the moment. The ground floor at Argyle Street, which is H block, has been laid out in detail and signed off on by the various stakeholders from the hospital. C block on level 3 is not as detailed but we believe that we will have that signed off on quite soon.

We would hope that construction of the program we are working on, depending of course on the outcome of today's committee, will be completed by May 2009, which would mean awarding contracts to the successful tenderer in about October 2008. That would give us approximately eight months, one month of which will be used by the Christmas period, so seven months to complete the two pockets of work.

Planning

The Committee questioned the witnesses as to whether staff had been included in the consultative process. Ms Viecielli responded:-

In terms of the planning, Michele and I have worked closely with all the staff - Michele particularly with the staff who work in the area - and in another tier of that, the medical staff specialists who work in that area as well. So it has been quite broad and quite inclusive, to the point where some of the nurses who have partners who are architects have done lots and lots of re-sketches as we sift through the many ideas to see what is functional and what will work. So the involvement has been quite good.

... One of the things we have looked at is functionality, separating functions, because at the moment they all cross each other, so putting together the functionality, separating out the staff areas from the patient areas, maintaining privacy. We had a number of principles that we needed to embrace in whatever work we wanted to do.

...It was two of the medical staff specialists who have come up with some of the really innovative ideas for that area, and then the nurses have drilled down the more operational, functional side of it.

Ms Trobbiani added:-

It has been very inclusive and they have been given many opportunities to have their say. Lots of consideration to workplaces that are not very conducive to positive outlook have been addressed and we believe that this project will enhance our environment very much.

3C redevelopment

The Committee questioned the witnesses regarding the redevelopment of level 3 of C Block and whether other levels of such block were in need of upgrading at a leter stage. Mr Alexander responded:-

> *That is initially a 1938 building. There has been a large investigation into the whole of the existing Royal as a base case for the business case to replace the Royal Hobart Hospital. To answer the question why wouldn't you just refurbish this one, any building complies with the standards of the time it was built and even under the Building Act 2000, provided you maintain those standards you do not have to reach contemporary standards, as you would know. So it is a pretty broad interpretation of what a contemporary standard is. We take the absolute view that irrespective of what the paper regulations and standards are, our patients' safety and our staff's safety is absolutely paramount. The reason I say that is that even things like floor slab thicknesses in that building do not meet current fire retardation standards so whatever you do, we are not going to meet absolute current prescriptive standards. The approach that we have to take is to do an alternative, what is called a performance-based approach, and there is a major consultancy under way at the moment. We expect to spend something like $750 000 - we do not have the figures yet but that is the sort of order of cost - on upgrading fire services through the existing Royal within the next 12 months and we will manage that out of recurrent funds. The performance-based approach is simply illustrated by the following. If you expect to have a two-hour fire rating in a floor slab and you cannot achieve it, if you can prove that you can get people out in an hour - to the satisfaction of the appropriate authorities, the Tasmania Fire Service and the clinical accreditation issues - then they are the issues we are dealing with. The whole points to the fact that the building is coming to the end of its useful life.*

Mr Cochrane added:-

> *We will be striving to ensure that in the areas we refurbish the environmental conditions, heating, cooling and light levels will meet contemporary standards. We will have the required number of air changes and be able to maintain a design temperature of 20 to 21 degrees, irrespective of ambient conditions outside. We have some work to do on H block on the mechanical services, but our main heating and cooling plant is in very good condition. It services that area, so we will be changing duct runs and plenum chambers and fan coils, but our primary services are all in good condition.*

H Block Entrance

The Committee questioned the witnesses as to whether funding would be provided to improve the H Block entrance in Argyle Street. The witnesses responded as follows:-

Mr COCHRANE *- It is funded within the current cost plan.*

Mr PADAS *- We have done minimal work to the front entrance. We realise it is not the most beautiful canopy in Hobart. We think we can give it some surface treatment to bring it up to our time. We think the air lock is necessary and there is a chance to use the glass to the air lock to do something colourful and playful. We have identified it as a paediatrics facility. Because we want to provide a good value for money solution we would not spend an extraordinary amount on it. It would be quite a simple solution.*

Mr COCHRANE *- Outside the current paediatric project we have some work to do to satisfy Hobart City Council from the DEM project where we made temporary parking on Argyle Street. We have to tidy that up to a contemporary standard. This will probably give us the opportunity to spend some money of the other Argyle Street entry, the main entry, not the dedicated entry to paediatrics. We will enhance that whole area and make it more attractive.*

Mr ALEXANDER *- Over the last few years we have had buoyant economic times. While that is good for everyone, it has made our pricing unpredictable. It depends on when you go into the market and on other jobs coming up. We have found in the last 18 months that prices in metropolitan areas have probably levelled off and standardised a bit, but we always have to have some contingencies. Occasionally there are elements that fall under the nice-to-have category, depending on the tender prices we receive. We fully intend to do that. The internal environment is really affected by being able to put in that airlock.*

Staffing/Demand

The Committee questioned the witnesses regarding the adequacy of staffing for the facility in the event the project receives approval. Dr Daubenton responded:-

Staffing involves a number of different areas. At the medical level the new funding has allowed for a new paediatric surgeon, which is about to be advertised, and a new gynaecology oncologist, which is an extra but is very necessary. That is going to be advertised in the next few months. It also allows for a child and adolescent psychiatrist, also to be soon advertised. It further allows for support nursing staff. Those positions need to be progressed and they are being worked on.

... We may not have all the staff required at the time of opening but we will certainly be able to start the service. Our existing staff feel very constrained in the current space, so just by having that extra space we will offer a better service with the existing staff complement without any improvements.

In reference to the graph entitled 'Predicted Demand for Acute Services' the Committee questioned the witnesses as to what management tools were available to

lower demand at the Royal Hobart Hospital as a consequence of the provision of satellite services. Mr Alexander responded:-

> *The three key facilities in planning to support the Royal are the integrated care centre planned for Clarence - that is combined with a federally funded GP super clinic; a tier 3, which is almost an integrated care centre, in Glenorchy; and another in Kingston. Overall the Tasmanian Health Plan is trying to limit the number of people who end up in beds, because that is the most expensive end of the program. The earlier we can intervene in people's potential ill health and reduced the effects, the lower the cost and the better the throughput. The facility in itself is adding to that. Dr Daubenton was saying that being able to treat people in a better out-patient environment saves their going into a bed with the required 24-hour care and so on. The generically named satellite facilities in Glenorchy, Clarence and Kingston are being developed from a clinical perspective to try to treat people closer to home, in a lower-cost environment that is more accessible for them and where they get an appropriate level of care which need not be as acute as at the hospital.*
>
> *Because we are working very hard to manage the capital investment in the existing site, in anticipation of moving to a new site, we hope to have by November a comprehensive plan of where we need to invest in the Royal and which are the key growth areas in the Royal. Just as moving out of the area next to the women's area allows a bit a expansion, some things will be drawn into those satellite facilities.*
>
> *The other side of that is the economy of scale argument. It becomes uneconomic to ask doctors to spend their time driving to satellite facilities, or there is not a sufficient number of clients to provide the same service at multiple locations. A lot of people are working at how we optimise that, because the overall cost of the health system is increasing far faster than anything except iron ore at the moment. Being able to manage and staff that sustainably is exercising everybody's planning at the moment. We are trying to substitute demand on acute services by getting people into more convenient and faster day surgery areas and intervening earlier so that they are not so ill when we first interact with them.*

Dr Daubenton added:-

> *I have had preliminary discussions with Catherine Katz about the creation of a DHHS-employed community paediatrician. One of their roles would be providing such a consultative service at specialist level at something like the Glenorchy super clinic. They would also have a role in the provision of medical services for the child protection service. There is scope to take some of the load away from this facility with those sorts of developments, but that is very much in its infancy.*

DOCUMENTS TAKEN INTO EVIDENCE

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

- Paediatric Enhancement Project RHH – Submission to the Parliamentary Standing Committee on Public Works.

CONCLUSION AND RECOMMENDATION

The need for the proposed works was clearly established. The current facilities are inadequate, inefficient and struggle to cope with the demand pressures placed on a highly critical area of service provision for the Tasmanian Community. The proposed development is a crucial element in the States Provision of Health Care.

Accordingly, the Committee recommends the project, in accordance with the documentation submitted, at an estimated total cost of $2,825,000.

Parliament House
Hobart
9 September 2008

Hon. A. P. Harriss M.L.C.
Chairman