2022 (No. 11)

PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

Royal Hobart Hospital Emergency Department Expansion Stage 1

Brought up by Ms Butler and ordered by the House of Assembly to be printed.

Legislative Council	House of Assembly
Mr *Valentine* (Chair)	Ms *Butler*
Ms *Rattray* (Deputy-Chair)	Mr *Ellis*
	Mr *Tucker*

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1 INTRODUCTION

The Committee has the honour to report to the House of Assembly in accordance with the provisions of the *Public Works Committee Act 1914* on the -

Royal Hobart Hospital Emergency Department Expansion Phase 1

2 BACKGROUND

2.1 This reference recommended the Committee approve the Royal Hobart Hospital (RHH) Emergency Department Expansion Phase 1 project to meet the growing demand in Emergency Department (ED) presentations and to create space for a staged expansion of the ED through to 2025.

2.2 The ED at the RHH currently faces difficulty providing adequate care to presenting patients. Facing high demand, the ED is often over-crowded, which consequently delays access to emergency care and lengthens waiting periods for inpatient beds.

2.3 The RHH ED has significantly outgrown its current facilities, leading to operational shortfalls including ambulance ramping, overcrowded waiting areas and compromised patient flow. Furthermore, the demand on the ED is forecast to experience sustained growth to 2035, with the ED projected to encounter an increase in annual patient presentations from 74,000 to 135,000 per annum.[1]

2.4 The proposed ED Expansion Phase 1 will be the first stage of the Department of Health's (the Department) ongoing expansion of the RHH ED. Phase 2 of the ED expansion is expected to be presented to the Committee later in 2022. Clinicians and nursing staff were consulted by the Department as key stakeholders in the proposed Expansion, offering their expertise in relation to the functional needs of an ED.

2.5 The proposed overall ED Expansion (Phase 1 and Phase 2) will incorporate a Model of Care program directed specifically towards the functionality of the ED, which has been developed through an extensive research and consultation process. The proposed Model of Care designates a total of 118 treatment points in the ED, with this number of treatment points based on projected ED demand.

2.6 The proposed Phase 1 works will be located in the RHH's vacated Paediatrics Department on the Lower Ground Floor of H Block, will consist of a purpose-built Short Stay Unit (SSU) and will include 28 treatment points. The SSU is for patients who require observation, specialist assessment and diagnostics but are deemed to only necessitate a short hospital stay, defined as a period of less than 24 hours. The proposed works have also been designed to have the capacity to operate as a pandemic response area, a planning protocol established in response to the Covid-19 pandemic.

[1] *Emergency Department Expansion, Royal Hobart Hospital*, submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022, p. 3

2.7 The SSU will be designed with a 'ballroom model around disaggregated staff bases', to cater for the efficient workflow of staff throughout all areas within the ED which will in turn enhance patient care.[2]

2.8 The proposed Phase 1 Expansion will include the following features within the SSU:

- 28 patient bays:
  - 12 bays will be fully enclosed to facilitate infection control;
  - 13 open patient bays;
  - 3 S-Class Isolation Bays, with attached ensuites, one of which will be designed to accommodate a bariatric patient;
- 2 procedure rooms;
- Administration area and staff facilities;
- Reception/ security;
- Multidisciplinary meeting room;
- Dirty utility room;
- Equipment storage area;
- Total accessibility compliance;
- Medication storage area; and
- Storage for allied health equipment.

2.9 Additionally, the project will necessitate the following structural work at the proposed location:

- Removal of existing windows and installation of new emergency exit doors on the Argyle Street façade of H Block;
- Purchase of new furniture, medical equipment, IT (Information Technology) and general resources;
- Relocation of existing electrical services;
- Fire egress and safety works; and
- Upgrade of mechanical and hydraulic services.

[2] *Emergency Department Expansion, Royal Hobart Hospital*, submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022, p. 7.

3 PROJECT COSTS

3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work was $9.85 million.

The following table details the current cost estimate for the project:

Phase 1 Budget	Cost Estimate
Construction Costs	$9,496,998
Contingency (15%)	$1,424,548
Post Occupancy Allowance	$100,000
Professional Fees and Authority Fees	$1,638,231
Information and Communication Technology Infrastructure	$200,000
Furniture and Equipment	$1,100,000
PHASE 1 TOTAL	**$13,959,777**

The funding allocation for the proposed Expansion is drawn from the Tasmanian State Government's allocation of a budget of $53 million for the completion of the entire RHH Emergency Department Expansion project.

4 EVIDENCE

4.1 The Committee commenced its inquiry on Wednesday, 16 February last with an inspection of the site of the proposed works. The Committee then returned to Committee Room 1, Parliament House, Hobart, whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Dr Emma Huckerby, Director, Emergency Department, Royal Hobart Hospital, Department of Health;
- Trish Allen, Nursing Director – Critical Care, Clinical Support and Investigation, Royal Hobart Hospital, Department of Health;
- Andrew Hargrave, Director, Programming and Delivery, Infrastructure Services, Department of Health;
- Mark Leis, Project Manager, Programming and Delivery, Infrastructure Services, Department of Health;
- Scott Verdouw, Director, JAWS Architects; and
- Tom Novakovic, JAWS Architects.

The following Committee Members were present:

- Hon Rob Valentine MLC (Chair);
- Hon Tania Rattray MLC (Deputy-Chair);
- Ms Jen Butler MP;
- Mr Felix Ellis MP; and
- Mr John Tucker MP.

Overview

4.2 Mr Hargrave, Dr Huckerby and Ms Allen provided an overview of the proposed works:

> ***Mr HARGRAVE*** *- … In March 2019 the Tasmanian Government, following the release of the Royal Hobart Hospital master plan and recommendations made by the Clinical Planning Taskforce, announced the commencement of Stage 2 of the Royal Hobart Hospital Redevelopment.*
>
> *The Royal Hobart Hospital Redevelopment Stage 2 was to include an expansion of the Emergency Department to meet growing patient demand; a comprehensive refurbishment of A block to provide temporary space for additional beds; an expansion of the ICU in its current location, providing space for an additional 12 beds and retaining close physical linkage to medical imaging; and a refit of J block to meet additional demand and provide for new clinical uses.*
>
> *A further announcement in relation to the expansion of the ED was made by the Minister for Health in September 2021, committing to an acceleration of the opening of 25 new emergency beds by the end of 2022 to assist in dealing with an increase in demand.*
>
> *The second announcement and the resulting project are specifically the subject of today's Parliamentary Standing Committee for Public Works meeting, and represent the first phase of*

the broader Emergency Department expansion as part of the stage 2 of the Royal Hobart Hospital redevelopment.

***Dr HUCKERBY** - … The Royal Hobart Hospital Emergency Department opened in 2007. It was constructed to accommodate 45 000 patients per annum. We exceeded that in the 2009-10 financial year. Last calendar year, we saw more than 72 000 patients and it is expected that we will be up to 95 000 patients within the next five years.*

This means that when patients arrive in the Emergency Department, the beds are often full of the patients who have arrived before that. Some of this is because of access block, but we have done a lot of work with admitted patients staying in Emergency Department beds. There has been a lot of work on flow and expanding inpatient services, so we know now that even when everyone in the Emergency Department has been in the Department for less than four hours - achieving full best practice patient flow - we can still be ramping up to eight ambulances. It is a function of just the number of patients coming in per hour and the number of beds that we have in the Department.

This is why the whole expansion is occurring and is being planned. It is also one of the reasons why this initial step to create a decant space within the Emergency Department is so critical: we cannot afford to close any of our acute beds to build the next lot of beds.

So, number one, this is being put in place as a strategy to allow us to get through the rebuilds. It's also put in because this is what we want; this is a final thing. This is not something that's going to then be repurposed and changed as part of the rebuild. We would ultimately be aiming to have this ED short-stay unit in as a function. Then, finally, with COVID having occurred, we're very aware that there are times when we need to manage potentially infectious patients in a way that's separated from the rest of the non-infectious patients. So, the way this is being structured, having the capacity to have an entrance, even though we won't be using it normally, through a different way into that area, we will be able to provide emergency care to a separated group of infectious patients if required in the future. So, it's future-proofing for future pandemics as well.

***Ms ALLEN -** If I may just add, this also is an area for our model of care as a short-stay unit, which is an important part of the ED care, patients who require more than four hours of care but less than 24. It gives us an opportunity to observe patients, to … provide them with that higher management of care and then stabilise them for discharge within the 24-hour period. There's a lot of multidisciplinary care that happens in that environment - allied health, nursing, medical support staff. So, it would be great to have a purpose-built area because currently that is in an environment that was originally designed as a medical ward.*

Growth in Emergency Department Demand

4.3 The current ED provides 64 treatment points, and is experiencing many issues with patient flow, resulting from an increase in demand for ED services. These issues include:

- *Prolonged waiting for ambulances to offload patients to the ED at peak periods of demand (i.e. ambulance 'ramping').*
- *Prolonged waiting periods in the single RHH ED waiting room, with mixed cohorts of patients (paediatric, adult, mental health, correctional) sharing the same waiting room.*
- *Prolonged waiting periods for inpatient beds.*
- *Slow throughput of patients through the ED.*[3]

[3] *Emergency Department Expansion, Royal Hobart Hospital*, submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022, p. 4.

4.4 The Committee noted the current growth in demand for ED services had not been expected when the existing ED was completed. The Committee sought to understand what had led to this unexpected growth in demand:

> ***Mr ELLIS*** *- ...we've got the current Emergency Department completed in 2011, 45 000 presentations. What additional capacity was put in when that was first built? I mean, we are looking at less than 10 years later and we have had basically near on 50 per cent increase over the top. Did we build it basically to the current demand, or did we build it with additional capacity that then just caught up with the trend?*
>
> ***Dr HUCKERBY -*** *None of us were actually involved in that initial planning but just talking back to the time, there was firstly a hope that Emergency Department attendances would not go up. There was a very strong belief that community services would be able to divert people from Emergency Departments. But that hasn't held up anywhere. That's worldwide. That was an opinion back in those times so they did not anticipate needing to grow in the way that we have.*
>
> *Then, I don't think anyone really expected that our population has become so much more frail and co-morbid, and needing much more hospital-level care for periods of time. So each individual person is needing more presentations to an Emergency Department than we would have thought back 11 years ago. The success we have in managing people with chronic illness and the elderly in their own homes is countered by them being much more frail and likely to need intensive input for a period of time before they can go back.*
>
> ***Mr ELLIS*** *- When we were trying to pick the trend in building the facility in 2011, we assumed no growth because it would be out in the community, and what we have actually seen, particularly in ageing western societies, is the opposite - we've actually had more growth than we had previously.*
>
> ***Dr HUCKERBY -*** *That is correct, yes.*
>
> ***CHAIR*** *- Supplementary on that, is there any correlation with the level of, say, GP services that are out there in the community in any way shape or form?*
>
> ***Dr HUCKERBY -*** *Yes. There is definitely a correlation but it is not the direct correlation where people think that people come to an Emergency Department with a GP problem. Most people don't. What happens is that if you cannot get into your GP as regularly - so you should be seeing them monthly and you are only seeing them every two months - you are much more likely to get sick and need to go to a hospital for hospital-level care than if you can actually maintain the normal amount of access to GPs.*

Model of Care for the Emergency Department

4.5 The development and design of the SSU has been guided by the Model of Care adopted for the overall ED expansion (Phase 1 and Phase 2). The Model of Care summarises the ways the ED will provide patient care across the different ED treatment streams to meet the projected increase in demand for ED services.

4.6 The Model of Care details 118 points of care (treatment points or, in effect, beds) for the ED post completion of the overall ED Expansion, which will be configured across the different ED treatment streams as shown in the table below:

Zone	Treatment points
Resuscitation zone	6 treatment points
Acute care zone	54 treatment points
Lower acuity mental health	2 treatment points
Lower acuity adult	18 treatment points
Paediatric	10 treatment points
Short stay unit	28 treatment points
TOTAL	**118 treatment points**

[4]

4.7 It is anticipated this Model of Care, and the 118 treatment points provided within it, will have a positive impact on the patient flow issues described in Section 4.3 above.

Patient Flow - Ambulance Ramping

4.8 The Committee sought to understand how the ED SSU might help to reduce ambulance ramping:

> ***Ms RATTRAY*** *- …In regard to your reference to the significant challenges with ambulance ramping, which we regularly hear about in the community: this proposed change is going to somewhat address that. Would it be fair to say that we'll never be able to address something like that fully or know if we can? Is this just part of that journey?*
>
> ***Dr HUCKERBY*** *- Yes. I think this is optimising the capacity to reduce ramping. Ramping is a funny term because ramping is really not in a ramp. It's in an area - a corridor or in a clinical space - where they are all co-located but they are still under the care of the paramedics. Where it's appropriate, we pull patients directly from there to the short-stay unit without going through the main Emergency Department. So, if we have a patient that an Ambulance brings in and they say, 'This is someone who's had a collapse', we have a quick look and say, 'Yes, the patient's probably going to need a little bit of care; some fluids and stuff like that'. But they don't need to be in the busy, noisy Emergency Department and we pull them directly to short stay from that area. It definitely helps with ramping and it's a great model for that.*
>
> *Ramping overall is something that has not been successfully eradicated anywhere but what you want to do is to not have it every day and for long periods. You know that for 15 per cent of the time you might have a small amount of ramping; if you have a purpose-built area that is the right size but you don't want to be ramping every day this will help.*
>
> ***CHAIR*** *- So it's the exception rather than the rule.*
>
> ***Dr HUCKERBY*** *- Yes.*

Patient Flow - Access Block

4.9 The Committee also sought to understand what impact the ED SSU may have on improving access to and reducing waiting times for ED patients requiring an inpatient bed:

> ***CHAIR*** *- …Clearly, bed block is something that causes concern and stops people from being able to be moved from emergency out into wards and the like. Can you explain how this won't make matters worse? How will it improve that circumstance, as far as the operation of the hospital is concerned?*
>
> ***Dr HUCKERBY*** *- By expanding our current 16-bed short stay area to a 28-bed area we're also implementing an expanded model of care. There will be patients who will be cared for in this area when it's created who are currently unable to be cared for in that area. That will lead to some patients having their whole care in the Emergency Department, normally, but a*

[4] *Emergency Department Expansion, Royal Hobart Hospital*, submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022, p. 4.

significant number of those patients are going to be patients who normally get admitted to a multi-day ward admission who will come into this area instead.

An ED short-stay unit has a very different medical model of care than an in-patient unit and is staffed to do so. Basically, there are multiple ward rounds during a day. There are consultants rostered in that area from 8 a.m. to 11 p.m., plus senior medical registrars and other staff who are able to make decisions immediately so that when a patient is ready to go home they can be discharged, whereas in the rest of the hospital a lot of ward rounds don't have the staffing that goes for those extended periods of time. It's a high-intensity area and that helps with flow.

Current Emergency Department Short Stay Demand

4.10 The Committee sought an understanding of the current level of demand for ED short stay beds:

***Ms BUTLER** - Do you know what the current numbers of people admitted to the short-stay unit are and what they have been over the last 12 months and maybe the 12 months before that?*

***Dr HUCKERBY -** If we take into account that there's been a lot of changes backwards and forwards with COVID-19, because we've had a 10-bed unit then we've had a 16-bed unit with all of that. But when we went to 16 beds this last time, we were seeing between 28 and 35 patients a day through the 16-bed unit. There were times when we would get up to 40 patients a day through that area. It depends on the patients that are suitable to go down there, whether they end up being short, short-stay patients or longer short-stay patients.*

***Ms BUTLER** - It will certainly be utilised.*

***Dr HUCKERBY -** Oh it's very well utilised, yes.*

Providing Pandemic Response Capacity

4.11 The Department's submission highlighted how the ED SSU had been designed with the functionality to also provide a pandemic response capability if required:

…Additionally, this unit will be able to perform as a pandemic response area.[5]

…COVID-19 has had a significant and profound effect on both the Health system and the people of Tasmania. The Phase 1 component of the project, Lower Ground H Block … has been identified as an area of the hospital that will be able to be quickly adapted in the future to address any new pandemic situations. The new Short Stay Unit will be established and engineered to be self-sufficient with external access as well as fast access to the ICU. A 'negative air flow' environment will facilitate dealing with airborne viruses and provide a value for money design for 28 Points of Care.[6]

…Since the beginning of the COVID-19 pandemic, it has become apparent that infection control needs to be a key feature of our society moving forward.

…The new Short Stay Unit has been designed with infection control at the forefront including the following features:

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[5] *Emergency Department Expansion, Royal Hobart Hospital*, submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022, p. 3.

[6] *Ibid*, p. 4.

- *The ability to physically separate the SSU from the rest of the hospital for pandemic preparedness.*
- *The site planning of the new SSU has allowed for a separate entry / exit from the rest of the hospital.*
- *Increased number of handwashing stations throughout the unit with Personal Protective Equipment (PPE) available at all stations.*
- *Creating Enclosed Patient Bays with motion sensor operated sliding glass doors to avoid the need to touch surfaces.*
- *Creating a negative flow of air in the patient bays to keep any potential airborne pathogens within the bay.*
- *Flooring materials have been chosen to be anti-viral to ISO 22196 and anti-bacterial to ISO 21702.*[7]

4.12 The Committee asked the witnesses to expand on the nature of the ED SSU's pandemic response functionality:

> ***CHAIR*** *- … We touched on COVID-19 and the way that was going to be handled. You might like to explain isolation arrangements and those sorts of things.*
>
> ***Dr HUCKERBY*** *- We've created a pod of 28 beds that have a negative flow of ventilation that is separate from the rest of the hospital, and will allow people to be in that whole area without spreading infection to the rest of the hospital. It has the capacity to have its own entrance if required. It also has direct access to ICU and Radiology because there is a lift at the back that goes directly out.*
>
> ***CHAIR*** *- ICU is very close to that, isn't it?*
>
> ***Dr HUCKERBY*** *- Yes; but without even having to go through the rest of the Emergency Department. It is a really good spot if you want to have a pandemic-related area.*

Paediatric Patients

4.13 The Committee recognises it is not ideal to have paediatric patients mixing with other patient cohorts in an ED. The Committee sought to understand if and how this issue was being dealt with. The witnesses noted the Phase 1 ED Expansion will include a 4-bed paediatric section in the SSU. However, the ultimate aim in the overall ED Expansion was to provide a separate ED treatment area for paediatric patients, including a specific paediatric SSU, with the added advantage of the initial 4 paediatric ED SSU bed allocation becoming available for adult patients:

> ***Ms BUTLER*** *- You were saying this morning that some of the existing materials in the existing paediatrics area will be moved into that paediatric section. Can you run through that for us?*
>
> ***Dr HUCKERBY*** *- When we first open the 28-bed area we will include a paediatrics section but when we do the full rebuild, the paediatric short-stay component will go into the paediatric precinct. That would future proof then to have another four adult spaces at that point. With the ultimate rebuild, the idea is to have the paediatric patient cohort visually and auditorily separate from adults for the whole patient journey through the Emergency Department.*

Bariatric Patients

[7] *Emergency Department Expansion, Royal Hobart Hospital*, submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022, p. 9.

4.14 The Committee sought to understand the number of bariatric patients the ED SSU would be able to accommodate. The witnesses noted the design includes one specific S-Class bariatric patient room, with additional capacity to cater for bariatric patients who are more mobile in the two other S-Class rooms if necessary:

> ***CHAIR*** *- … Bariatric patients - how many of those can you deal with? What's the capacity in relation to these emergency pods?*
>
> ***Dr HUCKERBY*** *- There's one specific bariatric bay which is very purpose built and able to accommodate not the highest level of bariatrics but it is the next highest up; this is my non-technical understanding of the architecture. We will be able to accommodate at least one bariatric patient in a bariatric specific room.*
>
> ***CHAIR*** *- That should suffice, in your experience?*
>
> ***Dr HUCKERBY*** *- It should, because the model of care is a short stay unit. It's more likely that a bariatric patient will need a multiple day stay, and we need to be able to accommodate some, but it is not going to be a big area for us as far as volume of patients going through.*
>
> ***CHAIR*** *- Compared to the total?*
>
> ***Dr HUCKERBY*** *- Yes.*
>
> ***Ms ALLEN*** *- If I may add, those S class rooms can also be utilised because generally people are mobile in short stay so if they're able to mobilise but you need a larger bed, for instance, the larger rooms such as the S class rooms there are large enough to fit a bariatric-sized bed.*
>
> ***Ms BUTLER*** *- Are there also allowances made for larger patients who may need hoist systems? Are those facilities available within that?*
>
> ***Dr HUCKERBY*** *- In the bariatric room there is the overhead hoist and everything.*
>
> ***Ms ALLEN*** *- Double tracks.*
>
> ***Dr HUCKERBY*** *- The bariatric room is fully kitted out with all the support structures in place to support manual handling for those patients.*

Storage Spaces for Equipment and Medication

4.15 The Committee noted the ad hoc nature of equipment storage throughout certain areas of the RHH. The Committee recognised that providing adequate and appropriate storage facilities for equipment and medication was a very important element that should be addressed in any redevelopment. The Committee sought an assurance that the prosed design of the ED SSU would include sufficient and appropriate storage spaces:

> ***Ms RATTRAY*** *- One of the areas that has been of interest right through this redevelopment that I've been involved in is about the equipment storage areas and medication and the general equipment. When we go to visit they are usually lined up against the hallway which is not very efficient. It doesn't look all that neat and tidy either. Assure me and the Committee - I am sure they're interested - that we have enough storage area for those items that are really important but seem to be sitting in hallways as we speak now.*
>
> ***Dr HUCKERBY*** *- With this Short Stay Unit, it has the best medication room that I will have ever worked in so, from that perspective, that's fantastic. The consumables storage area is really good from a size perspective and we have identified specific bays for drip stands and pumps and ultrasounds and wheelchairs.*
>
> ***Ms RATTRAY*** *- Trolleys?*
>
> ***Dr HUCKERBY*** *- It won't have trolleys, extra trolleys, in the short stay part. The trolleys will be in the bed spaces so it's the next part of the build where we've got to make sure that we have*

enough space for the trolleys, for everything else to be able to be stored without it being in the corridors. We agree: it should not be in corridors.

Acoustic Controls to Limit Noise

4.16 Noting that EDs can often be a noisy environment, which may not be conducive to a patient's treatment and recovery, the Committee sought further information on the measures employed to minimise noise carriage. The witnesses noted the capacity to dampen noise was limited by the requirement to use specific materials for sanitation purposes:

> ***Ms BUTLER*** *- What kind of acoustics and noise absorption will you have in place for that space at this stage?*
>
> ***Mr NOVAKOVIC*** *- I guess we are limited for absorption in materials for cleanliness and being able to clean those materials. Anything that absorbs sound also absorbs germs and blood and all that kind of thing. We are a little bit limited in that sense but we can do things in the ceiling for example and things like that, but there is a certain set of materials that we can use.*
>
> ***Ms BUTLER*** *- …There's floor coverings and ceiling coverings. What kind of materials would they be? You would hate to have this beautiful facility and it being very noisy.*
>
> ***Mr NOVAKOVIC*** *- I guess it would be vinyl flooring. We would have plasterboard set ceilings so there is acoustic treatment that can be done with that but the walls would be a vinyl sort of finish. I guess that really helps with the cleaning of that material and being able to wash that down. Once again, having something absorbent is not really ideal in this sort of situation.*
>
> ***Ms BUTLER*** *- But it certainly will be part of the actual design and build?*
>
> ***Mr NOVAKOVIC*** *- Yes, that's right.*
>
> ***…*** *there are enclosed areas as well that do provide acoustic privacy. Some of those enclosed patient bays would be good for them.*
>
> ***Ms BUTLER*** *- So, the glass doors would provide that assistance as well?*
>
> ***Mr NOVAKOVIC*** *- Yes.*

Project Timeline and Staging of the Works

4.17 Given its critical nature, the ED will need to continue to function on an uninterrupted basis during construction. Furthermore, the appropriate staging and timely completion of the works is crucial to the overall ED Expansion. The Department's submission makes these points clearly:

> *The RHH ED needs to continue to function during the build process. The greatest risk to patient safety is disruption to resuscitation and acute care areas. Neither area can have any down-time. The completion of this Phase 1 of the Short Stay Unit in LG H Block will facilitate the capacity required to complete the major component of the ED Expansion in Phase 2 of the project.*[8]
>
> *The RHH ED needs to continue to function during the demolition and construction process, therefore the staging of works is important for an efficient build. There are existing services serving other parts of the hospital that run through the proposed SSU space which will need to be kept operational.*[9]

[8] *Emergency Department Expansion, Royal Hobart Hospital*, submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022, p. 4.
[9] *Ibid,* page 10.

4.18 The Department's submission also summarises the staging plan for the ED Expansion Phase 1 works:

> *Below is a brief outline of the proposed staging of the project.*
>
> ***STAGE 1***
>
> - *Construct hoarding and airlocks to construction site to prevent dust in other hospital areas*
> - *Retain and protect existing Switch Room and electrical distribution boards to provide power for demolition*
> - *Demolish existing partitions, ceilings and fixtures*
> - *Demolish mechanical, hydraulic and electrical services to boundary of proposed SSU or isolation valve*
> - *Retain hospital fire escape to Argyle Street*
> - *Maintain access to existing lift lobbies*
> - *Maintain access to existing ambulance bays*
>
> ***STAGE 2***
>
> - *Construct temporary electrical distribution board to supply site facilities. Switch power supply to temporary board.*
> - *Construct new fire exit door to Argyle Street*
>
> ***STAGE 3***
>
> - *Construct new works*
> - *Retain access to new fire escape path from rest of hospital*
> - *Commission new services to SSU*[10]

4.19 Noting, the relatively short timeframe for completion and commencement of the new ED SSU, the Committee sought the witnesses views on whether this was achievable:

> ***Ms BUTLER*** *- Do you think, just for the record, that the commencement of operations - December 2022 - is a reliable date?*
>
> ***Mr LEIS*** *- It's ambitious, yes. It's on track at the moment. We're hitting all of our markers.*

Project Budget Contingency

4.20 The Committee noted the project budget included a contingency of 15% on construction costs. The Committee sought an explanation from the witnesses on the factors that had impacted the size of the contingency:

> ***CHAIR*** *- … Most often you get 10 per cent contingency but more often than not we are seeing escalations in materials costs over the life of the project, and it may well be 20 per cent. Is that material cost elevation sitting in the contingency there, or where is that? It seems to me that there is only one - either that or it is in the construction cost.*
>
> ***Mr LEIS*** *- We have allowed for that within the contingency at this stage, so the current amount allowed by the quantity surveyor is 12.5 per cent. That's once all the construction costs are*

[10] *Emergency Department Expansion, Royal Hobart Hospital*, submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022, p. 10.

done. We have added a little more to this one because we are seeing those material costs and building costs as high as 20 per cent above what is traditionally regarded, so 15 per cent is what we have here. We are hopeful we can still land it within that. The construction costs are generous as well, being in a working hospital environment.

***CHAIR** - That quantity surveyor allowance, 12.5 per cent, or the cap, is that something that is driven by government?*

***Mr HARGRAVE** - Not that I'm aware. It is more their understanding of the market and the volatility that exists in the market at the time that they undertake the estimating. … It is really their projection or best estimate about the market conditions and volatility, or lack thereof. At the moment, certainly, there is volatility in the market.*

Does the Project Meet Identified Needs and Provide Value for Money?

4.21 In assessing any proposed public work, the Committee seeks assurance that each project is a prudent use of public funds, is necessary and meets identified needs, and provides public value. The Committee questioned Mr Hargrave who confirmed that the project met these parameters:

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

***Mr HARGRAVE** - Yes, it does.*

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

***Mr HARGRAVE** - Yes, it is.*

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

***Mr HARGRAVE** - Yes.*

***CHAIR** - Do the proposed works provide value for money?*

***Mr HARGRAVE** - Yes, we believe it does.*

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

***Mr HARGRAVE** - Again, yes, we believe it is a good use of public funds.*

5 DOCUMENTS TAKEN INTO EVIDENCE

5.1 The following documents were taken into evidence and considered by the Committee:

- *Emergency Department Expansion, Royal Hobart Hospital*, Submission to the Parliamentary Standing Committee on Public Works, Department of Health, 2 February 2022.

6 CONCLUSION AND RECOMMENDATION

6.1 The Committee is satisfied the need for the proposed works has been established. Once completed, the Royal Hobart Hospital Emergency Department Expansion Phase 1 will provide a purpose-built Short Stay Unit to assist in alleviating the growing pressure on the Emergency Department due to increasing patient demand for ED services.

6.2 The proposed works will provide a 28-bed Short Stay Unit to accommodate Emergency Department patients requiring ongoing observation, specialist assessment and diagnostics, and where a patient's length of stay is determined to be less than 24 hours. The Short Stay Unit will also have the capacity to operate as a pandemic response area should the need arise. Importantly, the construction of the Short Stay Unit will enable the Emergency Department, especially the resuscitation and acute care areas, to continue without disruption, and will also facilitate the capacity required to complete Phase 2 of the Emergency Department Expansion project.

6.3 Accordingly, the Committee recommends the Royal Hobart Hospital Emergency Department Expansion Stage 1, at an estimated cost of $13,959,777, in accordance with the documentation submitted.

Parliament House
Hobart
2 March 2022

Hon Rob Valentine MLC
Chair