PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT BREAK O'DAY COUNCIL CHAMBERS, ST HELENS ON THURSDAY 11 MAY 2017.

ST HELENS DISTRICT HOSPITAL DEVELOPMENT

Ms SUZANNE ASHLIN, PROJECT MANAGER, ASSET MANAGEMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES; **Mr TONY PURSE**, CONSULTANT ARCHITECT, LOOP ARCHITECTS; **Mr PAUL COCKBURN**, CONSULTANT ARCHITECT, HBV ARCHITECTS; **Ms DENISE CALLISTER**, DIRECTOR OF NURSING, ST HELENS DISTRICT HOSPITAL, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mrs Rylah) - Thank you all for coming along today. A committee hearing is a proceeding in parliament. This means it receives the protection of parliamentary privilege. This is an important legal protection that allows individuals giving evidence to a parliamentary committee to speak with complete freedom without the fear of being sued or questioned in any court or place out of parliament. It applies to ensure parliament receives the very best information when conducting its inquiries. It is important to be aware that this protection is not accorded to you if statements that may be defamatory are repeated or referred to by you outside the confines of the parliamentary proceeding. This is a public hearing, members of the public and journalists may be present. This means your evidence may be reported. Would someone like to make an opening statement?

Ms ASHLIN - The current St Helens District Hospital was built in 1975 and currently provides 10 acute beds with an emergency response capacity, as well as consulting rooms for visiting health services. It serves a catchment population of up to 6500 people, with a high age profile as well as families. In holiday season it has a major influx of well over 15 000 people. The existing hospital was built in a minor depression on the block and is subject to periodic flooding during king tides, which backs up through the town plumbing system into the hospital's bathrooms and causes sewage overflow into the shower bays and basins. The site itself has also been subject to major flooding in the St Helens area. It has been evacuated on numerous occasions, with patients being transferred to other facilities. The current facility suffers from a general lack of space so there is a deficiency there and parking is very limited with only four spots on site.

Following a SERT bid process, which is a state government bid for proposals for government funding, we were successful in receiving money for a new hospital. Through the engagement of architects we did some site analysis. There was an existing site in Tully Street proposed, but council has since purchased a block of land in Annie Street and undertook consultation with the Department of Health about how we might acquire some land and build the hospital on that site. A feasibility study was undertaken to look at that site and determine the capacity and capability of building a hospital on that site. Some issues have been addressed and we have been working with council on that.

The new hospital is a like-for-like for services. It is not an increase in the number of inpatient beds. Over the period of nine months or so we have been undertaking some

stakeholder meetings with the staff and progressing it to the plans you now have which have been part of the submission.

The total project cost is estimated at $12.1 million and funding has been provided in the Tasmanian 2016-17 budget. I believe that the remaining funds are an allocation in the 2017-18 budget, which will allow the project to proceed. Design and tender documents are scheduled for completion in July. We hope to advertise that in July, with construction commencing in November 2017. It is anticipated to be a 12-month construction period, with completion due in December 2018. The people - are they able to make a statement?

CHAIR - Yes. Do members want to ask questions of Suzanne, or would you prefer to hear other opening statements if there are any?

Mr VALENTINE - Listen to the rest.

Mr SHELTON - I am happy to see if there are any more statements.

CHAIR - Does anyone want to make an opening statement?

Mr COCKBURN - I would like to talk about the nature of the arrangement between Tony's firm, Loop Architects, and mine, HBV Architects. We are working as architects in association on this project. We saw that as a valuable way of dealing with this project, given the number of staff members we have currently, and the resources we could put to this project.

CHAIR - You share liability in -

Mr COCKBURN - We have decided not to form a joint venture formally, so the liability goes to Loop Architecture. They are happy to do it that way.

Mr PURSE - HBV are contracted to us.

CHAIR - DHHS is comfortable with that arrangement? Very good.

Mr COCKBURN - We both have pre-qualification to the required level.

CHAIR - I would like to put on the record, before our hearing is over, that we had an excellent visit. Thank you very much, Denise and staff. That was insightful and very helpful in getting an understanding.

Mr SHELTON - First of all, let me point out that as a member of Lyons, I have significant interest in the project. History says that it has been an issue for a number of years, particularly with the flooding and so on. As long as people are aware that as a member you cannot get away from this when you are on a committee. There are certain projects within your electorate that are of great interest. After visiting the hospital and talking to the staff about the issue of flooding we know that council has done significant draining improvements on the main streets, so that is great.

I have two questions. One is to do with the perceived issues of flooding around the hospital now. It was highlighted to us that the hospital level, the ground floor, will be 300 millimetres above ground level, requiring 1.5 metres of fill in the lower area. The cost of that

300 millimetres all over the site has to be considerable. It has obviously been considered necessary by the engineers. Considering the compaction of that whole area, why is it necessary to raise it an extra 300 millimetres? I can appreciate that everyone is very nervous about flooding issues and so on, but in that particular site I would just like an explanation of why the extra 300 millimetres. I will go onto the next question after that.

Mr PURSE - The extra 300 millimetres has been advice from our consultants in order to get the building away from natural ground level. Obviously, that comes with the added work of importing some fill to the lower portions of the site. It was everyone's view that it was an unacceptable risk to excavate the site, given the current circumstances of the existing hospital. The cost of undertaking those works has been incorporated within our budgets from day one. The cost of importing some fill to that site would be of far more benefit than the alternative to not getting the building out of the ground.

Mr SHELTON - I presumed that was the answer. The next question that follows on from that is, the floor level is being raised that 300 millimetres and 1.5 metres on the lower end, the actual ground level and the car parking and the tarmac-ing, I presume will not be? They will follow ground level?

Mr PURSE - With the exception of portions of that lower corner, to accommodate our overland flow paths. Natural run-off still has the ability to flow away from the site, to the lower point.

Mr VALENTINE - To follow on from that, is the soil type very porous, or is it likely that large rain events would cause a significant surface flow?

Mr PURSE - Given the amount of sealed surface on that site, overland flow paths are a fairly significant aspect of that design, which our engineers have undertaken. The actual amount of porous run-off surface is limited.

Mr VALENTINE - Thank you.

CHAIR - How are you dealing with that additional flow from the bitumen area?

Mr COCKBURN - That is directed into council stormwater mains in Annie Street. The site is contained in terms of stormwater. It is collected through various bits on-site and discharged into council stormwater mains.

CHAIR - They meet the standards for one in 100 years?

Mr COCKBURN - That is correct. We are looking at upsizing the main stormwater main to deal with the one-in-100-year flood, which is 20 per cent over.

Mr VALENTINE - That is being upgraded did you say?

Mr COCKBURN - Yes. The existing drainage easement that runs through the property is being relocated and upgraded to discharge into Annie Street.

CHAIR - That will be available before the hospital is built?

Mr COCKBURN - That is correct.

CHAIR - Or as it is built?

Mr COCKBURN - It forms part of the contract, yes.

Mr VALENTINE - With respect to that, the council believes that the present stormwater main can cope with that extra run-off successfully? You are upgrading it on site -

Mr COCKBURN - We are upgrading everything.

Mr VALENTINE - Does the main itself have any issues?

Mr PURSE - To clarify, there is only a portion of our site that will be draining into the existing stormwater mains that continues past our property on the internal portion of the property. About 75 per cent of our rainwater run-off will be directed towards a new mains in Annie Street being supplied by council.

Ms ASHLIN - That new mains will be sufficient in capacity to handle that one-in-100-year event. Council has confirmed that.

Mr VALENTINE - That has clarified it, thank you.

CHAIR - I have a question regarding the land ownership. I note that it is recorded in here that it is council land. What is the arrangement with the government building a hospital on the site and council land?

Ms ASHLIN - We are purchasing a portion of land -

CHAIR - Marked on that map?

Ms ASHLIN - Yes. We are purchasing that from the council at an agreed price. It has been valued by the Valuer-General. Council has created a title for that now, within the last week, and we are going through the process at the moment. Council has seen a draft contract of sale and that is now with the Minister for Lands to progress that sale. It has been going through the Crown Solicitor process as well.

CHAIR - What I saw on the plans was an easement that went through the hospital site. What has been done about that easement on this new title?

Ms ASHLIN - The easement will be removed and a new easement will be in place for the adjoining property.

CHAIR - So it will have no impact? There is no infrastructure in that easement?

Ms ASHLIN - No there is not.

CHAIR - Very good.

Mr SHELTON - I congratulate the group and understand that a project control group has been involved right through this. As mentioned this morning, I was a TAFE teacher when we moved from Wellington Street to Allendale and went through that whole process of planning.

It does say in the documentation that the final sign-off is still underway. At the April meeting it was endorsed but you are still working through that sign-off. Any idea when that will happen?

Ms ASHLIN - That is for the room data sheets. To enable the documentation to be prepared for the written request for tender. The plan as it is in the documentation is the final design.

Mr SHELTON - Is the final?

Ms ASHLIN - What we are working through now are the room data sheets in terms of the layout of where things will be and how they will sit.

Mr SHELTON - Of each individual room and how it works, that is the final sign-off for that? It is important, particularly for the people who work there, that it is not only bureaucrats who get involved in these things. You actually take it to the ground level and make sure that everyone is comfortable with what happens in each individual room, and how that connects with the whole thing. There has been significant consultation. I applaud and appreciate the work and effort getting it to this point in time. My question was really around that sign-off and when that was expected, but it is a process that I am sure you are working through.

Ms CALLISTER - Yes. My staff and I have all had ample opportunity to be involved in this whole building project from the beginning. Getting to the sign-off point a number of consultations and forums have been held at the hospital within my staff because we are at the actual operational areas of these rooms now and every little change we come up with goes back and then comes back again. There has been a lot of argy-bargy backward and forwards just getting to the final room data plans. There are only a few minor things like power points or data points in the wrong spot - those types of things. I probably have about six to eight data plans on my computer just at the minute ready to sign off, and the biggest percentage has already been signed off.

CHAIR - What projections have been done - to use a colloquial term - to future-proof the hospital for growth in the population, the changing demographic of the population in this area? It is a relatively isolated area and we need to do it well.

Ms ASHLIN - We have undertaken an exercise to ensure there is sufficient land that, rather than build up, we can built out, if we have to, if we need future flexibility. We asked the architects to look at what we could expand to and there is provision for extra consulting rooms. In the plan you will see there are courtyards and more than adequate parking, according to council requirements. So we could use that area if we need to. Denise alluded earlier that there are currently 10 inpatient beds and her capacity is -

Ms CALLISTER - I run at around 46 to 48 per cent inpatient capacity. Most of our activity is actually in our emergency presentations and treatments. We have also looked at the consult rooms. Each consult room has been set up to be flexible and can either act as a video conference room or any visiting person. The same with if we need more consult rooms, the

activity room has a partition room that can be divided, and a number of the offices can also be flexed up to be a consult room should we need it for any visiting service.

We have made the rooms so that they are flexible. We have a bariatric room, which was mandatory in the standards to be in our plans. That again will be used just as a simple, normal-type room. The same with the palliative care room. That is classed as a bed, so they will be used as normal presentations for inpatients. So whilst we have 10 beds, they are flexed around to be used for all types of presentations we may or may not get. There is one room at this point, consolidated for independent renal dialysis, which has been isolated for that purpose, but should we not have any members in the community who have not been able to do dialysis independently, that room converts to its original state as an inpatient bed.

CHAIR - Regarding the future growth in the community, I imagine the local council has some data on projections on what they are expecting. Has that data been accessed to ensure that this hospital is going to be large enough?

Ms ASHLIN - We have not accessed any information from council. Obviously we have consulted with council on numerous occasions on the plans. They have not raised it as a concern about the capacity or the size. I am happy to undertake that if that is a requirement you want us to consult with council.

CHAIR - I want to be sure that it is fit for purpose and future needs, as we have had submissions concerned about the future capacity of the hospital.

Ms ASHLIN - That is right. The capacity was also raised by the secretary of the Department of Health as well, so again we have had consultations with Denise. Obviously, she has been onsite as the Director of Nursing for a number of years. We believe we have taken that into consideration.

Ms CALLISTER - Considering the way health needs to be going is that they are not necessarily nursed acutely in an inpatient facility. There will be more of a push to push them outside into the community to be treated in their home. We can only predict what the future may or may not be looking like. I envisage 10 beds will be more than ample for our future growth, even if the retiree population that come here are not wanting to be an inpatient but want to be at home. I am comfortable that number of beds is adequate to cope for a very long time.

Ms ASHLIN - And there is sufficient land if we need to redevelop and expand.

CHAIR - Could you explain, on the record, future potential for expansion from the current design?

Mr COCKBURN - From the current design we have allowed a number of spaces to the north of the site. As Sue mentioned earlier to do with expansion, particularly allied health and ward areas, we have identified four additional wards could be installed relatively easily without affecting the existing landscape or car parking. There is scope to grow further if necessary, particularly with allied health. By putting a double corridor in there it would be creating the same number of consult rooms as we have at the moment, so doubling those if necessary.

Mr VALENTINE - Given the problems the current hospital has with elevation, or the lack of, can you give me an exact height above sea level for this facility?

Mr PURSE - We are currently 8.6 metres above sea level in comparison to the existing facility which is in the order of 3.2 metres, so considerably higher.

Mr VALENTINE - The existing facility, with unusually high tides can cause a problem if it is at 3.2 metres. Is that because it backs up through the drainage system rather than inundating the land from the sea?

Mr PURSE - It would be a combination of all those issues.

Mr VALENTINE - So this new site is not going to have any of those issues associated?

Mr PURSE - It would not appear so, no.

Mr VALENTINE - You have a significant number of car parks and you also have external air-conditioning systems and neighbours to the north. Can you explain for the record how you are mitigating against noise intrusion to those suburban areas?

Mr PURSE - With the car park, we are introducing an earth mound along the northern perimeter of the car park and using the car park as a buffer in itself between the residential homes and the facility. The earth mound will be landscaped in such a way it will provide visual and acoustic privacy between the residences and the hospital entrance. The services to the building are on the southern side of the building and all contained within either acoustically-treated barriers or located in portions of the building which are protected by other parts of the building. We will not have plant exposed on any of the boundaries.

Mr VALENTINE - So the noise will go up rather than out? Obviously you need ventilation, otherwise you will not get proper cooling.

Mr PURSE - Correct.

Mr SHELTON - Rob and I are both out of local government and these planning issues around neighbours and so on are to the forefront. Those properties on the northern side of the new development, did residents of those properties come along to the public consultation phase of the process? Did any of them have any major issues with what was going on?

Mr PURSE - The main concern we had from one of the residents was loss of land to agist her horses. There do not seem to be any significant issues with the facility being there and our explanation of the project and the ways we were looking at mitigating any potential nuisance was sufficient to allay any concerns, if there were any.

Mr VALENTINE - The agistment was happening on council land anyway, as opposed to being the neighbour's own land.

Mr PURSE - Correct.

Mr VALENTINE - Building design: we have had a submission that covers a lot of issues. Rather than going through that one by one at this time, I would like to satisfy some of my own observations. I am thinking of the need for the design to have an official tick from authorities - for instance, radiation rooms meeting spec, those sorts of things. Can you run us through those

sorts of areas that have had external approval from various authorities that are needed for this hospital?

Ms ASHLIN - We have consulted as part of the consultation process - we have consulted with radiology for their requirement for that area. They have had quite a fair bit of input. They will need to certify it, so we are going through a process of having them certify the compliance of that room. It is going through that process now.

Mr VALENTINE - Are there any other specialist areas that need to be ticked off, like radiation? Are there any other aspects of the hospital's operations that needs a third party to look?

Ms ASHLIN - Again, as part of that consultation, we have had the Launceston General Hospital. As they are the larger teaching hospital, they have reviewed the floor plans and the room data sheets to make sure that what has been designed and proposed works for them and that they are familiar and comfortable with it. While Denise operates the facility at a local level, we just want to make sure that everyone at that level has been consulted and is across what is proposed.

Mr VALENTINE - Say with the ambulance service coming into the site, are the roof heights at the right height? They are not going to cause a problem for the height of ambulances and things like this?

Ms ASHLIN - That is right. Both Tony and I have met with Lynden Ferguson who is one of the managers at the Launceston Ambulance Station. I have met with him, had a review of the plans and have gone through that process. The site does have the capacity for Ambulance Tasmania to be present on site in future. Discussions with Lynden at the time -

Mr VALENTINE - As a base, you mean?

Ms ASHLIN - Yes, that is right. Discussions with them indicate that they are quite happy with where their current location is, and there is no intention to move. We have gone through that process and there is sufficient capacity there at the front of the site, should they choose to take up that option in future.

Mr VALENTINE - Another area is a more technical area with regard to information and communications technology. Can you let us know what sort of consultation has been made with respect to, for instance, wireless services that might be envisaged on site, and whether there are going to be areas of interference that might interfere with other medical equipment or whether the construction is going to prohibit certain operation of those devices?

Ms ASHLIN - At the very commencement of the project we engaged our ICT department. They provided us with their specifications for what is required in a new communications room. They have been consulted. It is an ongoing process. At the time when we need to order equipment and things, we will go through them again. They have reviewed the communication room and they are happy with the layout and the size in terms of air-conditioning and cooling and making sure that equipment is safe.

Mr VALENTINE - And secure?

Ms ASHLIN - And secure, yes, that is right.

Mr VALENTINE - It is a pretty important security item, to secure those items.

Ms ASHLIN - That is right, yes. The specifications obviously are handed to the architect, who takes all that into consideration as part of the design and build. Regarding wireless technology, there is a wireless survey being undertaken at present, which will determine the location of the wireless access points within the hospital. That is being done for voice and data capacity, which is for administration, as well as RTLS, which is the real time location system, I believe, which will accommodate the nurse call system. That survey is in process.

Mr SHELTON - We are talking about like in an ehealth circumstance, you have the capacity to run ehealth, not just for training, but to external specialists if need be, those sorts of things?

Ms CALLISTER - Yes, we have three portable video conference units that will come across. There are some in the education room which are not portable, but there is capacity in each of those consulting rooms and emergency to have that PC put in should we need it. That gives a lot of flexibility of where those points are. There are lots of data points in every conceivable room we could find to put in, in case we need a PC down the track. That is the way it will head.

Mr VALENTINE - With regard to the cabling, is that all fibre?

Ms ASHLIN - Yes. It is as per the DHHS specifications. Yes, that is right. We are also putting USB ports in at bedside for the modern technologies these days and mobile devices.

Mr VALENTINE - With respect to server rooms and those sorts of things, you mentioned they would have air-conditioning to make sure they are sufficiently cool.

Ms ASHLIN - That is right. We have consulted with our ICT department.

CHAIR - I would like to know about the emergency power situation. How do you deal with that in this hospital?

MR PURSE - We have an emergency generator. We are investigating two generators because we understand the actual power requirement in an emergency does not necessarily warrant the full force of a larger generator. Our consultants are looking at sharing that load between two smaller units in order to cut running costs and provide a more effective solution.

CHAIR - I am not aware of what emergency services you provide, but often emergency services are required when the world is turned up-side down and power is short and all that sort of stuff. Does this hospital have the facility with its emergency power to provide all the services you expect it would need?

Ms CALLISTER - We have a generator at the moment that does provide us with our emergency services. Again, that same system put through to the new hospital although as Tony says, it is exploring two units instead of one. But it will be a brand new unit because the old one is far too noisy and old to warrant a move.

CHAIR - Having two units would give you redundancy.

Ms CALLISTER - It is when the power goes off and our units, the major equipment and areas are all plugged into the emergency powers.

Mr SHELTON - On the electronic side and video streaming, it is not necessarily part of the new hospital design, but how much is the issue of community members needing specialist follow up? You go to a specialist, you have something done and they say, come back in a month's time. Rather than travelling to Launceston, are specialists using the facility and say go to the local hospital this is your time, we will book you in and have the consultation over the internet? Does that happen much?

Ms CALLISTER - We certainly have that capacity. It is available to the community. It is not being utilised a huge amount. There are only a couple of major specialists in Launceston who use it frequently. It seems to be more specialist pushed, with their agenda around what they feel comfortable about using. Whether they do not have the technology in their practices or whatever in Launceston I am not sure, but we certainly have the capacity here to promote anything or to offer that to any community member.

Mr SHELTON - That capacity is here now?

Ms CALLISTER - Yes, and will certainly be increased in the new facility because we will have more rooms to have that capacity in.

Mr SHELTON - It is critical as a state and is why it does not necessarily relate to the hospital per se. The issue is, where you have a minor operation and need a follow up, there is nothing wrong, you walk in to a specialist appointment and they say 'how are you', you reply 'fine' and you are out the door in 30 seconds. For anybody in St Helens who needs that opportunity to go through the process a new hospital as such will reinforce it to the general medical community, that this should be done for anybody in this situation. Given if there are issues, it is within the medical facility anyway.

Ms CALLISTER - It is the time factor

Mr SHELTON - Travel time?

Ms CALLISTER - Yes, and also the time factor around technology for the specialists to get on board, to push that further. The other thing was being in emergency. The electronic equipment that comes through, you would do an ECG and that would automatically be picked up at LGH where they could read it and flick back. We have not purchased those modules on some of the equipment we have because it is not available to us at the other end. That is the way we will go. We will have capacity in this new building to still be able to electronically get those things through. We are one step ahead of Launceston.

CHAIR - What is happening with the existing site?

Ms ASHLIN - That has not been decided yet. Medea Park has shown interest in purchasing it from the government.

Ms CALLISTER - Medea Park is a 62-bed aged-care facility and is outgrowing its space. There has been community recognition that there's a gap in housing or share housing facilities for more disabled or less competent people under the age of 65 in St Helens. If they are that severe, they end up having to be admitted into an aged-care facility when they are still only young. The chair of the board of Medea Park and the manager of Medea Park came for a site visit the other day, to have a look around and see if it was at all suitable. They wanted to get a feel for whether it was a project that may be worth exploring.

Ms ASHLIN - Part of our process is that once the hospital is relocated, we would ask through government if other government agencies have a need for the hospital. If they don't, it becomes surplus to our needs. We will have the Valuer-General undertake a valuation and it is placed, through Treasury, with a real estate agent and put on the market for sale.

Mr VALENTINE - Understanding the issues the site has.

Ms ASHLIN - Yes.

CHAIR - So demolition isn't part of this cost?

Ms ASHLIN - No.

CHAIR - I am aware of the issues around the old North West General Hospital and the old Mersey maternity hospital that is still standing and looking dreadful. But that is outside the ambit of this issue?

Ms ASHLIN - Yes.

Mr VALENTINE - Is there a move to generate solar power from the site?

Mr PURSE - There is. We are migrating the current system to the new site and reinstalling it.

Mr VALENTINE - What do you currently have?

Mr PURSE - We have a 50-kilowatt solar system.

Mr VALENTINE - That is a fairly big system. So that's all being moved to the other site and presumably at all the right angles for maximum generation. Is that just into the grid, not into battery packs or anything like that?

Ms CALLISTER - It's not currently. The inverters go back into the system.

Mr VALENTINE - The individual rooms were mentioned during our tour. Just for the record, you have checked that out with the Launceston General Hospital as to the design of those rooms?

Ms ASHLIN - That is right, through the Director of Nursing. We have provided her with the information and she has passed that to the appropriate emergency department or the appropriate areas for them to consult those rooms.

Mr VALENTINE - There was one comment made in a submission which said that multi-bed wards are outside the guidelines for new hospital developments. Do you want to comment on that?

Mr PURSE - Multi-bed wards are still allowed for under the Australian Health Facility guidelines.

Mr VALENTINE - Have you followed those guidelines to the best of your capacity?

Mr PURSE - We have indeed.

Ms CALLISTER - The other room consultation we had was with the renal dialysis people at Kings Meadows. Their engineers have been put in touch with your engineers to make sure that room meets those standards for the renal dialysis unit.

Mr VALENTINE - One of the questions raised regarding renal dialysis was that there was not enough capacity, that there should be two instead of one, if my memory serves me correctly. Would you like to comment on the number of beds you are making available for that?

Ms CALLISTER - The service we can provide in St Helens is an independent renal dialysis unit. That is not a unit used by people who need assistance from medical or nursing staff to run their dialysis. It is purely for those people who are educated and confident that they can come in and run the equipment themselves. It just replaces their home. It is set up for those people who would normally be dialysising in their own home and, should their home have stairs or not be suitable for a dialysis unit, this gives them an opportunity. I am very aware there are community members who go through dialysis and who do not have the capacity to manage their own independent dialysis.

Mr VALENTINE - The comment in the submission was that the planned new hospital does not cater for renal patients or mental health and dementia patients.

Ms CALLISTER - Correct. Part of our admission criteria is that we do not admit mental health patients, depending on the type. It is the risk to the staff when we have two staffing. We operate our nursing as a two-person shift. There is no orderly or wardsperson after hours and those types of clients tend to be unpredictable. If you need support, you can call for the police but maybe they are at a car accident, for example, so we end up with no service at all to provide those high-risk clients in our community. They are managed in emergency and then sent to Launceston because we do not have the capacity in a small unit to manage them successfully. They need further ongoing care and to be linked in with other providers.

Mr VALENTINE - You are not just shutting the door on them; there is the capacity through the emergency service to treat them?

Ms CALLISTER - That is correct, we always treat them. We have outreach mental health service from Launceston. They come to us once a fortnight and do all the case management of those we tend to send up.

Mr VALENTINE - It is tending into a policy area and I realise you can't necessarily deal totally with that in your capacity.

Ms CALLISTER - No, and the same goes for the dementia-type patient. Having said that, there is much more capacity with this new building to manage some of those clients who just wander. We will have a different security system where we can lock some doors to keep these people in. At the moment they can walk straight out onto the main road.

CHAIR - Could you outline security issues and how this new facility will improve those security issues that clearly exist with the present facility?

Ms CALLISTER - The new facility will enable us to have an excellent security - well, within the capacity of electronics, I suppose - because it is also built into areas. You have the 9 to 5 area, so that can be sealed off completely.

CHAIR - What are the 9 to 5 areas?

Ms CALLISTER - The allied health-type, oral health area and all the offices and consult rooms. After-hours you only have the ED and the ward area to manage from a security point of view, and that is all managed through the electronic coding systems that we have discussed with services engineers. There was that around it.

Also, with the new phone systems as well, with DECT phones. If you have one nurse down one end and one up the other end, they can press on those phones to get attention from each other. If you need to get that person on board, from that point, that will provide a lot more security. It is still not going to overcome when we press a duress alarm and we may or may not get anyone to attend. We do have an outside service provider, but again the police have only so many resources, the same as we have.

Ms ASHLIN - In terms of an emergency presentation, if somebody presents to the Emergency Department after hours, there will be a camera. They will press the button and they can speak into an intercom at the end where the nursing staff are. There will be a monitor where they can actually view who is outside to determine what the presence is there, as well as having a camera providing a further shot in case there is one person here and seven people further afield. There will be that ability as well. The staff will be able to talk to the people outside to determine the emergency and then admit them into the Emergency Department waiting area.

CHAIR - In terms of wandering patients in palliative care, or dementia-type patients who might be in hospital for some other minor reason, how will the doors be controlled so that can be certain that your patient is contained? How will that work?

Ms CALLISTER - I believe there is capacity in the electronic system, the security system, to program it around the rooms you want or do not want and the time frames. That is my understanding.

Mr PURSE - The various compartments within the building do have access control points in and out of each department so each individual area can be contained. For instance, the patient ward can be contained so patients cannot wander into the Emergency Department or the Allied Health Department after hours.

Mr COCKBURN - If they exit the building, an alarm will go off at that door.

CHAIR - Which the nurses will be alerted to?

Mr COCKBURN - Correct.

Ms CALLISTER - There will also be capacity to lock down the building. Sometimes there is a need to lock down the building to stop people from coming in. The police may phone and say 'such-and-such' and then you need to lock it down.

CHAIR - The nurses will be able to do that from those phones?

Ms CALLISTER - Yes.

CHAIR - The medication you have in the hospital obviously provides a security risk. Can you explain how that is being dealt with in this new facility?

Ms CALLISTER - The data sheets and plans all went through to pharmacy in Launceston for the head pharmacist to review that. There has been considerable consultation around the protection required in that room from - if somebody wants to come in from the ceiling because it is a flat roof, that there is enough protection from the front.

There has also been a lot of consideration around where the drug safe is to be placed in those rooms, including the one that the ambulance wishes to bring across. They are not right up against an outside wall where someone can drill through or whatever might be. We have had to reconsider all of that. To get to it through into the pharmacy from internal, it is a coded system, a swipe-card system to get into that room.

CHAIR - You will have a log of who has entered and who has exited, et cetera?

Ms CALLISTER - Yes, it is on the card.

CHAIR - Very good.

Mr VALENTINE - Do you have much call for maternity services at this hospital? I am presuming you probably do.

Ms CALLISTER - We do not actually have a lot of maternity services presentations really. Having said that, we have a service that does pre- and antenatal-type services. That is run in the child and family centre here. They were consulted about whether they wanted any consideration in this building to move their child and family nurse back into our building. They like where they are and are happy where they are currently.

Mr VALENTINE - Sorry, where are they?

Ms CALLISTER - Just here in this lovely wavy building, the child and family -

Mr VALENTINE - The child and family centre?

Ms CALLISTER - The child and family centre.

Mr VALENTINE - We are doing an inquiry on that. That was most useful.

Mr SHELTON - Nevertheless, the emergency service is always there?

Ms CALLISTER - The emergency service is there, and you will get some people who come in, and we have delivered babies where we are, yes.

Mr VALENTINE - You do not have much call from people who might want a home birthing experience, but they want to do it in a safe environment?

Ms CALLISTER - That will not be something that they will have available to them in this community because of the high risks that are involved. You not only need a midwife or whatever, but you also need an anaesthetist, you need an obstetrician, a paediatrician -

Mr VALENTINE - Of course you do. You do not have those services?

Ms CALLISTER - No, that service is certainly not available here.

Mr VALENTINE - That is fine. That brings me to page 6 of the submission, where the feasibility report identified a number of recommendations for Break O'Day Council to manage, including a public survey of neighbours to engage the level of support for the development of a new hospital, implement planning scheme members, et cetera.

Consultation of the broader community as opposed to just the neighbours, can you for the record say what went on there and what the feedback was like in broad terms?

Ms ASHLIN - Prior to going through this, a community consultation was held with a representative from the department and the general manager, who I acknowledge is present here today, and obviously neighbours. The property has residents, so they have been consulted and informed throughout the process. With the lodgement of the development application just recently, we have held a further community consultation forum. It ran for three hours, and we had probably over 50 people pass through the doors during that time.

Mr VALENTINE - General feeling?

Ms ASHLIN - Very positive. Having been able to see the plans - they like to see something visual - and when asked about the dates and time lines and things, they were pleased we could give them a date to when construction is expected to start. It is something that has been in the pipeline with them for quite a while. The general manager was at that session too, and it was good to have the council there to support the development of the hospital.

Mr SHELTON - Has the development application been passed by council?

Ms ASHLIN - It is going through the process now, yes. We had to respond to several questions, and we have done that. We have been advised that it will be advertised.

CHAIR - We went into the kitchen area today and heard a lot of noise. We spoke to Louise regarding temperature and noise. How will the new kitchen facility work? Will it overcome both noise and heat and any of the other issues in regard to the growth in the number

of meals-on-wheels that the hospital demand is for? I understand it has doubled in demand in recent times.

Ms CALLISTER - I will speak a little bit about the current kitchen, and then I will get the guys to talk about the new one. The current kitchen is so noisy and hot because we had to put in that new air conditioner to try to make the conditions bearable for the hotel staff to work in there. It is a very large air conditioner in a very tiny room. They have a chronic problem with the noise in that room. That has been addressed in the new kitchen, which is much bigger. The guys can talk more about the new kitchen.

Mr COCKBURN - The kitchen has its own air-handling system, which can be individually controlled by those actually running the kitchen. They get to choose. It is almost a separate building within the entire complex from a fire and air handling perspective. They have control of their environment in there and it will be significantly better in performance than they have at the moment.

CHAIR - I imagine the decibel level in that room is very high, just from standing there trying to chat. What sort of level are you expecting?

Mr COCKBURN - The problem with a hospital kitchen is reverberation. There is not a lot you can do in absorbing materials within a hospital kitchen or any commercial kitchen.

CHAIR - Because it is stainless steel.

Mr COCKBURN - Yes, and you cannot have acoustic treated ceilings and the like because it has to be an impervious surface. To a certain extent you need to expect that level of reverberation within a kitchen.

Ms CALLISTER - Having said that, they have all new equipment and they have been extensively consulted. New equipment will facilitate a more pleasant working environment, in a much bigger facility.

CHAIR - The kitchen is a high-risk area for fire. Can you explain the fire mitigation you have in the new building?

Mr COCKBURN - The kitchen is a stand-alone fire compartment. It is separated from the rest of the hospital by a 2 hour firewall constructed of concrete block and extends all the way up to the roof. The doors connecting the kitchen to the rest of the hospital are 2 hour fire-rated doors. They will be in the hold-open position and in the event of a fire alarm they will close and seal off the kitchen from the rest of the hospital.

CHAIR - How do staff get out?

Mr COCKBURN - You can still push them out.

Mr PURSE - There is also an alternative means of escape to the outside service area through a rear door from the kitchen.

Mr COCKBURN - Which also serves for deliveries, so we are not delivering items through the hospital to the kitchen.

Mr VALENTINE - Have these rooms had a technical tick-off from some other authority? Is it BCA you follow or some other?

Mr COCKBURN - One of our consultants is a building surveyor who raised all these issues very early on in the design process. We follow the advice of them. We have a deemed-to-comply situation rather than a fire performance-based solution for this hospital.

Mr VALENTINE - You have bicycle parking facilities for staff who might ride a bicycle to work. Do you have end-of-journey facilities for those people - showers, et cetera?

Mr COCKBURN - Staff have facilities, including showers. The staff numbers are not huge, so we figured one would be sufficient.

Mr PURSE - And appropriate locker space.

Ms CALLISTER - And two toilets, for the ageing work force.

Laughter.

Mr VALENTINE - As to project management, it is not rebirthing the Royal Hobart Hospital. It is not an insignificant project and has quite a significant number of risks associated with it. Having to decant from one facility to another, the amount of community involvement there might need to be with other third party service providers, and those sorts of things. Can you explain what project management regime is being employed? Is it following the state government's project management guidelines?

Ms ASHLIN - As to risk, we maintain a risk register which is regularly reviewed throughout the course of the project. Any risks are taken to our project control group, which determines the best course of action to treat and mitigate those risks.

Mr VALENTINE - And they are all documented?

Ms ASHLIN - Yes, they are, definitely. We have a project control group that meets once a month. We had a meeting yesterday. The chair is the Director of Clinical Operations in the north and north-west. This stage of the project is discussed regularly, budget issues, risk issues and Denise, through her reporting mechanisms, would report up to her director of nursing.

Ms CALLISTER - Through Fiona through to -

Mr VALENTINE - Keeping the community informed throughout the project and the decanting and all those major milestones, how is that happening?

Ms ASHLIN - We have undertaken community consultations. We have various newsletters, newspaper articles that are local. There is an opportunity to communicate the progress of the construction and the development as well as through the hospital flyers. The plans are on display at the hospital at the moment. I see that ongoing.

In terms of completion and relocation, as that time gets nearer, we will discuss the best way for that to happen in conjunction with Denise and her staff, to make sure that it is a seamless process.

Ms CALLISTER - Adding to that, we use our hospital auxiliary as a community representative group. We have taken the plans to them and this team has spoken to them about any issues they may foresee. That is another area through which we would communicate when we need to decamp.

Mr VALENTINE - You say you have talked with the ICT area and their department. Are they part of the project management group?

Ms ASHLIN - They will be brought in as we need them. We need their advice and consultation in the design and in the early stages of the project. We will bring them back in once construction starts, in terms of equipment installation. Once the building is completed we will want them to come in and have an inspection and make sure it is approved and meets their requirements.

Mr VALENTINE - I was thinking more that part way through you might decide you are going to swap things around because you have discovered that something is not going to work, then they will be consulted.

Ms ASHLIN - Definitely. Again, people are brought in from time to time as needed. If it is something that is going to impact ICT then we will consult with them.

Mr VALENTINE - We have covered the EL facility. You said that the video conferencing rooms can be used for that.

CHAIR - I would like to ask a couple of questions with regard to the budget. This committee is familiar with seeing a range of figures allowing for a contingency from unexpected issues in construction. I cannot see a contingency component in this list. Can you explain this to me?

Ms ASHLIN - There is a construction/design contingency of $430 000.

CHAIR - Yes, thank you.

Ms ASHLIN - Hopefully, if they have done their job properly, we won't need that.

Mr PURSE - We are having our project contingency monitored by our quantity surveyor to ensure that we stay within these constraints.

CHAIR - Right. Things like compacting the fill that you have to bring in and all those sorts or issues, that is where you can get an unexpected -

Mr COCKBURN - Our structural/civil engineer has given the quantity surveyor figures to work from for an up-to-date estimate that we are currently working through. That is factored in.

CHAIR - And you are confident with that?

Mr COCKBURN - Yes.

Ms ASHLIN - In terms of construction, the budget will go through a cost estimate prior to going to tender to make sure that construction figures are still on track. If it looks like it is over, then we will sharpen the pencil and hopefully see where things can be saved without impacting on the service and what we are offering.

Mr VALENTINE - There has been a geo-technical survey of that site?

Mr COCKBURN - Yes, there has.

Mr VALENTINE - How significant was the survey?

Mr COCKBURN - There have been a number of test holes around the site. Our structural and civil engineers are not alarmed by the outcome.

PUBLIC

Mr IAN MOYLE, PARAMEDIC, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mrs Rylah) - Welcome, Mr Moyle. Would you like to make an opening statement?

Mr MOYLE - I have reviewed the plans and they have changed slightly since I was initially given plans to look at. My major concerns are that the development of this hospital impacts four municipalities around the area. I am not sure if a health review has been done in all those municipalities that this is going to be a major hospital within each municipality. There is another hospital within this municipality that is possibly going to be impacted as well.

As an ambulance officer, an intensive care paramedic, I have worked in this area for the last three years. The increasing case load is dramatic. I have some figures that I will talk about later that show there is an increased requirement for health situations and the transport of patients, as well as the number of patients. A report put out by a group of university students who came here a couple of months ago points out the 2011 census shows that the average age here is at least 10 years higher. Employment opportunities such as forestry have diminished. People of retiring age head to this area. This leads to problems when they become unwell and want to go back into their homes in, say, Launceston or Hobart because they can't afford to go back there. Selling up and trying to purchase back in areas such as Launceston leaves them $100 000 out of pocket, which they can't afford.

There is a large ageing population in the area. I don't think the plans for 10 beds - one is lost to renal and two are double-bed wards - meet today's requirements. We have triple-bed wards at the hospital at the moment. I believe there needs to be rethink of the plan. What you are putting together at the moment is a mirror image of what we have there now, just with an extension on the end of it.

It leaves questions about the staffing and the ability to staff it with the same staffing you have now. It is 80 metres from the ambulance door to the furthest ward and only two staff on night shift. I spend a fair bit of my time as a paramedic in there helping those staff when I bring people into that area. I do it because I can see the strain on the system. I am not quite sure, even with the ambulance service, that they have got their heads around the impact for the number of people in this area and the ageing community in this area to have. For instance, over a 10-year period there was only 3650 patients transported within this area. In the 28 months I have been here, there were 2250. Theirs was 31 cases a month. At the moment it is 81 cases a month and rising.

We have a very large transient population coming to this area. At the moment we have a large tourism push. There is the transient population that holiday here, and the risk of holiday recreational activities is a lot higher now than it was in 1972. In 1972 you might have had motorbikes, et cetera, but you did not have quad bikes, which is the highest lot of fatalities. We now have a lot of people in this ageing group that like their motorbike riding. We have a lot of motorbike riders come through this area visiting from interstate. We have international people arriving with international licences driving hire cars who have never driven a right-hand drive car causing accidents and giving us a lot of problems.

The mountain bike trail is being built throughout the whole area where there is very little telephonic or any type of communication. When people are injured, and end up in this hospital as well as the one at Scottsdale, with major injuries we spend hours out of this area trying to recover these people. The use of helicopters does not always work. I would say 50 per cent of the time the helicopter is grounded, and 50 per cent or more of the time the aircraft is not available to transport patients for that two hours. Therefore I spend a fair bit of my time transporting patients from this hospital and the other hospital in this area out of this area.

I am not quite sure whether the plan we have will meet the community needs until a major health review is done for those four municipalities and the towns within those municipalities. The ageing population - we need to stop and not waste $12.1 million building a duplicate of what we have. The flooding problem at the moment has been solved. It has not happened since the major sewerage and stormwater upgrades have been put in. We need to take another breath and look at whether we are going to make effective use of this $12.1 million. Thank you.

Mr VALENTINE - They are interesting observations Mr Moyle makes. I am wondering at this point how we can address those given a lot of it is policy issue. It is a development that has already been given the tick so am not sure how this committee handles that. Maybe it is something we need to discuss.

CHAIR - It is not our role to respond to the policy matters, apart from raise them in our document if we see fit in our submission.

Mr VALENTINE - In the report?

CHAIR - Report, yes.

Mr VALENTINE - Maybe if there is one question I can have commented on by Mr Moyle, Number 5, 'The workflow for nursing in the wards and emergency areas are excessive and too disjointed.' I note you are talking about the distance from one end to the other. When you say 'disjointed' I wonder what you mean -

Mr MOYLE - The wards themselves are nicely compacted within a certain area. You have a kitchen area and major entry into the hospital, and then the emergency department - I am not quite sure whether that can be condensed to make the system better. Whether the kitchen could be shifted, et cetera, and then make the emergency areas and the wards closer together so the nursing staff - and as Denise has said, at times there are only two people. That is possibly from six o'clock in the evening seven o'clock in the morning there's usually only two people on staff. I am not sure if those are the exact times but there are only two nursing staff on site for the major time the hospital is open. We still come in 24 hours a day. There are patients knocking on the door, especially during the summer time when the population goes from 6000 to maybe over 20 000. I am not quite sure what it is but if you look at the whole area, and going down through Bicheno, there is a phenomenal number of people who end up in this area. We end up with the jobs and take them to this hospital because it is the only place that has x-ray facilities. Many times we take them directly through to town knowing they can't get the final treatment, but in doing so we lose the ability to respond to other situations in the area.

Mr VALENTINE - In that response to my question, there are policy issues in all that. In point 6, you say 'security for after hours is a nightmare' - are you talking about the current facility or the new facility?

Mr MOYLE - The new facility. Even though they can be locked off, there are only going to be two people on site. Even though you can, say, get the day 9-to-5 areas and lock doors, people are going to be coming to the front door, knocking on the front door after hours. The other areas - they are closest to the street, they are areas that be broken into, et cetera - and these two people are going to have to be the secure people for them. As Denise has said, even though they have an external provider and ask for police to attend, it is going to be difficult for them to secure this building totally and keep it secure, and do their work as well.

Mr VALENTINE - We will ask the previous witnesses back to answer that.

CHAIR - As an ambulance officer - and I haven't been to the hospital for a very long time - would it be very often that you would admit patients beyond the treatment area and into the ward?

Mr MOYLE - I don't very often take them direct to the ward. They are mostly going to the emergency department area.

CHAIR - On this plan the treatment area is close to where the ambulance comes in, is that right?

Mr MOYLE - Yes, it's not too bad - 15 or 20 metres, something like that, which is excessive compared to the new LGH. If I have to have access to that area at the moment, Denise is saying there is going to be card access, et cetera, but if the nurses are at the other end of the hospital, it is an excessive length of time for them to admit me or to be able come and see their patient. As soon as someone is there, one of the hospital nurses - that's an EN, an enrolled nurse, and an RN, a registered nurse, are usually there - the registered nurse usually ends up in the department of emergency services area trying to look after the patient. That is why the ambulance officers here spend a fair bit of their time supporting that but, if more cases come in, unfortunately we have to down tools and go. That's the nature of the job.

Mr SHELTON - It's your contention then that we don't spend this money and that it stays as it is for a period of time?

Mr MOYLE - Unless you have done a due diligence of the whole area healthwise, I think you are making a mistake to go ahead straightaway. I know it was under the pretext of 'Let's get a new hospital'. The council was on board and purchased land. This hospital was built in 1972 or 1974, I believe. It is the fourth hospital in this town over a period of time. The centre of the town could do with some development with that block of land. I believe there is the ability to shift this, which makes it good for the town, but I am not quite sure if it is good for the whole community, as in the whole area.

Mr SHELTON - The issue that the committee and the community are dealing with is, given that the hospital has had significant flooding in the past - and that is not guaranteed to have been negated completely - that it is a 1975 building and so there are, no doubt, occupational health and safety issues from a 1975 building to today's standard. I am sure you are not driving around in a 1975 ambulance. In your contention about not spending this money,

what is your recommendation that we do? Given that you have highlighted a number of issues where the design need to either expand.

Mr MOYLE - It is not a 1975 design. It was built in 1975. In 2002 this hospital was rebuilt. It had a fair bit of work done on it. There were certain areas - as in the flooding - that could not be fixed until the street-flooding problem was fixed. Those things have occurred. There was delay of maybe 12 months to two years to see that. There is a better flow for the traffic than there is for patients and the nursing staff. The traffic outside - I think more thought has gone into that than has actually gone into the workings within the hospital.

CHAIR - I do not have any other questions. Do you have any questions?

Mr VALENTINE - Only from Mr Moyle's submission, which deals with the resuscitation area needing to have physical separation from other emergency beds.

CHAIR - Please ask that because then we can ask Mr Moyle to withdraw and we can bring back the other witnesses. Please feel welcome to answer. Mr Valentine, would you like to ask your question so Mr Moyle can answer.

Mr VALENTINE - The question number, your point 7.

Mr MOYLE - The design at the moment is that the resuscitation area is slightly larger but it also impacts on the other three patients in that area. The physical barriers between that and the other patients is a very good situation. The design of the new LGH DEM has actually separated them totally as well.

The reason for that is that some of those people in those other beds could be relatives of those patients. A physical barrier allows for other things to happen. It allows for more storage and resuscitation equipment to be handled there. We have retrieval services come within the hospital bounds from outside.

At the moment they are undertaking some clinical procedures where they are open up to the other areas, which I believe should not be done. They need to be done in at least in a semi-sterile area and the DEMs are not sterile at all because everyone arrives there. There are no theatre spaces within this that they could take that patient to, so they are putting in central lines and things like that. Any type of infection ends up centrally and the patient can have adverse effects.

With the ability of being able to separate that emergency department, maybe you don't have to build another theatre, but at least those people can work within the confines of a fairly separated area, and work together without disturbing or making an impact on those other patients.

Mr VALENTINE - Thank you.

CHAIR - Thank you, Mr Moyle. If you would kindly withdraw, we will bring our other witnesses back and see if we can get some answers for you.

Ms SUZANNE ASHLIN, **Mr TONY PURSE**, **Mr PAUL COCKBURN**, AND **Ms DENISE CALLISTER** WERE RECALLED AND EXAMINED FURTHER.

CHAIR (Mrs Rylah) - We need to address some of the concerns Mr Moyle has raised. I would like to leave it in your hands as to how you answer those concerns. I want to make it clear that we can't deal directly with policy issues so an explanation of that is not required, but if you could identify what is policy, what is design, research and consultation that has been undertaken, that would be helpful.

Ms ASHLIN - I might start and touch on the St Marys facility. That is a policy, but just noting there is no intention to close any services or alter any services. That is out of scope for this project. It has been discussed at the CEO level within the Tasmanian Health Service. At this point in time - and I would say probably into the future - there is no intention to close or alter any of the services operated out of St Marys, or for that matter out of St Helens.

CHAIR - That means there are two hospitals in these four local government areas Mr Moyle mentioned? Is that my understanding?

Ms CALLISTER - St Marys has a hospital. It has a one-bed ED and eight sub-acute beds. They are running totally independent to what we run. We communicate obviously and do team work but there's no plans at all to change any services to that facility, nor to ours. This was planned to be rebuild of what we currently have, from a service perspective. You were talking about the design. I believe in that submission there was mention of the kitchen and resuscitation and that he would like to change the kitchen area and have the ED there. The challenge we have is that in small communities we need to keep the ward area and the emergency area completely separate. Because of the small community everybody knows everybody, so anybody who comes into the ED now walks down the common corridor and they know who's who in the zoo and they all walk straight through into ED, which is risky business. To make that area a lot safer for the patients, so they're not being exposed to emergency type behaviours, clinical decisions and conversations, it is much better to have them separated. That is why they are opposite.

The kitchen facilitates the ward; it has nothing to do with the ED. It was logical after discussions with staff and architects, and from visiting other sites. We went to other sites that have been recently renovated to see what worked and what didn't work. It was an opportunity to have them separate. Currently they are not that separate and it's a much better option to manage the public, inpatients and the ED presentations. That is why the kitchen is at the back of house, to facilitate the wards and the Meals on Wheels.

CHAIR - Mr Moyle mentioned the distance nurses will have to walk, and therefore time delays because it is a long hospital. Can you talk through those issues?

Ms CALLISTER - From the nurses' point of view it is a distance because the ED area has been expanded on what we currently have. The resuscitation bay has been put at the top of the emergency area because the nurses' station is there. We have to keep in mind we may only have two or three a month triage 1 and 2 patients who would need any type of resuscitation. We have triage 3s that come up, but they're not full-on like retrieval or anything like that.

CHAIR - So 1 is the highest level and 3s is lowest?

Ms CALLISTER - No, 5 is the lowest - we go 1 to 5. For retrieval and full resuscitation we would be look at maybe two a month.

Mr VALENTINE - Can you explain retrieval, please?

Ms CALLISTER - Retrieval is when the patient has to be stabilised and sent to Launceston. The condition of the patient warrants having a retrieval team come down and sedate them, stabilise them properly so they are safe in transit. That involves the Tas Ambulance coming down with an anaesthetist or a specialist or whatever, and they intubate the patient and set out the outlines, and put the necessary drugs and infusions in there. That's why we wanted the extra space in the ED, so we can facilitate the area. Then they would be transferred back in the plane usually, if the plan is able to fly. Sometimes they have to go back by road, come out by road and back by road.

Mr VALENTINE - Depending on the weather?

Ms CALLISTER - Yes. That is from the nurses' point of view. Yes, there is a bit of a distance from the bottom of the ward, which would be the triage 5s. The triage 1s would be right up next to the station. That is the closest to the ward. My nurses have all been consulted. They do not have any issues with that distance.

CHAIR - Do you believe this matter has been well considered?

Ms CALLISTER - I do.

CHAIR - Well consulted on?

Ms CALLISTER - Yes.

CHAIR - Without limitation in terms of what you need to operate the hospital efficiently?

Ms CALLISTER - Yes. I have consulted with the staff constantly and considerably on what works, what does not work. I am very comfortable and confident they are included in all of the decisions, even around taps. Whatever, what sort of lighting do you want? What sort of space do you want? What cupboards do you want? I have not made those decisions or signed off on those decisions lightly.

I have consulted with all that I can possibly consult with, keeping in mind I have not consulted with every single nurse on every single item because of the shift work that is involved. I have certainly consulted and they are very comfortable with the decisions and the design, and they are very excited around it.

Ms ASHLIN - Similarly, the plans have been provided to the executive and directors of nursing within the Launceston General Hospital. They have provided any feedback in terms of data sheets and things, but in terms of general layout, there has been no concern raised. Similarly, Ambulance Tasmania at the management level has been provided with the latest revised plans only a month or two ago. Everybody has ample opportunity.

Ms CALLISTER - Our plan has been sent to LGH ED as well. They did make some suggestions about a couple of items, but we also have to keep in perspective that emergency ED is not exactly the same as a real triage point to stabilise patients and send them off. LGH ED has masses of staff, so if somebody walks in, someone will see them, whereas we have limited staff so we need to be able to manage the best we can.

It needed to be open so we can see what is going on. It needed to be open so there was not a risk for any staff member behind a cubicle. That has happened to me. Hence what we had here had a cubicle, and I took it down because I got caught in there. That is a risk we cannot afford in a small community, so there is no partition, just curtains. That is why that has occurred. The nurse's station can look straight down at every full bed and see what is going on. They can also look down the ward to see if there are any call bells happening.

Mr PURSE - From day one the importance of that facility to be operated by a limited number of people was a factor, which is why the nurse's station is the hub of the hospital with all the other areas sectioned off from it. It has visual access to both the ward area and the emergency department.

Mr SHELTON - I have heard the figure mentioned before, what is the increase in floor area?

Mr PURSE - More than double.

Mr SHELTON - More than double. Even though issues have been raised about distance, it is accepted that we might have to take a few more steps because we are getting better facilities within the new hospital that will make the nurses' lives better. They will still walk the 10 000 steps a day, no doubt.

Ms CALLISTER - If they don't walk it at work, they will do it at home. Getting back to the extra space that we have, it is almost double. You have to keep in mind all that allied health area has been really accentuated with more consult rooms, so that has taken up a lot of that extra space. Also, we will have single rooms with ensuites. We do not have any of that now, so that is going to make your footprint much larger.

Mr COCKBURN - As well as increased storage.

Ms CALLISTER - Yes, increased storage. We have all that as well, so obviously your footprint is going to be much larger. The nurses are quite comfortable with the distances as such and have been able to see what is available. I am very comfortable with that.

CHAIR - Would it be fair to say that comparing hospitals designed in the mid-1970s versus now, a modern hospital is a much more efficient workplace and therefore you do not need to staff it with as many people because of design technology and all of those issues? Is that right? Please give me some guidance.

Ms CALLISTER - I would agree with you to a point, yes. Practices have changed. Technology has changed things. Whilst it has made things easier in one way, it has also compounded another and given more duties that have to do with technology. We are treating different types of patients there now that we would never have treated back in 1970. A lot were having babies back then because you had the specialists to deal with them but we don't have

them. Those sorts of things have moved on because the specialists are not available in rural areas anymore. We need to deal with the people, the community, on the basic health needs that they have at that moment.

CHAIR - Mr Moyle contended that we are basically replacing the ward area - that was my impression - and we are basically doing a very similar transfer in area if we separate the allied health area and the extra storage and those other bits. We are really replacing it with the same size. My interest is: are we doing it much more efficiently?

Ms CALLISTER - We are.

CHAIR - The population has grown over that period of time, but are we operating it more efficiently? You have outlined to us already that there are a whole lot of services that we no longer provide because we need far higher standards than we had 40 years ago.

Ms CALLISTER - Yes. Community expectation is far higher now and they would not put up with a lot of what went on in the 1970s anymore. With the ward, it is not like for like because the rooms are single rooms with ensuites or there are two rooms with ensuites. We have one ensuite at the moment.

None of those rooms meets standards at the moment. We cannot get lifters in there to lift these people. We had someone fall, slip off their bed mattress and were sort of a bit under the bed, and we could not even get that patient out. It was 2 o'clock in the morning, who do we ring? We cannot get the lifters and things in. Hence we needed to have a standard put in around single rooms and ensuites and we have the hoists in the rooms to assist with the movement of the patients. Whether they be larger, heavier patients or not, it does not matter. It still takes the workload off the one nurse that is looking after this patient. They can use these hoists to move them around. It is certainly going to reduce the amount of workplace injury.

Keeping in mind, everybody has an ageing workforce as well. You have to protect those workers and with these hoists in place, you need to have this space in the rooms. We cannot possibly do that with what we currently have. Whilst you said we are moving like for like, we are not moving like for like.

CHAIR - Further to that, Mr Moyle mentioned some statistics in terms of the increase in the number of retrievals being done. Does that reflect the change of more specialist services being provided at the higher level hospitals in Launceston versus what used to be here 10 years ago or 20 years ago? I cannot exactly remember the time frame of Mr Moyle's statistics.

Ms CALLISTER - There are lots of variables in that data. For a period, it depends on the levels of confidence and competence of your local on-call personnel as to their decision making, whether they need to be transferred out to Launceston. I am not talking about the retrieval. The retrievals are going to take place no matter what, but there are not many of them in a year. It is the others that are sent by road. We had a significant number over a couple of years where clients were being transferred to Launceston, in what I would call a 'soft transfer', more of a second opinion issue. Ian has already spoken to me once before around how the data has dropped off since we have changed our medical contractors. There are a lot of variables around that type of data and whether they needed to be sent, is it because there is not enough competence here and they need the competence at the other end.

Mr VALENTINE - It is 30 a month to 81 a month - I think the quote was, but there seems to be a significant difference.

Just to clarify, you mentioned the hoists. Are these hoist hanging points at every bed or is this a mobile hoist and does not require hanging from the ceiling?

Ms CALLISTER - The hoists are put into the ceiling, not every bed but there is one in the bariatric/palliative care room, in single rooms, the ED.

Mr VALENTINE - So they are physical hoists that stay in place?

Ms CALLISTER - They stay in the ceiling and then you hook up the mobile motor and hoist up to the points. That is how they work, but you have to have the track in the ceiling. There is one of those in the second bay in ED to assist us. There is one in the treatment room, so we have them in nearly every bed space and for those that do not, you can manage your inpatients around their illness and move the patient to where you might need it.

Mr VALENTINE - As to the privacy issue, being a small community it is important people have privacy, that their next-door neighbour does not know they have a certain condition or whatever. How are you guaranteeing that is the case?

Ms CALLISTER - The separation from the wards to ED will improve that type of privacy.

Mr VALENTINE - But you cannot guarantee it.

Ms CALLISTER - No, I can not guarantee any such privacy because usually the community tells us first. Social media has hit there before we even know what is going on. They can even tell us who is coming into the hospital with the ambulance.

Mr VALENTINE - I grew up in Dunalley and was there for 20 years and there was no social media then but it still got around.

Ms CALLISTER - I was a patient at the LGH ED two weeks ago and there was no such privacy there of any sort.

Mr VALENTINE - But at least there is some attempt to improve it?

Ms CALLISTER - We have attempted to separate the emergency and the clientele that goes with some of those emergency presentations need to be kept separate from the wards.

CHAIR - Do you have any other comments you wish to make?

Mr COCKBURN - Through the design process we worked with the staff. We ran them through a number of scenarios that may or may not eventuate and tried to work out what would happen if a door was left open or that sort of thing, in order to get to a decision in terms of the planning of this building, to make sure it mitigates all those risks.

CHAIR - You are satisfied?

Mr COCKBURN - Yes, I am satisfied because I am working with the staff to come to a solution.

CHAIR - Would anyone like to make a closing comment before we close the -

Ms ASHLIN - Just in terms of your consideration, as we have previously reiterated, the staff have been fully consulted and I believe we have addressed all their concerns. They have been involved in the process from the beginning. The proposal, the plan put forward, is acceptable to the staff, as I have said. We have undertaken community consultation, who are in support of the proposal. We are going through the process now of acquiring the land and proceeding with the project.

Ms CALLISTER - I will make one more comment regarding Mr Moyle's comment around perhaps a small theatre. We do have a treatment room in this facility we are building which you could use for minor procedures. To have a theatre in a small hospital like this is irresponsible. I have been a theatre manager for 25 years. You do not have the speciality personnel to deal with it safely. It then can encourage cowboy practices, which we have to be very succinct around in a small rural area to protect our public from having these types of things take place.

If you are going to have a theatre, you have to have an anaesthetist. My point is they struggle to get them in metropolitan areas, and then you have to have the surgeons or those who have the expertise and the skills to do those minor procedures or whatever they are planning to do. The cost and the maintenance of running a theatre is huge. It would be an absolute travesty to waste the taxpayers' money in providing a theatre for a small rural site. Unfortunately those times have left us. We all used to have little theatres in these small hospitals. There was one here, but you have to have the specialities and the skills to go with that. That is bigger than this room.

CHAIR - Thank you very much. Safe medical practice or a safe health system is what we all want. I thank you very much for your evidence today. Mr Moyle, thank you very much for coming. I will now close the hearing to the public and we will deliberate.

Before you leave, I need to read this formal part to you. As I advised you at the commencement of your evidence, what you have said to us here today is protected by parliamentary privilege. Once you leave the table, you need to be aware privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you said to us in here today. Do you understand that?

WITNESSES - Yes.

CHAIR - Thank you very much. Much appreciated.

THE WITNESSES WITHDREW.