UNEDITED TRANSCRIPT

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT THE GRANGE, CAMPBELL TOWN ON MONDAY 10 DECEMBER 2001.

CAMPBELL TOWN HOSPITAL REDEVELOPMENT

Ms ANNE BATES, MANAGER, CAMPBELL TOWN HEALTH AND COMMUNITY SERVICE; **Mr GRAEME McGEE**, BUSINESS SUPPORT COORDINATOR; **Mr RALF ZENKE**, SENIOR PROJECT MANAGER CAPITAL WORKS; **Mr PAUL GILBY**, ARCHITECT AND **Mr NOEL VOLLUS**, ARCHITECT; **Mr ROD MELDRUM**, DISTRICT MANAGER; AND **Ms MARY BENT**, DIRECTOR, COMMUNITY AND RURAL HEALTH WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Wing) - We welcome everyone to the hearing. Ms Bent, would you like to lead the presentation?

Ms BENT - Mr Chairman, we are here today to consider the submission to your committee for the redevelopment of the Campbell Town Hospital into a new facility and a new service model called the 'Campbell Town Multipurpose Service'.

The multipurpose service program is a joint State and Commonwealth program which is designed to improve services for rural communities, particularly rural communities with a population under 5 000. It is particularly targeted at developing integrated and flexible services based on local needs. It has been found in the past that small communities which had hospitals based on models of hospitals in the early twentieth century found it very difficult to retain sustainability and viability as rural populations decreased and as the ageing population increased. What the MPS provides us with is the opportunity to change the way that these old facilities work to make them more appropriate to contemporary needs and to foster their viability by us being able to pool funding from a range of funding sources, including the Commonwealth and the State, to ensure that they have the flexibility to meet local needs.

The key principles of the service model are community involvement, and in Campbell Town we have been actively involved in the community since about 1998 on this proposal; services based on needs, and again in Campbell Town there has been a significant need for assessment undertaken in terms of looking at the community's health and community's services type needs. That feeds into the development of the MPS, but of course also into the development of the new facility. We have a focus on high-quality services and that is particularly important in aged care where, as I am sure you are aware, the Commonwealth quality standards is now very rigorously applied and can affect capability of receiving funding. At the moment the old facility does not meet any of the standards in terms of service model, in terms of privacy and dignity for the clients, nor does it meet the accreditation and certification requirements in relation to the building fabric.

Another element of the multipurpose service program is that it needs to focus on delivering coordinated care, which means that the design of the services and of the

facilities need to be such that people can work together to service the best needs of individuals and that there needs to be a case management or coordination facility within the service. The teamwork and multiskilling aspect is absolutely critical in terms of being able to deliver both of those aspects about quality and coordination. Again, that is fostered and can be helped along by the design of the building. This is the sort of briefing that we gave to our architects when we commenced this process.

The existing facility was originally designed as a school and added to over the years and it is manifestly not suitable for the purpose that it is being used for at the moment. Services are spread amongst different buildings, so access is difficult for clients and communication is difficult for staff and it is certainly considered unsuitable in terms of the contemporary residential aged care. So we sought to provide a challenge to our architects to design a facility that facilitates community access and involvement. We are very concerned that the community and health services buildings within a community act as a community centre as well, that we can facilitate after-hours meetings and involvement of the community and use by the community of the building. It needs to encourage services to work together to provide coordinated care and it needs to provide the quality environment that is necessary for residential aged care.

We also needed to function within the constraints of the existing site and the fact that we had a heritage building on site; that it was flexible enough to meet future needs because we are aware that, while the Commonwealth aged care program has certain standards that they require to be met by 2003, the goalpost moves again in 2008, so we needed to make sure that what we are building now will meet those standards as well and that we are able to use the new technologies that are available in Health at the moment, particularly telehealth.

CHAIR - What was the significance of 2008?

Ms BENT - The Commonwealth, in terms of the aged care residential program, has set some standards for 2003 in terms of safety of buildings and the quality in terms of privacy for residents. They become much more stringent in 2008, so some of the things that we are able to do now we can't do after 2008.

CHAIR - So are you going to do them now or are you going to comply with what will be the requirements in 2008?

Ms BENT - Yes. It is primarily around the number of people in rooms, access to en suites and access to private areas in terms of sitting rooms and those sorts of things.

We sought to have a new facility which would provide an accessible and purpose-built environment for the provision of a wide range of services, recognising as we do that the Department of Health and Human Services is not just a health service but it provides a wide range of community-based services and community welfare-type services as well. So we needed to make provision for those sort of needs as well as for the traditional health needs. Again, high-quality environment for residential aged care - absolutely critical. The other benefit is that by developing a multipurpose service model within the Campbell Town area, we have been able to attract from the Commonwealth an extra $600 00 in recurrent funding, which has meant that we will be able to expand the service system in the Campbell Town area out across the Fingal Valley. That is something that

is obviously very beneficial to the community. I have to say that with each multipurpose service that we develop, the potential is there to attract Commonwealth funds. It depends upon the gap between what is the existing number of aged-care beds in the community and what's judged by the Commonwealth appropriate. Campbell Town was particularly low and so we have been able to make this fairly significant windfall in this regard.

CHAIR - It is interesting that, despite that quite wide area, the population is surprisingly low, isn't it?

Ms BENT - Yes, that is right. That is the issue around all these small local communities, that the services without this sort of model - that means that we can use the beds and the staff flexibly with the minimum of bureaucratic overlay so that we don't have to report, for example, to the Commonwealth on the use of every bed, as we would if we were a nursing home. we can make the small rural community services much more viable.

CHAIR - And it is very important to have them available in the communities where people have been accustomed to living. I have always supported that.

Ms BENT - Yes, in terms of maintaining the social fabric of communities it is absolutely critical that the aged-care residential services stay as close as possible to the community.

CHAIR - And also to reduce the trauma of people having to leave their homes and not having to leave their areas to which they are accustomed.

Ms BENT - We believe that this is a very exciting development. It is one that we have been looking forward to in terms of providing a substantial increase in the quality of the building and the services that we can provide to the older population of this area in particular.

CHAIR - Similar to the one at Beaconsfield, is it? The design is different but -

Ms BENT - The design if very different. Beaconsfield was the first multipurpose service and we have learnt a lot from that development. This one, I think, will take us the next step. One of the things that we learnt in Beaconsfield that we have applied here is the need to have a very strong community partnership group with very active involvement from the community. Beaconsfield has struggled a little bit in that regard. They're doing a lot more now than they were but Campbell Town has been very strong with regards to that ever since we've started planning so there is a lot of community support and community interest.

Now it is time for me to stop talking. You've met Paul Gilby, have you?

CHAIR - Yes, we have previously. We will just take the preliminary at this stage, Mr Gilby - information that will help us understand the inspection more and make that more meaningful and then we will come back and take detailed evidence.

Mr GILBY - It helps to see the plan as we talk about this - and it will be brief. First of all, there is the connection to the township. Whereas the current hospital is accessed off Church Street, we will now have an access off High Street, which will be one-way

through to Bridge Street with an oval turning circle that brings you into the heart of the new complex. The current entry off Church Street will be used as a service road for access to the kitchen and also dropping people off at the multipurpose centre. The new facility is getting an identity and a connection to the main street of Campbell Town.

The heritage fabric, the fabulous old hospital, which we have a heritage report on, is a significant building. It has a number of additions that are unsympathetic - you can see one on the right-hand side there; those are being removed. Then there is a minimal glazed connection that connects this heritage building back to the Webster and the new development. This means that the heritage building will stand on its own and the value of the old fabric will be enhanced. We are integrating the new and the existing - the two existing buildings that are being retained here; the new development all on one level to form one whole development with a central core activity entry area with branches off it, as you see.

The residential acute care is a 22-bed residential four-bed acute care. All the rooms are identical; individual rooms with en suite, however acute care are likely to take the first few rooms close to the nurse station, which is located right at the apex of the new development. We have two wings, 12-bed, 14-bed, and each wing ends in a small house-like group of units around a sitting space; appropriate staff, administration right in the middle; accident and emergency coming off the entry road, which is close to the nurse station and close to the GP consulting rooms and close to the entry that is close to the kitchen/dining/lounge for the residents and staff facilities, that is the staff room, is centrally located for use by all the disciplines which allows case mix enhancement in that different staff meet at one staff point in the middle where they are able to give better in terms of discussions on individual residents or people.

Shared consulting spaces: we have a number of consulting spaces. Some are specific to one person where they have a full-time position but there are a number of allied services where they are on a one day a week or two day a week basis and so where possible we have spaces designed such that they can be shared. There are a range of meeting spaces. Just to come back on that, the residential wings connect to the centre. We then have the allied health services, which are dental, podiatry, physiotherapy, social work, drug and alcohol - all of those things in this area - and in the Webster wing we have such thing as family and child care and community services and they have off it a large meeting room which is able to be used after hours. It can be accessed directly by vehicle and that large meeting room also has a couple of small meeting rooms with it - just to give you a feel for the place. The old nurses home is an L-shaped building. The north wing comes off and the south part is retained as is. It has some nurse accommodation in it.

CHAIR - I can't recall seeing anything in the submission about the dimensions of the individual rooms for the residents. You may have overlooked that but, in any event, could you tell us what the dimensions are?

Mr GILBY - Yes, I can.

CHAIR - There is a ceiling height given but I can't recall reading about the room dimensions.

Mr GILBY - The main room is four metres by four metres - 16 square metres. There is then that small part of the room that goes up to the doors in each case with the ensuite in one corner.

CHAIR - So the ensuite is extra to the 16 square metres.

Mr GILBY - Yes, is extra to the 16 square metres, so the rooms overall would be 18 square metres plus the ensuite and the en suites are five square metres.

CHAIR - Yes, that's good, thank you.

Ms BENT - One of the issues, Mr Wing, as I'm sure you are aware, is that now with people being much more dependent when they move into nursing homes, the use of equipment is necessary for their care - wheelchairs and other assistance - so rooms needs to be large enough to be able to accommodate those sorts of demands. It's a very different situation than it was a decade or so ago where people were much more mobile when they entered nursing homes. It is interesting to note that Mr Gilby and his associates have been involved in the development of the nursing home Eldercare in the Huon Valley and there they have set up a model room - they're in the process of doing it now - so that people can test it out and staff can go in and say, 'We need to have it here or there' and we'll have access to learning from that testing in Eldercare as we design these rooms.

CHAIR - Thank you. Any questions before we break to have the inspection. That is all the preliminary and, Ms Bent, thank you very much for that. That is really interesting and we'll now break and have the inspection and then resume later.

Site Inspection

CHAIR - We shall resume the hearing. Ms Bent, Mr Gilby and ladies and gentlemen, thank you very much for the inspection which has been very interesting, helpful and understanding to what is proposed. The submission is a very good submission but the only thing is that it's on the wrong sized paper. We are trying to have a word to all departments that these are a very cumbersome sized documents and we have asked that submissions be on A4 and with plans folded over - I think Mr Donnelly is sending a circular out to each department.

Ms BENT - Our apologies.

CHAIR - No, you did not know that. We do like to have A4, but it is a very good submission and we thank you for that and a good project. I don't foresee any difficulties with it and I don't think my colleagues do, so I just mention that at this stage. Who would like to speak next?

Mr GILBY - Do you want me to run into more detail?

CHAIR - You don't need to go into a lot of detail. We have read the submissions and we're aware of them and you've given us a good outline, but any other points that you'd like to add additional to what you have told us.

Mr GILBY - We are meeting aged care requirements of course in the new facility and the very important areas there are the appropriateness of facilities for staff handling, occupational health and safety and residential privacy. Residential privacy means in this case they have their own room. At the most you can have two to a room for some rooms but in this case they all have their own room. This also allows each room to be used either for residential or the acute care so there is that flexibility by the rooms all being generally the same matrix. Because they have their own en suite there is that privacy of facilities. The en suites are capable of taking the equipment that is generally needed in these types of facilities now and, in particular, we have the en suites with the door on the diagonal corner. When that door is open it means that it gives more room to the en suite itself for moving equipment and because the door is on the corner, it's easier to bring equipment in the door to the bedroom and through into the en suite. So access to the en suite from the passage and from the resident's bed is easier with the door on the corner. So that is the model we have chosen here.

I have already mentioned how the residential fits with the accident and emergency but this is an example of where we are doubling because the accident and emergency is also the treatment room for the residential care. So instead of having one facility for residents and another facility for the community, we have one facility and it is maximising use. Likewise, we have the residents have their own sitting areas up at the ends of the resident wings but we have the dining/lounge facilities that come off the main entrance way where there's that flexibility of use that they can be used both with the residential care and they could be used for functions within the community itself within the whole facility. So that degree of overlap is important here as we're trying to give a lot of flexibility to the way spaces can be used.

CHAIR - The original building was constructed in 1880, is that right?

Mr GILBY - Thereabouts - 1888, I think.

CHAIR - We had that discussions because somebody said it was 1888 and I said I thought it was 1880 and I just noticed in the submission on page 5 it says it was constructed in 1880 as a district school.

Mr GILBY - There might be a typo there.

CHAIR - Yes.

Mr McGEE - The stone building was first occupied on Christmas Day 1888, so it would have started in whatever year in the 1880s.

Mr GILBY - We have got a heritage impact analysis that has been done on that building and of course that has picked up on the significance of the old sandstone fabric that you saw over there and the inappropriateness of the extensions that lie to either side which we are removing.

CHAIR - Yes. You did estimate that you wished to have an extra $330 000 to complete the project as desired. There will be $250 000 extra made available and you are able to absorb the difference of $80 000 by reducing the original cost. What changes will be made for that reduction of $80 000? How are you able to save that?

Mr GILBY - We are minimising changes to the heritage building and the Wesbter wing. That is not totally inappropriate in that both are going to be used for services that need office and consulting-type spaces. We are going out of our way not to pull those walls apart in any way so where a space might be a little large or a little small for its activity, we are accepting that that has to be that way. The community is getting a number of spaces that are near appropriate and they use them the way they are now, the way you saw when you walked through, so we are minimising work to those.

Mr MELDRUM - If I could just add to that as well. We are very fortunate at Campbell Town to have a qualified builder/handyman on the staff and for areas like the old nursing home we do have some capacity to continue to upgrade them following the redevelopment and I would assume we could do the same in the Webster wing; if there are any minor internal modifications that were required we could do them inhouse.

CHAIR - Did we see that builder downstairs at the hall?

Mr McGEE - No.

Mr MELDRUM - The builder was putting a desk together in the CNC room.

Ms BENT - It was obviously important, Mr Wing, that any alterations we made to the project plan had the least impact on the clients and patients and that was one of our guiding principles, so that their rooms and their facilities and the clinical facilities are maintained at the appropriate quality. I guess what we are saying is that, as with many other projects, we use the facilities we have and we make the best of them we can within the available resources.

Mr GILBY - I also should point out that there is a phasing to this because the residents who are currently over the road stay there during the construction phase and we do have the construction phase organised in a phased development that will allow the new structure to be completed to the point where residents can occupy that, then we go into the Webster wing and that gets brought up to standard for the community consultation and, finally, we go into the heritage building and the doctors surgery rooms that are just adjacent to that and they are the last things to come off. So in stage one we only build half of the oval access road and by phase three we have completed the access road, demolished the rest of the GP consulting rooms. In other words we have a plan for how the development can be staged to allow residents to continue in occupation.

CHAIR - As to the timetable, it says that design development is scheduled for completion in early December, what progress is made there?

Mr GILBY - We're up to the design development stage. We will be doing design development but that is not completed. It will be finished in January and then we'll go into documentation. We still aim to be on target for the March calling of tenders.

CHAIR - We don't have a scale of costs. We have the overall cost, a budget allocation of $3.2 million, but I'm not aware that we have any split-up showing how that is calculated and we usually do.

Mr GILBY - We have got some on file but we need them copied.

CHAIR - Do we have a photostat machine here?

Mr MELDRUM - There's one at the hospital.

CHAIR - 'Artworks allowances' - what does that cover?

Mr GILBY - There is an artwork component of $40 000 -

CHAIR - Provisional sum and art work, yes.

Mr GILBY - Artwork in public places - there's a 2 per cent up to $40 000 - and we are having discussions with an artist currently with the view to having artwork that is sympathetic to and coordinated with the new building, so rather than bring an artist in when the building is three-quartered finished we'd prefer and are aiming for that artwork to be integral with the building and to be very much a part of it. At the moment it's likely to be the reception desk and waiting room, furnishings and even that might extend out to furniture outside on the oval which just develops a stepping stone rapport with the town. So we are using the artwork to become a feature and an integrated part of the new development.

Mr KONS - Just having a look at the documentation, it says that fire sprinkler installation allowances weren't included in that.

Mr GILBY - We're not fire sprinkling the building. Not many hospitals are at the moment and this one is small enough that it meets the BCA in all requirements, including smoke detection, a full detection system through it, but it will not have sprinkler which is a sizeable cost on this. It would be another $100 000.

Ms BENT - And it's not required by the Commonwealth accreditation -

Mr GILBY - It's not required by the Commonwealth accreditation provided it meets all the other BCA guidelines. The building is broken up into fire segments of a sufficient size with the right exits and the right fire detection system.

Mr KONS - Can I also just make a suggestion that as you have the heritage report there that there are some heritage funds available every year. I don't know whether public buildings can access that but there may be an opportunity to chase that up.

Ms BENT - A good point.

Mr MELDRUM - If I can just come back to the significance of the entry access and I guess general community access to the service. Hospitals tend to be places that people only go to when they are sick and they tend to be a little, I suppose, daunting for some community members. This is about transforming the hospital into a multipurpose service with a very strong community feel. So the use of the artworks to enhance the reception area and that large oval garden area is part of that attempt to create a village feel and improve access and user-friendliness for the facility so that it becomes more than a place

that you just visit when you're sick, but is part of the whole-of-life health and wellbeing approach.

CHAIR - Any questions? Thank you very much. I think that is very straightforward and a really good project. Thank you all very much for your help.

THE WITNESSES WITHDREW.