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THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT BRADDON HALL, BURNIE ARTS AND FUNCTION CENTRE, BURNIE ON THURSDAY, 7 JUNE 2012.

NORTH WEST CANCER CARE CENTRE

Mr GAVIN AUSTIN, ACTING CEO, NORTH WEST AREA HEALTH SERVICES; **Ms VICTORIA BROWN**, PROJECT MANAGER, NORTH WEST AREA HEALTH SERVICES; **Ms SHERYL SIM**, MEDICAL ONCOLOGIST, NORTH WEST AREA HEALTH SERVICES; **Mr GREG COOPER**, ACTING DIRECTOR, ASSET MANAGEMENT SERVICES; AND **Ms DEBBIE THOMPSON**, PROJECT ARCHITECT, GHD PTY LTD, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Harriss) - Welcome, everyone.

Mr COOPER - I would like to thank you for providing the opportunity for the department to place on the public record the development of the department of emergency medicine and the cancer centre stage 1. Before we get to the specifics of the project, I thought it would be useful to talk about the global Department of Health capital works program. At the moment we have a total infrastructure spend of \$183 million. In excess of \$160 million has been allocated for capital works around the state, so as you can see the department is doing a significant amount of investment in health infrastructure.

In respect of department of emergency medicine projects, this is the fourth of the sites that are being redeveloped. We started with the Royal Hobart Hospital, which was commissioned back in 2007. We have recently opened the LGH and the Mersey. The cancer centre is part of a statewide cancer centre program, which is in excess of \$50 million. We have had the Holman Clinic project at the LGH and we have projects of a new patient centre and medical oncology at the LGH happening at the moment. We have just let the new cancer centre at the Royal Hobart Hospital, so it is a statewide program of which this is just a critical element within that. As we talked about earlier, it is drawing on the resources of, say, the LGH cancer services that it already has.

Mr BOOTH - Greg, you said you will be drawing on the services that are already at the LGH and that exist in the network, can you give us a justification for this project to have its own MRI facility and the reason behind having the cancer unit at Burnie when you are duplicating a service that is already at LGH?

Mr AUSTIN - The MRI is a facility that clinicians value highly in diagnosing patients. The facility at Launceston is running at capacity and has a substantial waiting list. This facility will save patients having to travel an hour and a half down and an hour and a half back from the north-west to Launceston. It will free capacity for the Northern Area Health Service and the LGH to decrease the waiting list to more appropriate times.

In terms of the cancer centre, the work done by Helen Tubb at the Northern Area Health Service around cancer modelling shows that the LGH's three bunkers will be running at

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full capacity until around 2015 and a fourth bunker will be needed by 2016. From the patients' point of view, the people of the north-west travelling for an hour and a half to have a minute of treatment and then travelling an hour and a half back is a substantial burden. For those patients who elect to take the free bus that is provided very graciously by the Cancer Council, the patients have to wait for all the other patients on the bus to have their treatment. Sometimes that is an impost of around six and a half hours on their day, so it is a big difference from a patient point of view. From the state's point of view, it is going to meet an ongoing need for these services which, as you heard earlier this morning from Sheryl, some of the anticipated growth for these patients is around 30 per cent for the state as we are an ageing population with chronic and complex needs.

Mr BOOTH - For the record, does the Launceston General Hospital site have site constraints that would prevent the construction of another bunker to adequately meet the needs of the north-west and the north?

Mr COOPER - I would say that is quite likely. A good consultant may find a space there, but from my understanding of the LGH, walking around the site and all the recent construction, it is built up very close to where the existing Holman Clinic is and there doesn't appear to be any free space left on the site.

Mr BROOKS - On the travel time to and from the LGH, are the patients very ill on the way home after the treatment?

Ms SIM - For patients who have radiotherapy, for example, and travel to Launceston at this stage, they may feel very sick and experience nausea on the trip. For those patients who already have travel sickness, that will be compounded by the radiotherapy effects. The effects of this nausea may last for several weeks or months after their radiotherapy, so for additional trips they may have for consultation that would be a burden for them.

Mr BROOKS - Are you aware of any or have you heard of any patients who have discontinued treatment because of that or the travel?

Ms SIM - I have had a few patients who have had to discontinue treatment because of the burden of travel and the illness associated with it.

Mr HALL - Gavin, in treatments that the LGH does at the moment, what percentage come from the north-west?

Mr AUSTIN - Currently 40 per cent from the north-west.

Mr HALL - When we say the 'north-west', can we delineate that? Where is the boundary?

Mr AUSTIN - The boundary for the north-west is Deloraine.

Mr COOPER - This project consists of \$16.5 million towards the new oncology service, which is differentiated from the earlier discussion about radiological services. That is a further \$16.5 million bid that the commonwealth is still finalising to provide to the state, so we do not have those dollars available yet for this project. In addition to the \$16.5 million for the oncology services, we have just over \$6 million allocated for improvements to the Department of Emergency Medicine, an expansion of that space to

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improve its ability to handle its current number of presentations. It was originally designed for 12 000 presentations and we are currently seeing approximately 26 000. It has a similar case history to the Mersey, which has recently gone through its upgrade. It is to improve the flowthrough to reduce waiting times and better manage the number of patients who are going through the hospital.

The state purchased the North West Regional Hospital two years ago now, which enables us greater opportunity to get the master planning we require for that site appropriate and to meet our needs with our dollars rather than increasing leasing costs et cetera by getting a third-party private provider to provide those services.

Mr BOOTH - Is there a national benchmark of a unit cost per treatment per patient you can relate this development to? Across the north of the state we have a fair duplication of health services, with three hospitals across the north of the state, and presumably the costs of delivering services in each of them is more than if you had them all in one central location, or is that not the case?

Mr AUSTIN - That is the case. There were moves under the Tasmanian Health Plan for some consolidation but for political reasons that was not carried through. The intervention of the federal government at the Mersey meant the Mersey was retained as a key element. The Mersey currently is seeing 26 000 people in its emergency department, as is the North West Regional Hospital, which is about the same as Launceston sees - approximately 50 000 presentations.

It is split on two campuses and a more expensive model than if you had one hospital, say based at Ulverstone. Historically, having the Mersey funded by the federal government means there is not an additional burden on the state.

Mr BOOTH - Has that intervention constructed a health system that is inefficient in the north of the state or unviable in the long term? What are the long-term consequences of this intervention?

Mr AUSTIN - The long-term consequences are that you would have to migrate roll-delineation across the four hospitals in Tasmania so that you move towards having services provided at each hospital to optimise what they could do efficiently. If you were to say that the Mersey should become a short-stay surgical centre and if you knew that throughout the state of Tasmania if you wanted an endoscopy you could have it within four days at the Mersey or wait for two years at any of the other three hospitals, as a member of the public you may well choose to go to the Mersey. That is where the whole rationalisation of services in Tasmania is under constant review and discussion in terms of achieving efficiency as we move into activity-based funding - where is the most sensible place for services? Otherwise, you can get duplication at the top end, which is what has happened in other areas where you get two cardiology services and two neurological services competing, say at Launceston and in Hobart, and that is not what you want either, so you have to have a rationalisation of services. They can all be very efficient.

The vision that was articulated for the Mersey in the Tasmanian Health Plan was very much short-stay surgery with an emergency department stabilising the patients and then being able to go on to other centres from there, which is not unlike a lot of other

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hospitals throughout Australia. I can be efficient but currently a lot of the inefficiencies revolve around the fact that you are doing things because you have made a political decision to do them rather than a clinical decision. A lot of the decisions that are taken around health services are not done by the clinicians; they are done by other people.

Mr BOOTH - So our suboptimal system is the outcome when you have political interference in the design of the health system?

Mr AUSTIN - The danger is you create a level of risk in clinical safety. The thinner you run the services the less critical mass you have, which means your clinicians have to be on call more and more and that call burden means it is unappealing, which means by default you end up with locums being more interested in doing that for a short stint as opposed to permanent staff. So it proves to be suboptimal.

Mr COOPER - If you have more locums there at higher rates for salaries, so that has an impact on the system.

Mr BOOTH - That is really the question I asked earlier as to whether there is a standard unit cost or an average unit cost per procedure that we would be benchmarked against?

Mr AUSTIN - That is what the health reforms are working towards. They have found that incredibly complex. I think they have been talking for two years now and even now there is still a lot of push-back from all the states of Australia wanting differentials for different features like education, training, regionality, rurality. It is not a simple discussion.

Mr BOOTH - These plans we are looking at now, this project is a long-term project, not just a short-term, two-year, five-year thing. We are making expenditure commitments today that are going to be the only ones you will make for probably 10, 15 or 20 years. If we go ahead and do that, do you think the system across the north of the state sustainable with that three-hospital model? What will be the consequences of locking in the decision to do infrastructure projects now that lock in the three-hospital model rather than being able to have a more efficient model?

Mr AUSTIN - The four hospitals of the north-west can all be efficient and this development will not hinder that. Originally the North West Area Health Service was pushing for just this stage, which is the oncology stage that they saw as absolutely essential. The more expensive stage and the one that was subject to extreme debate was whether you should have radiation treatment at the North West. This part of it is essential. The presentations for the emergency department have the clinicians in the emergency department and throughout the hospital at the North West desperate for access to an MRI. That is being donated, both the build and the machine. In terms of an improved oncology centre, Sheryl would be better to talk to that, but there is an absolute need for an improvement to the current facilities. This bid is probably what you would do regardless for the population of the north-west. It is not going to limit the efficiency of the hospital. There is not the need for a grand number of staff, as there would be if you proceed to radiation therapy, which is another model again.

Mr COOPER - If we could continue that discussion on the oncology, as you can see from the report, the existing space is extremely crowded. There are probably two or three

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treatment chairs in a space that should really be a single chair. So we are creating an environment that gives improved amenity for the clients. The design of the new facility is in three levels, so clients have an opportunity to sit back and relax as best they can and enjoy the views out over the ocean. Below the oncology is where we will have consultants and consulting rooms, and below that are the future radiation bunkers and all the back-of-house spaces associated with that. We are constructing the new MRI facility, as Gavin mentioned, through private donations, and a significant expansion of the Department of Emergency Medicine, which will create short-stay units and fast-track units to improve the treatment and processing time for patients who arrive at the emergency department.

This is following a fairly standard consultation process. We are communicating very broadly with the community. We have ownership from the local community but also at the federal and state levels. We are receiving a lot of peer input from the LGH for the radiology services should we get the funding for that. Having recently undertaken the DEM redevelopment at the Mersey, Victoria project-managed that and so knows a lot of the short cuts and ways we can improve that construction, like the shortcomings of working on an existing site and how we work around maintaining services while still having 26 000 presentations turning up at the front door every year. That is going to be a very complex process for us. That is why we have a staging arrangement at the moment, seven or eight stages just to enable elements to be constructed, then some decanting and moving as we gradually increase the floor space.

Mr HALL - On page 15 you talk about the consultation and governance and the stakeholders you have talked to; you talked about the community but then there is a long list of others. Did you receive any adverse responses there and did you make adjustments to the design because of those peer group reviews from other people?

Mr AUSTIN - We did, especially the neighbours. We hired a cherry-picker and put it at the height the roof will be and made sure the neighbours' views were not going to be interfered with. We've had two or three neighbour meetings now and had them all over to discuss the project and they are now satisfied with the project. We have not had any opposition whatsoever.

Mr HALL - In regard to peer reviews from, for example, emergency specialists at the Mersey Hospital and other people at the LGH, their views were all taken into consideration?

Ms BROWN - Absolutely. There have been a lot of changes to the design.

Mr HALL - Was that helpful in the process?

Ms BROWN - Yes, definitely.

Mr AUSTIN - Tasmania Ambulance has been involved too around the modelling of the ambulance bays, and changes were made after consultation with them.

Mr COOPER - In terms of the budget, we had the project costed at the end of the schematic design stage, which was signed off six to eight weeks ago. That was part of the consultation element where we had to work back and forth. A very early cost budget

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came back where we were probably about \$1 million over budget at that stage, so we had to find some savings through the project, which we have done. At the moment for the north-west cancer centre, with the \$16.5 million allocated, we look like being \$125 000 over budget. For the DEM, which has just over \$6 million allocated, we are about \$200 000 over budget. We have already worked out how we are going to manage that. We have quite considerable contingency allowances in the project to allow for ongoing design changes as we get closer into the detail of the project, so they are quite reasonable figures. In these budgets we have identified a doubling-up of some of the cost elements. The works of the new ambulance entry area is costed both in this project and also in the adjacent road realignment project, so that pulls back approximately \$200 000.

Mr HALL - I noticed those contingency amounts. My first reaction was, given there is not a lot of public infrastructure being built in the state at the moment, there ought to be a fairly competitive environment in that respect. I would have thought you may have been able to come in under budget, or is not just the infrastructure part where you run into some hurdles? Is the cost of the medical equipment part of that?

Mr COOPER - That is part of the overall project budget. For example, in the cancer centre there is \$16.5 million. The actual construction of the building is just over \$8 million and a further \$800 000 for the MRI facility, but then we have around \$1 million for IT and equipment. The MRI machine is estimated to be \$2.5 million, which is out to tender at the moment. There are quite considerable figures there for the specialist equipment going into the site. We believe we have quite generous budgets in furniture and equipment in the Department of Emergency Medicine redevelopment. The figure for that is almost \$500 000, but that is an element we can adjust if we were to receive higher tenders. We could look at reusing more of the existing DEM furniture than ideally we would like to.

Mr HALL - One would presume that virtually all that specialised equipment would be manufactured overseas, so the exchange rate at the moment would be assisting with the cost?

Mr COOPER - Yes, that would help.

Mr HALL - I look at the \$2.5 million for the MRI, and I think there is another MRI machine on the coast, located privately at Devonport. Is this more specialised and has more capacity than perhaps the one that already exists under a private system?

Mr AUSTIN - This one will be available to all public patients on the north-west.

Mr HALL - An MRI machine is an MRI machines, so is that basically the bottom line?

Mr AUSTIN - It will be the latest and most modern that is available currently. We have gone in a joint tender with the Royal Hobart Hospital.

Mr BROOKS - My old chestnut of art in public buildings, I understand that is a requirement but will there be any money left over from the art requirement for the car park that we could possibly use?

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Mr COOPER - We can confirm that the original budgets for the car park had an allowance for art in public buildings, but now we are into the project we have confirmed with Arts Tasmania that it does not meet the criteria, so we are not spending any on art in that project. On that specific question, no, we won't be. It will give us more contingency in the car park construction project should any unfavourable conditions arise.

Within this project we have gained an overall benefit. By combining the two projects together we reached that \$80 000 cap, whereas if you had each project go out as separate projects over a different time frame it would probably have been closer to \$140 000 or \$150 000 that would have needed to be allocated. So combining the projects has been beneficial.

On the issue of art in public buildings, it is a mandatory requirement through Treasury. There is a lot of research that says providing a good, amiable facility rather than stark, white clinical walls also has its benefits.

Mr BROOKS - I understand that, but I do not think we need to spend \$80 000 on art. I am sure if we asked for contributions from local artists we would probably get something that would not cost that much money and we could put it back into health services. Considering the car park, I'm sure there are some talented artists in the north-west who would possibly paint a mural or something. I think we need to become more proactive about where we spend our money rather than just having a bucket that says this has to be spent on that. I know a requirement of this project is that under the current needs it has to be allocated, but I put it on the public record that I am not hugely supportive of the process of that allocation from a legislative point of view. Notwithstanding, it is a requirement so it has to be in there.

I want to just talk about the tendering process and the time frames for the project. Advertisement by August 2012?

Mr COOPER - Yes.

Mr BROOKS - Given the current projects that are available, we would envisage a large number of tenders. Will that change the way you approach it or advertise it?

Mr COOPER - I think it will be fairly standard. It will be openly advertised in the three newspapers. There will be weighted criteria, given the value of the project. We want to make sure, particularly in a working environment, that contractors will do all the right things: put up dust-control systems, manage noise, manage the staging appropriately. We will be making sure they are part of the assessment and that the contractors will be capable of doing those things.

Mr BROOKS - Do you set the criteria?

Mr COOPER - Yes.

Ms BROWN - We have infection-control documents, health and safety documents, that we submit as part of the tender so they know right from the beginning what our expectations are.

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Mr BROOKS - I have a question around the use of Tasmanian-based companies. Whilst I know it has to be open to all, will that be considered as part of the tender, the ability to support local communities rather than other communities?

Mr COOPER - I suppose our opinion is that the scale of this isn't going to attract a mainland organisation. The local building industry now is geared up very well for projects. The construction value that will go to the market is \$12 million to \$15 million in terms of its capital dollars. There are probably around six or eight companies statewide that can quite easily manage that scale of project now. I suggest they would have a significant competitive advantage, being local, to any mainland organisations that attempted to come down and price it.

Mr BOOTH - You state in the documentation that the design will provide contemporary, functional and efficient facilities with the focus on the maintenance of amenity, security and low life-cycle costs. Can you detail the design parameters you used there, what energy-efficient measures have been taken, what the life-cycle energy costs of the building are going to be, double-glazing, insulation et cetera?

Ms THOMPSON - We are doing modelling and we are getting as energy-efficient a building as we can afford within the budget. We also have done an EST review of the building using the green star tool. Our buildings don't comply with the green star activity; it is too much of an extension of the existing building. The green star was just used as a guidance thing; we could not get a green star for this building because of the nature of the building and the existing conditions. We have worked through that and I think we are doing reasonably well. We will meet the regulatory requirements for the building and we will go beyond that where we can.

Mr BOOTH - You've said you are doing what you can within the project budget; are there some limitations on what you have been able to do purely because of budget that could end up being a costly choice?

Ms THOMPSON - Within the projects there probably are but there is also work outside the projects and infrastructure upgrades which are being reviewed at the moment, which are separate to these particular projects but which should enhance the EST of the whole site. It is more about the bits and pieces. The whole site has to be considered separately, because it is budgeted separately, to the specific projects we are working on. We're working on reasonably small areas to get the things in where they need to be within the existing facility with the neighbouring facility et cetera happening.

Mr BOOTH - In the overall scheme of the size of the whole hospital, you are saying what you are doing is not very consequential?

Ms THOMPSON - It is inconsequential in terms of green star; we couldn't get a green star rating on it.

Mr BOOTH - Are you using double-glazing et cetera?

Ms THOMPSON - Yes, we are going to those measures.

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Mr COOPER - Things such as putting in high levels of insulation we endeavour to do wherever we can. It's a fairly minimal capital cost so it is to the benefit of everybody to do that. The reality of this construction is that it is well ahead of the energy efficiency of the rest of the building. The department ultimately needs to bring the rest of the building up to the same energy efficiency as we are constructing now. That is a longer-term process that we have done. We have just undertaken an energy audit of the existing complex and identified a program of works, for which we are seeking separate funding to implement.

Ms THOMPSON - In terms of carbon footprint reduction, that is a far more important process than what we're doing at the moment. We are doing the best we can, and I think we're doing very well.

CHAIR - I would like to come back to the matter of the cost overruns you have identified, Greg. The document shows \$199 000 and \$125 000, and I presume you factor out of that the \$150 000 identified on page 31. You take that out and your net is \$174 000 over budget, but you still think you can massage that sufficiently with consultation to still come in on budget?

Mr COOPER - Correct, yes.

CHAIR - You made a comment earlier about the radiology services, if you get the funding? What is the risk to getting the funding, or are there risks?

Mr COOPER - For this project there is no risk. This project can proceed totally independently of the \$16.5 million we are still waiting on. We are not dependent on any of those dollars propping up this budget. Initially, when we thought we had the [inaudible] for stage 2, that is what we were doing but we have had to compromise because we couldn't get the certainty of that announcement from the commonwealth in writing. So we are working on the basis that that funding may not turn up for two or three years, therefore this project has to stand alone.

CHAIR - That is as I understood it, nonetheless the reference we are considering is for the package. We are considering the \$38.8 million as a package and that was the reason for the question - and you've confirmed it. There may still be a risk but from what we heard earlier in the day, the federal minister has indicated to you that the funding is on its way but we don't have a letter to confirm that yet.

Mr COOPER - No, that is right. We're playing it very safe as to what we are aiming to achieve under this tender that we hope to put out.

CHAIR - The other matter related to costing - I am looking at page 31 of the submission - is that you made the observation as to the competitive nature of the market and you have identified that there. You also say it may result in additional savings because of the competitive nature of the market at the moment and, if that is the case, there would be funds for 'remaining projects'. What remaining projects are you referring to if there are those additional savings?

Mr COOPER - There are a number of site infrastructure issues which we need to work through. The nurse-call system, for example, is on its last legs so under this project we're

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putting in the backbone for a whole new system. Ideally we would like to expand that system. There has been broad master planning.

Mr AUSTIN - Probably the next two key projects for the north-west are moving the pharmacy from the other end of the building - it is in the North West Private Hospital at the moment - and that is not a great thing for patients. It is a substantial walk if you're leaving the ward to collect your pharmaceuticals. Part of this overall master planning is moving the pharmacy. There is a saving in rental costs every year if we were to move the pharmacy. The master plan calls for the pharmacy to be by the front door, and in this development we have that space allocated for the pharmacy.

The next big project is the expansion of the outpatients area because it is woefully inadequate at the moment. If an extra consultant turns up from Hobart to run a session, we have to cancel sessions we already have programmed to fit them in. It is an absolute collision of space at the moment. That is not a very expensive project and a few extra rooms would make an enormous difference to the number of people who could be seen in the outpatient clinics.

Ms THOMPSON - We are basically allowing for it to be a multi-storey building which will help us utilise the site better - continuation from what we have by using the same lifts and things like that. There was allowance for that in the cancer centre design that this could be continued on. We're not reliant on the single-storey domestic construction which is the existing hospital.

Mr AUSTIN - The DEM upgrade will allow for two separate paediatric patient rooms and a secure mental health room. The clinicians in the emergency department are looking forward to that intensely - a separate place for the children, a separate place for the mental health patients and an isolation room at the North West Regional Hospital. Those are all excellent features that are incorporated in this design.

Mr BROOKS - Do you think the design and the building adequately deliver what they need to?

Ms BROWN - I think we have designed the best emergency department we can with the budget we've been given. It will cater for the needs of the department based on the current presentations. The fact that we are able to incorporate fast-track and short-stay units will mean people spending less time in the acute section of the emergency department. I would work there quite happily, based on the design, if that's any assurance to you.

Mr BROOKS - It is, and the committee's brief is to make sure that the design is suitable for the need and will meet existing and future requirements. If it is not, now is the time to say so.

Ms BROWN - It certainly meets all the requirements based on the guidelines and standards. We haven't cut any corners with anything like that. It's going to be a functional and contemporary emergency department and will cater very well for approximately 26 000 presentations per year.

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Mr BROOKS - What is the life expectancy of this project? What are projections on future demand when we will need to look at it in the future to put in more resources?

Mr AUSTIN - We see it as between 10-15 years.

CHAIR - The building will be able to stand up for 50 years but with the state of health there will need to be refurbishments, changes and reconfigurations to suit changes of service and increased service requirements et cetera. As Gavin said, probably every 10-15 years we will need to work through it and change it.

Ms BROWN - Standards and guidelines are upgraded all the time, so you can only raise to a bar and then the bar is raised.

Mr BROOKS - We heard that Launceston will be at capacity in the next two to three years and the addition of services on the north-west will help alleviate that, given the flow of patients from Burnie. I think it is important it is on the public record what expectations and projections you have on increased potential. I know you can't place an exact date or number on it, but I'm just making sure we're not going to be back here in three years time.

Mr COOPER - It is the other challenge with health. There is so much change, new drugs being created, new tools being invented. We could be back here in, say, 10 years time and instead of bunker spaces of the scale we need now we would probably get three in instead of two because of technology changes. That is probably the biggest problem we have; we can't predict what's going to happen so we need to create a space that is flexible for those changes.

Mr BROOKS - And this addresses that as best you can?

Mr COOPER - Yes.

Mr BOOTH - Are the forward projections based on a population cohort across the whole of Australia or on the actual demographic of the north-west coast?

Mr AUSTIN - It is based on a demographic of the north-west coast. There is quite strong growth in Circular Head and Port Sorell.

Mr BOOTH - But in terms of age demographic and potential medical needs of that area?

Ms SIM - Those statistics we have talked about today - 10 per cent growth, 10 per cent increase of incidence of cancer over 10 years. This is a rise from Australian statistics looking particularly at the north-west.

Mr BOOTH - Specifically for the north-west?

Ms SIM - Yes.

Mr BOOTH - So that takes into account the ageing demographic?

Ms SIM - Yes.

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Mr BOOTH - Will you need a hospital that big in 20 years time?

Ms SIM - We have doubled the number of chemotherapy chairs in the new cancer centre. We currently have six and we will have 12 in the new design. We have added on two paediatric wings and an isolation room and separate treatment room, so we've tried to account for a doubling of the treatment we can provide.

Mr BOOTH - So it's well thought out in the view of you all, particularly the medical practitioners, that it's going to cater well for the needs of the north-west in the future?

Ms SIM - Yes. We have not just accounted for treatment. We know with a cancer journey a patient undergoes issues around prevention, diagnosis, treatment, survival and end of care. We have accounted for all those issues. We have a health promotion area, a wellness centre, support services, palliative care, occupational therapy, allied health, coordinators et cetera all incorporated into that building. Patients with cancer need to have all those services within that one building so we thought that through and thought about the flow and their needs.

Mr BOOTH - Is the wellness centre a new concept?

Ms SIM - A lot of cancer centres do have that now. It is an area where they can sit with their family perhaps. There are lots of booths with pamphlets and information and maybe some internet stations where they can access information, and areas where they can relax. Some people come in for support groups and maybe volunteers can practise aromatherapy or massages in that area as well. It is quite important and thought to be very essential for therapeutics.

Mr AUSTIN - The funding and staffing for that centre comes from the Cancer Council. As less use is made of the bus they will divert more and more funding towards the wellness centre. They have been involved in the consultation and design all the way through.

CHAIR - Thank you all very much for the presentation.

THE WITNESSES WITHDREW.