THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET ON THURSDAY, 28 OCTOBER 2010 AT THE FEDERATION ROOM, DEVONPORT ENTERTAINMENT CENTRE, DEVONPORT.

MERSEY COMMUNITY HOSPITAL, LATROBE, DEPARTMENT OF EMERGENCY MEDICINE REDEVELOPMENT

Ms SHARON MASON, GENERAL MANAGER, MERSEY COMMUNITY HOSPITAL; **Mr GAVIN AUSTIN**, FINANCE DIRECTOR, NORTH WEST HEALTH SERVICES; **Ms VICTORIA BROWN**, ACTING NURSE UNIT MANAGER, MERSEY COMMUNITY HOSPITAL; **MR GREG COOPER**, MANAGER MAJOR PROJECTS, ASSET MANAGEMENT SERVICES; **Ms JULIE DUFF** AND **Mr PETER HOLLOWAY**, CONSULTANT, LHDM ARCHITECTS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Thank you all very much.

Mr AUSTIN - This is the redevelopment of the existing Mersey Community Hospital's Department of Emergency Medicine. A total of $7.504 million is available for the project. It is fully funded by the Tasmanian Government, and the services will be expanded with the development of a fast-track unit and a short-stay unit. The total program will incorporate not only this piece of work but the redevelopment of HDU theatres and the day-clinic oncology facilities.

CHAIR - Gavin, the message from the Governor states $5.3 million as the project cost. The documentation we have in front of us indicates $5.521 million. I know it is not a huge amount of money, only a couple of hundred thousand. Is there any particular matter that ought to be drawn to our attention to address that difference?

Mr AUSTIN - Not that we are aware of. At this stage we do not have the final QS estimate so the figures that we are working off are tentative. The budget of $5.3 million is certain and I have a little bit more than that.

Mr COOPER - The figure in the project cost in the report also reflects some of the preliminary works but the number that went into the document to the Governor had not identified what that quantum was at that stage. So now we have a better understanding that a little bit of car parking work needs doing, the temporary buildings and so forth. There is about $200 000 associated with that.

CHAIR - Does that show up anywhere in the submission?

Mr COOPER - If you look at page 24, there is $4.061 million allocated to the main building works, and then we have a line item of $200 000 for the site preparation, car parking-type works that we need to do. So that should read $4.261 for the subtotal. Then we have art in public buildings, fees, loose furniture and equipment. There is quite a quantity of equipment that we need to install, given that it is a whole new service. The

creation of a short-stay unit requires a whole range of additional equipment, specialist medical equipment, and that is all within this figure.

CHAIR - So the $3.3 million was external of that $200 000 shown there?

Mr COOPER - Yes, that's correct.

Ms MASON - You would have had an opportunity to see some of the existing deficiencies. As I alluded to this morning, originally the department was only ever intended for 8 000 attendances. That has progressed at times to 24 000 to 26 000, and the current configuration of the department does not lend itself to having sufficient patient flow to optimise patient care. So the key areas are the insufficient space between the treatment bays, lack of privacy for patients and in particular the ability to provide that separate area for children in paediatrics. Lack of a short-stay unit increases throughput through the DEM; including that short-stay unit will allow for meeting the State's clinical services plan which indicates that a short-stay area would be available. There is lack of space for the ambulance, we do not have a decontamination space and we haven't sufficient areas for general storage.

Ms DUFF - One of the big issues when you have had a trauma was the deficiency of an area for relatives to go to. You can picture that area where the patients were; they literally had to be in the middle of that, grieving or whatever. That wasn't allocated in the first redevelopment many years ago, so just the space alone will allow for that.

Ms MASON - For staff, it is very cramped and there is very limited office space. There is space enough for two people to go in for a cup of tea to have a break, so it is about wanting to provide an improved environment for staff to be able to work within, as well as for the patients.

Ms WHITE - You currently have 24 000 presentations a year but your recognised standard is a capacity of 8 000, so to accommodate 42 000 and meet recognised standard requirements is obviously a big jump.

Ms MASON - Yes, that is anticipated population growth for the Devonport area and that transient population we have, so the facility would meet the 42 000 capacity.

Mr BOOTH - How many years forward is that projection of 42 000? In terms of redundancy, are you projecting that this development will work for the next five, 10, 20 or 30 years in terms of capacity?

Ms MASON - I think we would be certainly looking at a five- to 10-year, but I can provide you with some specific demographic data to back that up, but I do not have that to hand.

Mr BOOTH - Are you satisfied, then, that the work done now will provide sufficient capacity under the current scenario for, say, five years? Can you be specific?

Ms DUFF - Id' say 10 years plus. As Victoria pointed out this morning, there is the change in flow and the fact that there is actually a flow that wasn't built into the very first. It's not always about the size, it's about the flow and the available waiting areas et cetera, so certainly I would say 10 years, easily.

Mr BOOTH - We did talk about some of these things this morning but we need to have it on the record so I am sorry if we're asking the same questions again.

Ms DUFF - Yes.

Mr BOOTH - That is the purpose of it. With regard to the flow-through, you were talking about bed-blocking. Everybody knows that is occurring, so what percentage of your beds currently are blocked on average and how much of that blocking is driving the urgent need for this development?

Ms MASON - Certainly it is very much on a seasonal basis. A good example would be to talk about our medical ward. We have the capacity for 24 to 28 beds and we have recently been existing on an average of 38 to 40 medical patients, so there have been a lot of medical conditions - chest pain, et cetera - admitted to the DEM.

Mr BOOTH - They would normally go through another area, you mean.

Ms MASON - We get referrals through GPs or through the Department of Emergency Medicine. Basically, we've had quite a busy medical area that is overflowing into surgical areas and creating some bed blockage within our current bed capacity that ranges from around 70 beds. We've found that significantly over the last two to three months which then creates a scenario where we're having to hold patients down in the DEM when necessary for longer periods of time than we would like to.

Mr BOOTH - So as well as that you have people who should normally be in palliative care or aged care?

Ms MASON - Yes, with our heads of agreement our bed capability is to provide palliative care beds and what we do find is that we have a cohort that requires transfer out into the rest home and other facilities, and there have been some issues around beds becoming free for patients requiring respite care. There hasn't been the throughput of that into the community either, which then creates the need for patients to stay in hospital for longer periods of time.

Mr BOOTH - So, in your view, is that an appropriate use of emergency medicine funds, to provide palliative care and respite care beds in the DEM?

Ms MASON - No, we wouldn't be providing those in the DEM, we'd be providing those in the main body of the hospital, so it's getting that throughput out into the residential homes. We are doing some work with the Eldercare team. There is a variety of different packages that are being released that will help in the coming months to facilitate that throughput into the community and reduce the bed blockage to allow acute patients to be admitted into the most appropriate place.

Mr BOOTH - Could you provide the committee with those figures - the demographics and so forth?

Ms MASON - I haven't got those with me but we can provide them at a later date.

Mr BOOTH - Thank you.

Ms DUFF - Just to clarify that matter Sharon was speaking about, that cohort of patients we're talking about there, in reality every morning when I arrive you would have anywhere between two to six patients waiting in the DEM who actually should be in the ward areas, but because of these patients we've just spoken about they cannot move through to the ward. So they could be within that emergency department for anywhere up to 24 hours or longer, which again is unfortunately a national problem. Probably other hospitals would say, 'If only we had only six patients', because if we ring Launceston with what we call bed-block issues they can have up to 16 and Hobart can have up to 26 in that situation. The benefit of that new short-stay area we were speaking about this morning is that we will have somewhere to retain them. Up until now those patients had to take up those bays that you saw in that open area so therefore anyone who walked through the door who actually needed a trolley, often there was not a trolley available. That is what Sharon was saying - that's the backlog. We obviously also have to care for patients within the in-patients area so there's that responsibility.

Mr BOOTH - So how long would someone perhaps remain untreated on a trolley?

Ms DUFF - Not untreated, never untreated.

Ms BROWN - Do you want me to explain a bit about short-stay units and what the idea is? It seems like maybe it's a good time to cut in.

Mr BOOTH - Yes.

Ms BROWN - Short-stay units are part of contemporary emergency medicine practice, not only in Australia but also in America and a lot of peer countries. Short-stay units have three main functions - for observation, specialist assessment and diagnosis, and short-term high-level management. So we are looking at periods of stay from six to 24 hours.

The advantage of this, as well as being advantageous to patients and their carers, is that it is complementary to how we in a hospital like to run an emergency department in that it increases the ED turnover, reduces the length of stay on average for patients within the emergency department, and facilitates ambulance offloading, so we don't get ramping of ambulances because we can manage the patient flow better.

So it increases the overall bed capacity of the hospital and a clinical example is probably the way we manage our chest pain patients at the moment. It is a very frequent presentation to the emergency department at the Mersey. Every patient who comes in with chest pain, after six hours, has to have an ECG and a blood test. Instead of having to sit in an acute bay in the emergency department, they can go along to the short-stay, after their initial work-up and assessment. If those blood tests and ECGs are fine, they can either be discharged home with follow-up or transferred to Launceston. At the moment they are sitting in bay 1 or 2, which means we have fewer trolleys then to take in the next lot of patients.

I know we mentioned in the document a lot about triage categories and so you have a little bit of an understanding when we talk about 1, 2, 3, 4 and 5 categories, category 1 is for resuscitation patients, someone who needs to be seen immediately, and at the moment

they go straight into Resuscitation. Category 2 is someone who needs to be seen within 10 minutes, category 3 is within 30 minutes, and categories 4 and 5 are what we call semi-urgent and non-urgent. These are patients who might otherwise go to GPs, and they need to be seen within 60 minutes for a category 4 and up to 120 minutes for a category 5. So that's just to give you little bit of an idea.

Mr HALL - I did bring this matter up whilst we were at the hospital, but just for the public record, it talks on page 8 about the high dependency unit and the fact that that has been done and dusted in that respect. In terms of an ICU, for the record, just explain the difference between an HDU and an ICU and where the line is drawn, for example, where you have to then send patients off to an ICU to, I presume, Burnie and/or Launceston?

Ms DUFF - That area that we spoke about, we are now what we call a high dependency unit. An intensive care unit comes under a standard whereby you have to have an intensivist around the clock, so 24 hours a day on-call and within that unit. That is a national problem, there are not many intensivists out there, and I guess is part of the reason and only part of the reason that we became an HDU. In an HDU we have clear policies whereby after six hours our patients are transferred out, so we have a lot of retrievals out to the North West Regional Hospital, Burnie, or whatever hospital and that could be as far as Melbourne, and they are retrieved according to the workloads within the other hospitals.

Mr HALL - So in an ideal world, if those personnel were available, would it be an advantage to have an ICU unit at Latrobe?

Ms DUFF - As I said, that was only part of the problem there. There is not a problem with the set-up that we have. We have to also look at the fact that we are a rural area and we're not only talking about intensivists here, we're talking about medical and nursing teams available and the numbers within. You have to look at inefficiencies, duplication of equipment - there are many areas and that's why I said it was just one of the areas that was looked at. Our set-up at the moment is absolutely sufficient.

Mr HALL - So in general terms you think that the population in the Mersey region is catered for in that respect, in being able to transfer patients?

Ms DUFF - Yes, it certainly is.

Mr HALL - It is not an issue there?

Ms DUFF - No, not an issue at all. We have policies and it's a good retrieval system.

Mr HALL - I have another question that goes to page 24, which talked about the project cost. On the bottom it says CPI and cost escalation allowances of $110 000 and then there are construction contingencies built in. Normally before this committee we usually have construction contingencies as a separate item and it is usually about 10 per cent or thereabouts of the total capital cost. Is there any reason why you have done it this way?

Mr COOPER - I pulled the figures together. It was just the way in which our quantity surveyor had provided the prices; it was all embedded with that, so I hadn't taken it out.

Mr HOLLOWAY - It is identified.

Mr COOPER - It's roughly in the order of 10 per cent.

Mr HALL - Okay. I just found it a little bit confusing when I read it because that's not the way it's usually tabulated to us. So we can be assured that 10 per cent or thereabouts has been taken into account?

Mr COOPER - Yes, that's right.

Ms WHITE - In the short-stay area that you're developing, what sort of furniture will you have there? Would they be beds or chairs or both?

Ms BROWN - If you think that people could potentially be there for 24 hours we really need to have beds. Also looking at acuity, just because they are short-stay doesn't mean that they are not of a reasonable acuity, so again you need to provide trolleys - not a hospital-bed trolley, more an emergency trolley which has provisions for emergency resuscitation and good mobility.

CHAIR - I notice from the submission and also from your contributions as we toured the site this morning that you've had ongoing community liaison in the development so far and that will need to keep going because of the reconfiguration and the familiarity of the current configuration for people in the community. How will that be undertaken going forward? People who are familiar with the place when there is an emergency are going to need to be up to speed.

Ms BROWN - We have a media liaison department within the North West Area Health Service and we've already developed a communication strategy in conjunction with them about how we're going to approach this very issue. We're putting an action plan together with time lines, starting from now and going right through to the end of the project. We are looking at internal and external stakeholders and are starting off with discussions with all the staff within the hospital and making sure that they're all up to date with everything. There are meetings planned with both Devonport and Latrobe councils to give them a briefing on the project and how it's going to affect things such as car parking and access to emergency services. Elisa from our media unit is also preparing some media releases and will be doing that every three to four weeks throughout the project so that people in the community can be aware of what's currently happening, what stage of construction we're at and how it might affect things such as access. So we have given this quite a lot of thought. There are lots of other little things that I haven't mentioned, such as bulletin boards and posters to go up around the place, using local community newsletters. That is all factored into our communication strategy.

CHAIR - With everything fitting into place as planned, is it still the expectation that the project will come in by October next year?

Mr HOLLOWAY - Yes, the current program is completion in October.

Mr BOOTH - So you haven't gone to tender for any of this, it's all just based on the quantity surveyor's estimates?

Mr HOLLOWAY - No, the preliminary works tender will be called on Saturday and the main contract, subject to this hearing outcome, we anticipate in December. The preliminary works give us a buffer for that so that the main contract will be able to continue straight on on completion of preliminary works.

Mr BOOTH - Will the tender be time-constrained in that somebody wanting to apply will have to make an immediate start?

Mr HOLLOWAY - Yes. We will have a completion date that will be defined by a number of working days and the contract period will commence from the date of notification. That is normal Australian standard of protocol for the contract period.

Mr BOOTH - But given what's happening with the availability of trades and so forth at the moment, is it wise to restrain it in terms of the tenders by a short time frame for the start because that would limit you to builders who have the capacity for redundancy at the moment and might exclude a lot of competition out of the tendering process?

Mr HOLLOWAY - What we find is that working in a hospital environment we cannot afford to be lax or give any latitude whatsoever to contractors and subcontractors. Our principal focus is getting this completed and allowing the hospital to continue to function with minimal inconvenience. If we had an open-ended contract it would be difficult to say when it would be finished because -

Mr BOOTH - Yes, you might have misunderstood me. It wasn't an open-ended thing, it's just that you could have a time frame for completion of so many months but you might shift the staff date by a month, which presumably wouldn't be the end of the world for the hospital.

Mr HOLLOWAY - No, the commencement date is moveable to some extent and that's part of the reason we split it into two contracts, so that it does give us a little bit of latitude there, but as far as actually doing the work we have to have that period so that we can get the works done in a limited period.

Mr AUSTIN - We recently put out another piece of work for tender and we had 11 respondents. There was a high level of interest already expressed by at least two or three of those contractors for this; they were waiting for this work to be tendered. They knew about this because it's been in the media and there's a fair amount of hunger for the work. We were quite surprised with the high level of response to the latest piece of work. In the past we have only had one or two respondents and to get 11 was amazing.

Mr COOPER - I think what we're finding is that historically there has been the school stimulus package but that's all tapering off and the building community in the north and north-west is looking for decent-sized projects to get involved in and they're ready to jump straight into it.

Mr BOOTH - And they're nationally tendered, presumably?

Mr COOPER - This is only going to be tendered through the *Advocate* and the *Examiner* in the north and north-west; that's all that's required. There are probably five or six large prequalified builders in the area that could quite adequately do the work.

Mr HOLLOWAY - The code of tendering actually does give an incentive to tenderers to state if they have a commencement problem in their submission and we actually had one with the residentials where one of the tenderers couldn't start for four weeks. It wasn't the lowest tenderer in this instance but the incentive is there to be upfront to tell us so it can be fully considered.

Mr BOOTH - Does that mean to say that you're tendering amongst a preselected, prequalified group of construction companies?

Mr COOPER - That is Treasury guidelines. We have to work within Treasury's procurement guidelines for all registrations, the building industry register within Treasury up to certain limits, so some builders are prequalified up to $25 million. Builders that will tender for this will need to be prequalified up to at least $4 million or something of that order.

Mr BOOTH - But will they only be builders from the north and north-west?

Mr COOPER - We will find that Hobart-based builders will tender for it because it's also advertised on Treasury's tender website and it may get some interest from mainland builders, but I think they tend to find that they've got enough work of their own over there and once you have five or six contractors tendering locally you have the competitiveness required.

Mr BOOTH - Well, maybe, but my experience has been that if you do not make sure it is an open tender then you do not necessarily get value out of it unless there are other reasons for restricting the number of people who can do the work.

Mr COOPER - But we are open tendering. It is not selection or anything.

CHAIR - I note in the submission that, given the constraints of one of the operating theatres being substandard in size, there have been, if not challenges, some difficulties in retaining accreditation. How close to the mark have you come in terms of accreditation because of those deficiencies?

Ms MASON - We have had the mid-cycle review with College of Anaesthetists recently and the area it is referring to is the requirement to have a metre gap between the recovery beds. I have to say we are pretty much the same as Launceston and Royal Hobart in that they do not meet the standards either. It is understood that we will be working towards meeting the standards as part of our redevelopment and that it will be addressed when the redevelopment takes place. There is not the opportunity to change the configuration of the theatre as it stands. With regards to wanting to enlarge the third theatre, that is about enabling ourselves to do a different variety of work and to follow the focus of Mersey becoming sub-acute with a focus on a facility of speciality around day surgery. To enlarge that theatre will allow us to do more laparoscopic work, which is traditionally day theatre surgery. So not meeting the accreditation is owing to inability to have that metre gap between the recovery beds and matching the recovery beds to the numbers of theatres.

Mr HALL - We know the catchment area of the Mersey hospital but for accident and trauma emergencies is there a demarcation line such that somebody makes a decision whether they go to Mersey or the LGH or the North West General?

Ms MASON - Deloraine is the demarcation line for our coverage, and the Leven River.

Ms BROWN - The bridge at Ulverstone.

Ms MASON - It really depends on the nature of what Tas Ambulance are required to attend, then they will make a decision at the time. In liaison, possibly all alpha, which is the highest category, will automatically go to Burnie or Launceston, whichever is nearest.

Ms BROWN - That is because of their intensive care units.

Mr COOPER - Yes.

Mr HALL - Okay. It occurred to me whilst I was riding my pushbike near Elizabeth Town that if I got knocked off by a big truck, which I almost did, where would I end up?

Laughter.

Mr HALL - Now I know.

Mr COOPER - The DEM project itself is in the order of $5.5 million, and we are also looking at redeveloping the theatres. We had a budget figure of $1.1 million for that. Also oncology and day clinics require significant work because there is under-capacity in those spaces, so we have concepts there for another $3 million. I think we are doing submissions at the moment, essentially to the National Health and Hospitals Fund, because there are other options we need to do to improve the Mersey as a whole. We have $7.5 million from the State Government at the moment, which only sees us part way through that overall journey of the redevelopment. We need to obtain additional funds to make the Mersey the optimum hospital that they want it to be.

Mr BOOTH - More savings from this project would be added on to that and be part of it?

Mr COOPER - Correct. So if the tenders come in at $3 million and gave us an extra million dollars, then that would mean we could do more within that budget within the oncology area. If we were unsuccessful in any further bids then essentially we would just need to constrain our hopes and expectations within the day-clinic-type area and just do minor refurbishment work.

Mr BOOTH - You talked about a five- or 10-year capacity as a result of this development; it does not seem like a very long time frame, particularly given that it will take a while to do it. Have you been constrained in terms of what you have designed and what you want to build because there has been a cap in a budget, or are we looking at something that is like the ideal world and this is what you want?

Ms BROWN - I do not see that it probably is even a 10-year life. Because the flow of the unit is going to be improved there should be no reason that we should ever grow out of the department. Obviously with advances in medical technology and the evolution of

medicine as a practice, things change, processes change and best practice changes over time. That may be where we need future renovations - in line with that. That cannot be foreseen. But as far as facilities go, I see this as being a permanent solution to our problems.

Mr BOOTH - That is what I was going to ask, so thank you.

Ms WHITE - You have funded some of the costs through recurrent funding savings to the tune of about $1.5 million, which is substantial. Has that been achieved over a number of years or have you foregone some improvements and saved up your kitty for this particular project?

Mr AUSTIN - The $1.2 million was achieved by savings in 2008-09. We were allocated $1.4 million for the HDU project and we achieved that for $1 million. So it has been a combination of things by which we have arrived at that $1.5 million.

Ms WHITE - It has not put you in a position where you feel you have been compromised because you had to save?

Mr AUSTIN - No.

CHAIR - Thanks very much, folks.

THE WITNESSES WITHDREW.