2021 (No. 21)

PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

Royal Hobart Hospital Intensive Care Unit Expansion Project and Paediatric Outpatients Relocation Project

Presented to Her Excellency the Governor pursuant to the provisions of the Public Works Committee Act 1914.

MEMBERS OF THE COMMITTEE

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

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1 INTRODUCTION

To Her Excellency the Honourable Barbara Baker AC, Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia.

MAY IT PLEASE YOUR EXCELLENCY

The Committee has investigated the following proposal:-

Royal Hobart Hospital Intensive Care Unit Expansion Project and Paediatric Outpatients Relocation Project

and now has the honour to present the Report to Your Excellency in accordance with the Public Works Committee Act 1914 (the Act).

2 BACKGROUND

2.1 This reference recommended the Committee approve works to undertake two projects, namely the:

- Royal Hobart Hospital Intensive Care Unit Expansion Project;
- Royal Hobart Hospital Paediatric Outpatients Relocation Project.

Royal Hobart Hospital Intensive Care Unit Expansion Project

2.2 The Royal Hobart Hospital (RHH) Intensive Care Unit (ICU) provides high-level acute, clinical support for the various specialist and subspecialist medical and surgical services operating within the hospital. The ICU provides a safety net for those patients undergoing major surgery, procedures and treatments, and for managing complications of these. The ICU also supports those patients who present to the Emergency Department (ED) with severe acute reversible illness or injury. ICU care may also include end of life care and support for potential organ donation.

2.3 The current ICU is a 23 bed facility, however the current configuration does not meet contemporary standards. There is also increased bed demand for high acuity patients that require ICU level of care. Furthermore, the needs of a rapidly growing and ageing population as well as the impact of chronic disease and pockets of socio-economic disadvantage, are expected to drive demand for critical care medicine for the Tasmanian population, generating an increasing demand for ICU services.

2.4 Ultimately, under the RHH Master Plan 2020-2050, the intention is for the ICU to be moved to a new purpose built facility in a new L-Block building. However, the ICU expansion is required now to meet the ongoing demand of ICU bed space at the RHH until a new ICU is constructed. This project is strategically important to the RHH in addressing the intermediate requirement of the intensive care unit until the

construction of L-Block, as well as providing increased critical care capacity for the Tasmanian community

2.5 The RHH ICU Expansion project is designed to provide a contemporary environment with the aim of improving service delivery and workflow, and, as a result, should provide an improved patient experience.

2.6 To deliver on these aims the ICU expansion will include the following elements:

- 12 Additional Patient Beds, including 2 negative pressure isolation rooms, with the 12 bed spaces to meet current Australian Health Care Facilities Guidelines for sizing and access to natural light;
- iGlass doors at the entry to each enclosed room and windows or sliding doors between adjacent rooms, to optimise observation of patients and patient safety in emergencies, and to enhance patient privacy;
- Medical gases and power requirements will be located on ceiling mounted head and foot pendants to accommodate mechanical ventilators and monitors;
- Infrastructure to support haemodialysis and/or continual renal replacement therapy at each bed space.
- Individual temperature control for all rooms to cater to individual clinical needs (i.e. burns patients);
- Access to natural light in all bed spaces; and
- Medical gases to be supplied to all bathrooms,;
- Additional Family/visitors spaces;
- Additional Storage, charging and clinical support areas;
- Integration with the existing Intensive Care Unit to incorporate workflow and clinical staffing efficiency;
- All service areas to be easily accessible from all bed spaces;
- A new balcony overlooking the Hospital forecourt on the Liverpool Street side to provide an outdoor and therapeutic treatment space;
- Mass isolation capability to allow the unit to be mechanically and physically separated from the rest of the Hospital in the event of a pandemic situation; and
- Upgraded plant and equipment to service the Unit.

2.7 These works will provide an improved physical ward environment for patients, their family and staff. Continuity of care through improved workflow should also result in an improved patient experience and reduced length of stay.

Royal Hobart Hospital Paediatric Outpatients Relocation Project

2.8 The RHH Paediatric Outpatients Clinics (POCs) is located on the lower ground floor of H-Block and provides treatment to children and adolescents up to the age of 18 years. The POCs are currently operating at capacity, with insufficient floor space for expansion. The clinic space is also poorly configured and outdated for the patient cohort.

2.9 As part of the RHH Master Plan 2020-2050, the ED will be expanded in its current location to meet growing patient demand in the interim, until such time as a new ED is constructed in a new M-Block building. This means that other services, including the POCs, will need to be relocated to accommodate the expanded ED.

2.10 After assessing potential sites for relocation, Level 3 in the D-Block building was selected as an appropriate location. This site is currently vacant and previously housed Maternity and Neonatal Intensive Care, which are now located in the new K-Block. This location is also in close proximity to K-Block, where inpatient Children's and Adolescent's wards are located, and also central to major pathways and lifts to access other RHH services.

2.11 It is anticipated that the POC will provide the community with an expanded service capacity that conforms to current AusHFG (Australasian Health Facility Guidelines) standards, and improves Paediatric and Adolescent Services for patients and families now and into the future. This will be achieved by:

- All new spaces meeting current Australian Health Care Facilities Guidelines for sizing and access to natural light;
- Providing an improved physical environment, incorporating multidisciplinary office spaces, patient waiting area and playroom, dedicated ambulatory care spaces for patients and families who are admitted as day patients, improved infection control spaces to be able to manage the cohort of paediatric and adolescent patients using this service;
- Providing an improved physical environment that is both child and adolescent friendly to cater for the needs of these very different cohorts of patients;
- All service areas (clean utility room, 'dirty' utility room) being easily accessible from all areas;
- Medical gases and power requirements being located in treatment rooms and treatment bays;
- Infrastructure to support IT requirements being available in all appropriate areas of the new POC;
- Ensuring continuity of care to improve the patient experience, with replication of K-Block colour pallet and themes for continuity;

- Providing staff facilities including staff room, change rooms, and showers, to ensure that staff are able to carry out their work without the need to leave the ward space.

2.12 The proposed plans include the following elements:

- 7 Additional Consulting Rooms;
- 2 Additional Treatment Rooms;
- 8 Dedicated Treatment Bays for Paediatric Ambulatory Care Unit patients;
- 6 Dedicated Treatment Bays for Paediatric Haematology / Oncology patients;
- Hoist Capability for non-ambulatory patients;
- Additional spaces for patients and families including a waiting area, play area, and dedicated quiet waiting area to provide a low stimulus environment;
- Additional storage and clinical support areas;
- Dedicated isolation capability to accommodate patients requiring infection control measures in the outpatient setting;
- A treatment room with a burns bath, improving facilities for outpatient burns patients;
- Access to natural light, not available in the current outpatient space;

2.13 This project is strategically important to the RHH to allow for the expansion of the RHH ED. The relocation of POC will allow the ED to expand its current location on Lower Ground J-Block into the Lower Ground H-Block space vacated by POC while providing expanded and improved facilities for the POCs.

2.14 The provision of health services for infants, children and adolescents, will be greatly improved with the building of the new POC at the RHH and will facilitate the continuum of care from the patient journey into the hospital setting until discharge back into the community. It is expected to allow greater access to health services for this very important cohort of patients and enable the provision of improved ambulatory care services for children and adolescents.

3 PROJECT COSTS

3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work is $30.5 million.

The following tables detail the current cost estimates for each project:

Royal Hobart Hospital Intensive Care Unit Expansion Project

Construction Costs	$11,560,000
Construction/Design Contingency	$685,000
Post Occupancy Allowance	$100,000
Professional Fees and associated costs	$792,510
Other Fees	$45,000
Information and Communication Technology Infrastructure	$456,000
Furniture and Equipment	$1,808,000
Other client costs	$489,000
Tasmanian Art Scheme	$80,000
PROJECT TOTAL	**$16,015,510**

Royal Hobart Hospital Paediatric Outpatients Relocation Project

Construction Costs	$7,743,590
20% allowance of current market conditions over the tender estimate	$1,800,000
Construction/Design Contingency	$405,979
Contract Contingency	$430,000
Professional Fees and associated costs	$749,630
Post Occupancy Allowance	$100,000
Tas Arts Scheme	$80,000
Information and Communication Technology Infrastructure	$777,000
Furniture and Equipment	$1,500,000
Client Costs	$235,000
PROJECT TOTAL	**$13,821,199**

4 EVIDENCE

4.1 The Committee commenced its inquiry on Monday, 20 September last with an inspection of the site of the proposed works. The Committee then returned to Committee Room 1, Parliament House, whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

- Rick Sassin, Program Manager, Department of Health and Human Services;
- Glenda Sorrell, Project Manager, Matrix Management;
- Darren Jones, Architect, BPSM Architects (Royal Hobart Hospital Intensive Care Unit Expansion Project); and
- Mark Kukola, Senior Associate, Philp Lighton Architects (Royal Hobart Hospital Paediatric Outpatients Relocation Project).

The following Committee Members were present:

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

Royal Hobart Hospital Intensive Care Unit (ICU) Expansion Project

How Will the Design of the ICU expansion Improve Patient Care?

4.2 The Committee recognised the current ICU did not provide a contemporary environment for patients or staff. The Committees sought to understand how the expanded ICU would improve conditions for the treatment of patients:

> ***Ms RATTRAY*** *- We also heard this morning that the 1980s design of this area of the hospital, the Florence Nightingale sort of approach, is no longer contemporary. That would be useful for people to understand. It is pretty evident but it would be useful to understand that concept.*
>
> ***Mr JONES*** *- Health care like anything evolves due to technological advances and general advances through scientific discovery. The key thing in moving from what was described this morning as Florence Nightingale to contemporary standards is predominantly about infection control. One of the biggest issues in recovery times for patients is around particularly minimising the opportunity for external infections to take hold.*
>
> *As you can imagine, anybody in ICU unfortunately is in a severely weakened state and is heavily compromised. Therefore, it exposes them to an environment where they are more readily susceptible to external infections. In the older models mentioned this morning, you have open patient rooms and multiple patients sharing areas, which increases the risk of cross-contamination. The model we are proposing in the current design is an individual room per*

patient model that can be completely separated from the other patients, thereby significantly reducing the risk of cross-contamination associated with external infections and enhancing the recovery prospects of the patients.

***Ms RATTRAY** - We were also informed by the good doctor this morning that, around privacy as well, the old material curtain, which has morphed into something non-reusable now, is no longer appropriate in those sorts of spaces when it comes to serious conversations families may need to have with the medical staff.*

***Mr JONES - ……** If you walk into any inpatient room and you see the curtain drawn across, it is not much more than a shower curtain in terms of weight or thickness, therefore there is little or no acoustic privacy. Whereas, all these rooms being individual rooms, have a solid wall construction, they have acoustic insulation in the walls, and we also have a sliding door across the front so the door can be opened, closed, or be partially open. The door is glazed so when it is closed, you can have high visibility of the patient if required but if you are looking to provide visual privacy, the glazing is electric glass* [i.e. electrically switchable from transparent to opaque].

Increase in Number of ICU Beds

4.3 The Committee sought to confirm what additional bed capacity the ICU expansion would provide:

***Ms BUTLER** - How many existing ICU beds are there at the moment? How many ICU beds will there be after this construction?*

***Ms SORRELL -** I can answer that. The clinicians told us there will be 35 in total at the end and 13 of those will be up to the standard and Q class. There is one Q class per state. They already have that one, so one of those extra 12 we are building, they already have their Q class one. In total there will be 35 at the end of the build.*

***CHAIR** - For the record, what is a Q class?*

***Ms SORRELL -** The Q class is the one where they put anybody in that has to be isolated.*

***Ms RATTRAY** - How many are there at the moment?*

***Ms SORRELL -** That would 35 minus the 12 so we would have 23.*

Proposed Location of the Expanded ICU

4.4 During the site visit for the projects, the Committee noted the former maternity ward had existing facilities that could be potentially repurposed to accommodate the new ICU. The Committee questioned the witnesses on the suitability of reusing the old maternity ward and why the proposed location had been chosen:

***Ms RATTRAY** - …… reflecting on what we saw this morning - …… the paediatric place where we went and we also looked at the old maternity birthing section, they all had ensuites. Here we are in the ICU adding bathrooms when the former maternity section already has those and they're going to be removed. Was there any thought about having it round the other way ……?*

***Mr SASSIN** - For clarification purposes, it is important to note that the location of the ICU is paramount toward the MRI, the examination for the electronic testing. That's the reason for the physical location. Plus, there is an existing ICU located and this is an extension of that.*

Ms RATTRAY *- Was that a reasonable question when we were looking at adding bathrooms but we're taking them away from the paediatric improvements?*

Mr JONES *- It's a reasonable question but there is an element of technicality when assessing all of this. There are two parts to it: one is looking at the model of care and the second is relationships in terms of buildings. There are two parts to it as well as the technicality element attached to just purely the age of that existing infrastructure. The age of that existing infrastructure is about 25 to 30 years old.*

Ms RATTRAY *- The maternity birthing unit?*

Mr JONES *- Yes, in terms of the existing maternity birthing suites. It was about 25 to 30 years since the last refurbishment.*

Every design we do in relation to hospitals and healthcare is based on the Australasian Health Facility Guidelines. These guidelines are a national agreed standard that sets out the minimum recommendation requirements for not just the ICU but multiple different types of hospital functions, whether it be a single bedroom for an inpatient, through to a treatment room, even to a clinical office.

So, if we were to go back and simply examine the existing maternity suite, none of those would match or comply with the current health facility guidelines. That is the first thing. So, even if we did go in there, we would have to significantly modify it. The functions are completely different in terms of maternity versus ICU. There is a significant difference in care acuity. For the record, but if you said five out of 10 for maternity; ICU is 10 out of 10 with regard to level of care.

Without significant modification, you can't put one unit in a previous unit. The second part of it, is the fact that maternity was existing in D Block on Level 3. The existing ICU is currently based on Level 1 of H Block. You are talking about them being two floors apart as well as in separate buildings. In terms of staffing, it means that it is very difficult to run a unit that is segregated by such a substantial difference in that sense. That is why we went with the existing available space on Level 1 of H Block, because it is adjacent to the current ICU.

Consultation

4.5 The Committee was interested to understand what consultation was undertaken and how this had influenced the projects design:

Ms RATTRAY *- Consultation. Chair, I asked in our meeting this morning about the feedback from the ICU patient families conducted in 2019 and what impact it had on the design. I think that would be useful to have on the public record.*

Mr JONES *- Certainly. From my perspective I, as the architect, engaged with a designated user group which in this particular case was formed by Felicity Geeves, who is the Nurse Unit ……and Andrew Turner, whose title is -*

Ms RATTRAY *- He is Staff Specialist - Critical Care Medicine and State Medical Director.*

Mr JONES *- They were my two key stakeholders in terms of formulating our design response. They themselves brought their own consultation that they had undertaken with their own staff. Plus they also have, for want of a better term, a user feedback process where they see feedback from family members of patients as to what they think may be appropriate or how they may see the service or the environment being approved. They've taken all that feedback and mixed it with their own requirements to come to me with the overall requirements for the project.*

Ms RATTRAY *- What were the two key factors that came from the consultation process with ICU patient families?*

Ms SORRELL *- It was the natural light, which they really required, and the external space, which reduces delirium.*

Ms RATTRAY *- I also had privacy, so there were three.*

CHAIR *- Do we have the membership of the Project Reference Group? ……Does the membership of the reference group include community members?.....It says: 'clinical and consumer stakeholders'.*

Mr JONES *-……The Project Reference Group is formulated, as I said, by the likes of Felicity Geeves as the nurse unit manager; Andrew Turner as the director; and their relevant stakeholders being their own staff and the user feedback that they receive from patient families.*

CHAIR *- There is not likely to be a community member on that Project Reference Group?*

Mr JONES *- No, as I understand, there is no direct community member.*

CHAIR *- ……When consulting, sometimes people get missed. Do orderlies get consulted? There might be specific issues with lift widths and things like that?*

Mr JONES *- There are always issues. From my perspective, leading the design team, I rely upon my clinical user group to consult with all of the relevant stakeholders that they believe are appropriate to consult with.*

CHAIR *- Sometimes, people like that might have specific issues that they keep running into when they're transferring patients here, there and everywhere……It might be quite significant. You would think that that would be picked up.*

Mr JONES *- A typical reference group involves facilities and engineering who are responsible for maintaining the facility and services; infection control; to a lesser extent, emergency management. Security falls into the basket of orderlies. Environmental management is cleaning.*

Air-Conditioning Requirements to Allow Isolation of the ICU

4.6 Noting that it was proposed that the new ICU section could be isolated in the event of a pandemic situation, the Committee was interested to understand how the air conditioning systems would function to enable this capability:

Mr TUCKER *- We talked this morning about how the air-conditioning operates. Can you put what we discussed on the record?*

Mr JONES *-Yes. The mechanical systems for the ICU have been designed to comply with the AS 1668.2. Because there are elements of relationship to fire detection attached to them, part 1 also comes into it. There is also a section under the Australasian Health Facility Guidelines which deals with operation, design and mechanical plant within a hospital and we also referenced the Victorian Health Facility Guidelines. They have a very detailed specific subset of requirements associated with isolation rooms. They are our reference points in relation to the design of mechanical plant for the ICU. That is the background.*

The second part is that the ICU has been designed as 12-bed unit. Each bedroom has its own independent stand-alone system per room, to minimise and ideally eliminate cross-contamination between infectious patients if required.

It is also provided with two N-Class isolation rooms - N-Class being negative pressure -that allow for infectious patients to be isolated from the rest of the ward. The additional factor to this proposed ICU is that the mechanical plant has been designed as a stand-alone system, so that all 12 beds and the entirety of the unit can be isolated from the rest of the hospital to be used as a 'pandemic' ward. That pandemic can be the basis of any infectious disease, not necessarily our current pandemic.

If it is needed to be used as such, the entire unit can operate on a stand-alone basis both mechanically and electrically. Also, we have set it up so that physically it has got a very defined access point for staff coming and going where they can dress and undress in their required PPE.

***Mr TUCKER** - We spoke about the outside CO2 and carbon monoxide levels. What are we doing there?*

***Mr JONES -** Our fresh air is driven by a fresh air intake system that comes wholly and solely from outside of the building.*

For example, carbon monoxide is a heavy gas and exists at a low level. Our air intakes are somewhere in the order of seven to eight metres above the ground, so in terms of an adjoining floor level, they are substantially higher than CO2 would naturally rise to. Given their proximity to where the road is, any CO2 or carbon monoxide would substantially disperse. These air intakes would not be subject to any form of ingest associated with them.

***Mr TUCKER -** We also spoke about the air going out of the hospital. Do you want to briefly mention that?*

***Mr JONES** - Certainly. Given that each individual room is temperature and air-controlled the air is recirculated within the room through a HEPA* [high efficiency particulate air] *filtering system within the room to pick up and trap any form of particulate. It also means that when the air exhausts, it exhausts out of its own air-handling unit. At a normal level that's fine. What we also have a system of a separate set of duct work that connects to all of the air-handling units. So, in that pandemic mode, it connects and feeds directly into that exhaust system which then exhausts three metres above roof level and this is roof level at level six, which makes it about 30 to 35 metres above the adjoining ground level. Thereby, it's not likely to cause an issue with any sort of public thoroughfare or any passers-by.*

***CHAIR** - Can you explain the issue of negative pressure as you explained it this morning?*

***Mr JONES** - A negative pressure room is set up so that you have the main room itself which is the patient treatment room. There is also an antechamber, or airlock, between that and the adjoining, more public space of the hospital. They are set up with a pair of doors that are interlocked, meaning that only one pair of doors can be open at any one time. When you go into the room you go via the antechamber; open the door, you step into the antechamber, those doors close and lock before the other doors are allowed to electro-mechanically open.*

That's also done on the basis that there is a difference in air pressure between the patient bedroom or patient treatment room, the airlock and the adjoining corridor. The adjoining corridor is at a higher pressure than the antechamber, which is at a higher pressure than the adjoining patient bedroom so, at no point, if there is an infectious disease present in the room is it allowed to ventilate into the open circulation space. Air is always being sucked into the room.

Provision for Medical Gases in Patient Bathrooms

4.7 The Committee was aware that there would be capacity to deliver medical gasses to patients in each new bathroom. The Committee sought to understand why this was important:

> ***Mr ELLIS*** *- What is the rationale behind the medical gases going into the bathrooms?*
>
> ***Mr JONES*** *- The reason for the medical gases in the bathrooms. There are two patient ensuites, one each associated with the two isolation rooms and there is a general patient bathroom. Just because they are in ICU does not automatically mean that the patient is ventilated; they simply require a very intensive level of care. The staff still do have the ability to move them from their room into either the ensuite or the general patient bathroom to shower them, to wash them. The reason for having medical gases in the patient bathrooms is so that patients can be transferred from one space to another and maintain their supply of oxygen or provided with medical air for a particular procedure if required.*
>
> ***CHAIR*** *- That would be for safety reasons too, in the event of oxygen bottles being dropped and all those sorts of possibilities.*
>
> ***Mr JONES*** *- Yes, whilst we do make provision for oxygen bottles as a stand-by scenario, they are very much a last resort.*

Location of the Undercover Deck

4.8 The Committee noted the provision of an undercover deck for patients was in an area overlooking the hospital entrance. The Committee sought to understand why this could not be located in a better setting for patients:

> ***Ms RATTRAY*** *- With regard to the last dot point in the first section under Primary Objective, we had a look at the area that is the under-cover deck provided to allow ICU patients to be taken outside…….Why can't the outdoor covered area be further back? The ambience of that area is not ideal as it overlooks the carpark or the entrance area.*
>
> ***CHAIR*** *- So, further north?*
>
> ***Ms RATTRAY*** *- Yes. If anyone goes there they will say that would have been a much better area, as I did today, but there are reasons why that couldn't take place. I would like that on the public record.*
>
> ***Mr JONES -*** *Certainly. While the intention of that outdoor balcony is to provide fresh air and sunlight to the patients, we also have to aim to achieve an element of patient privacy and confidentiality given the fact that the general public walks in front of the hospital along Liverpool Street.*
>
> *The closer it is to the front of the hospital the more sunlight and open air is provided but it exposes those patients to a greater level of scrutiny from the general public walking past and removes large elements of their personal privacy. Therefore, by setting it back as we have, we still achieve elements of sunlight, certainly achieve open air, but also achieve the elements of privacy we are looking for for patients. Those patients are ICU patients, so they are very vulnerable patients. You don't want to place them in an environment where they are being exposed to general public scrutiny.*
>
> ***Ms RATTRAY*** *- Thank you. That is a reasonable explanation. There is also a lift that impedes somewhat around that area.*

Mr JONES *- Yes. That lift services the three floors below so we are unable to relocate it.*

Catering for Patients' Family Members

4.9 The Committee recognised the importance of enabling access and providing appropriate facilities for family members, during what can be an often lengthy and worrying period. The Committee asked the witnesses what facilities would be provided for family members to support their welfare and comfort:

> ***Ms BUTLER*** *- While we're looking at the room layouts, I am not exactly sure how an ICU area works insofar as the amount of access family members might have to visiting people in the ICU. Is there an area within those rooms for families or a space for families?*
>
> ***Mr JONES*** *- Yes. Directly behind the reception within the ICU, which is directly accessible off the lift lobby, there is what we call a family room. The whole idea is that if you're there visiting a family member who is currently a patient with ICU, you present to reception. They can either direct you, as was mentioned this morning, into what we will call the new ICU or towards the old ICU. But also depending on the level of care being provided to your family member, you may first be asked to wait in the family room. In which case, they have the family lounge waiting space directly behind the reception, which also acts as a control point so that reception has the ability to buzz you in and out of that family lounge area. It also means that it prevents unwanted visitors from arriving within the unit.*
>
> ***Ms BUTLER*** *- So there will be a level of comfort, as such, for family members who may have to stay there for long periods of time?*
>
> ***Mr JONES*** *- Yes. The whole idea is that there can be a situation where, if you are outside of visiting hours for a variety of reasons or there has been an emergency that means your family member has been delivered either via ambulance or from another part of the hospital to the ICU at 2 a.m., you have somewhere you can go.*

Tender Process

4.10 The Committee understood the tender process had already been undertaken but a contractor had not yet been selected. Noting that only one tender bid had been received, Committee sought further information on the tender process and how a decision would be made on the bid received:

> ***Ms RATTRAY*** *- Supplementary to Ms Butler's question, we were informed that there has been only one tenderer for this project, so that makes it fairly easy to choose, doesn't it?*
>
> ***Mr JONES*** *- It does and it doesn't -*
>
> ***CHAIR*** *- If they're deficient, it makes it hard.*
>
> ***Mr JONES*** *- There are two factors at play here. Because of the nature, scale and the size of this particular project, there are only four or five contractors in Tasmania who are pre-qualified for Treasury and Finance at the relevant level. Working within a hospital environment adds a level of complexity so you are looking to encourage the receipt of tenders from appropriately qualified an experienced contractors. It does unfortunately tend to start narrowing the field even more. Then on top of that there are the market conditions as well.*
>
> ***CHAIR*** *- They are pre-approved though, aren't they?*

Mr JONES *- They are pre-approved, yes.*

Ms RATTRAY *- Can I just go back a step for my own personal level of comfort? The state would never just award a tender if it did not meet the appropriate requirements. Just because there is one, and we do not have any others to choose from, and we need this project as a state and a community, we would never compromise any of the required aspects of this?*

Ms SORRELL *- I can answer that because I wrote the report that went to the committee. It was a conforming tender. We had a number of clarifications that went back and forth to the builder along the process. We have all of that in writing. That has all gone to the committee so that they can see that. In actual fact the tender was almost bang on the estimate of the cost of the project so we were very fortunate in this one in that it wasn't a too hard a report to write.*

CHAIR *- The point is taken. It makes it hard if there is only one and they are not up to scratch somewhere.*

Ms SORRELL *- If it was a non-conforming tender we would have had to report that.*

Timeframe for Completion of Works

4.11 The Committee noted the timeframe for completion of the project and sought confirmation that this could be achieved:

Ms BUTLER *- Under the Executive Summary, it has that the expansion was hoped to be completed by 2024. On page 5, it has a set date of completion for July 2022. Is the 2024 a different project, or are we ahead of schedule?*

Ms SORRELL *- Currently, this project has been out to tender and has come back. We have done the tender assessment. That has gone out to the RPC for approval. The report went in this morning and we are waiting on it coming back, but we are looking at appointing a contractor this year.*

Ms BUTLER *- Has this been bumped up at all?*

Ms SORRELL *- Not to my knowledge. I have just come into this project now. It was being handled by somebody else before me. My understanding is that it is July 2022 that we are planning on finishing.*

Ms BUTLER *- Do you think it is likely that we will reach that July 2022, especially in light of COVID-19 and the need for ICU beds? Do you think that you will be able to meet that?*

Ms SORRELL *- Yes, the builder has given us a program that meets our time frames and his program is to that time frame of completion.*

Project Costs and Contingencies

4.12 The Committee sought clarification on the amount of contingency allocated for design and construction and other allowances provided for in the project budget:

CHAIR *- With respect to the costs, you have Construction/Design Contingency and it is only 5.9 per cent. Contingencies can quite often be higher than that. I think they can; you tell me.*

Ms SORRELL *- I can answer that because I am a quantity surveyor. We have a 5 per cent design contingency at a particular level of the project plus a 5 per cent construction contingency.*

What would have happened at this point, is the design contingency would have been completed because the design is complete and this will be the client's construction contingency for any latent defects, et cetera.

Mr JONES - *Also, what is included within the construction cost of $11.56 million, is some provisional sums to take into account some elements such as asbestos removal, which we know needs to take place but we haven't fully resolved a likely quantum. Therefore, we have allowed a sum of money within that $11.56 million for its removal. There are a few other little bits and pieces like that.*

CHAIR *- The post-occupancy allowance of $100 000?*

Mr JONES - *No, sorry, provisional sum. It is a sum of money that is identified for expenditure within the $11.56 million construction cost. It is similar to a contingency without actually being a contingency.*

CHAIR *- Okay. What is the$100 000 post-occupancy allowance about?*

Mr JONES - *That allows for, once the occupants have moved in and identified, some minor issues that need adjustment.*

CHAIR *- Information, ICT $456 000. Is that mainly cabling? Is it going to include the service as well? That is a fairly high figure.*

Mr JONES - *No. The cost of the cabling and the cost of the backbone infrastructure is again included in the $11.56 million. That is an allowance from ICT themselves to provide service, all the active equipment and also covers their relevant time costs.*

CHAIR *- Furniture and Equipment. That is the fit-out?*

Mr JONES - *That's the fit out. It includes things like, for example, all the loose furniture, desks, patient beds, patient chairs, medical pendants.*

Managing Construction in a Working Hospital

4.13 The Committee recognised the difficulties in undertaking construction works in a working hospital. The Committee sought to understand what systems would be in place to ensure continuity of care and the minimisation of disruption to patients and staff:

Ms RATTRAY *- I might ask about the access for the workers… … that is an important feature*

Mr JONES *- … …I am very conversant and aware of the requirements of operating within an operational hospital and, therefore, dealing with issues associated with patient privacy, patient care, maintaining operability, infection control, et cetera. To minimise the disruption from the contractors coming in via other parts of the hospital, what we have incorporated, as part of the construction documentation, is the construction of a site village over the top of the exit ramp from the Department of Emergency Medicine. Once this project is in a position to commence, the public will see a general site village located over the top of the ramp.*

Ms RATTRAY *- Lots of 20-foot containers.*

Mr JONES *- No, more your typical site shed. Site shed, meeting rooms, that sort of thing will be located on what we call a gantry over the top of the exit ramp. The intent of that is it will be constructed at the same level, being the first floor, as our proposed work zone, so that when the contractor needs to access the work zone, he walks directly off his gantry. We*

nominated a location, given that they have to construct that new balcony, that be the entry point to the building.

***Ms RATTRAY** - The disruption to services: that was explained as well, and that would be useful to also have involved in this.*

***Mr JONES** - All projects run what's called a work zone permit process and the intent of that work zone permit process is to fundamentally monitor and, therefore, mitigate any risks associated with any form of disruption within the hospital associated with the construction.*

The permit process covers all tasks associated with the construction or fit-out, in this case, the ICU. It commences with the contractor filling out a work-zone permit to receive approval to take possession of the work zone. That is the first point.

Then, there is a series of work-zone permits that he will issue all the way through the project, to do with a major shutdown such as a switchboard replacement, switching off, changing over, commissioning medical gases, any form of water outage and any form of shutdown associated with mechanical services. They also have to provide work-zone permits anytime they go to undertake even a minor investigative process, outside of their work zone. The purpose of this is to give the hospital full knowledge of what is going on all the time, so that risks associated with disruption to patient care are mitigated.

The process involved, once submitted by the contractor, involves facilities and engineering on behalf of the hospital, the emergency management team in the hospital and also infection control. There is engagement with all of the appropriate clinical users within that user group.

***Ms RATTRAY** - So, there will be no problem with a proposed shutdown being fed into the system and someone like the nurse manager, like Felicity, turning up and saying 'No, we haven't got what we need to operate'. That won't happen?*

***Mr JONES -** No, that won't happen.*

***CHAIR** - It is a liability thing too, I suppose.*

***Mr JONES -** It is a risk mitigation strategy. Because we all acknowledge that it is an operating hospital and patient care is paramount and therefore we are looking to do everything we can to mitigate undertaking something that may involve someone thinking they are only switching off a light switch, and which has a detrimental outcome.*

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

4.14 In assessing any proposed public work, the Committee seeks assurance that each project is a good use of public funds and meets identified needs. The Committee questioned the witnesses who confirmed that the project was meeting an identified need and provided value for money:

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

***Mr SASSIN** - Yes.*

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

***Mr SASSIN** - Yes.*

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

Mr SASSIN *- Yes.*

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

Ms RATTRAY *- Are they gold-plated?*

Mr SASSIN *- No.*

Mr JONES *- … … it's an appropriate standard. It complies with the Australasian Health Facility Guidelines.*

CHAIR *- It's not an overspend?*

Mr JONES *- It's not an overspend, no.*

CHAIR *- I think that's what the member is getting at, that it's not being gold-plated.*

… … The question is: yes or no, and you've said 'yes', I believe?

Mr SASSIN *- Yes.*

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

Mr SASSIN *- Yes.*

RHH Paediatric Outpatients Relocation Project

Improved Capacity to Provide Paediatric Outpatient Services

4.15 After visiting the current Paediatric Outpatients Clinics (POCs), the Committee recognised the current space was inadequate and poorly configured. The Committee sought to understand if the new facility would provide a larger space with an enhanced configuration and what impact this may have on the level and range of services that could be provided:

> ***CHAIR*** *- … … In terms of the space that this is taking up, it is not gold-plated but it is adequate. That is what we heard this morning. Is that correct or is it desirable that it should be a bigger space?*
>
> ***Mr JONES*** *- I think the space is adequate for what they require.*
>
> ***CHAIR*** *- Allows for growth?*
>
> ***Mr JONES*** *- Yes. But I don't think it has been taken to the enth degree. I think they are quite comfortable getting the space allocation.*
>
> ***CHAIR*** *- Okay.*
>
> ***Ms BUTLER*** *- It is my understanding from the questions we asked this morning that the space they will have after their re-location is a lot bigger than the current space they have. Is that correct?*
>
> ***Mr KUKOLA*** *- Yes, it is bigger. The expectation is that their level of service will increase as well so those additional spaces and rooms are required.*
>
> ***CHAIR*** *- It is a better use of space than they have at the moment?*
>
> ***Mr KUKOLA*** *- No doubt about it, yes.*
>
> ***Ms BUTLER*** *- It is quite tired.*
>
> ***Mr KUKOLA*** *- Yes, and the corridors are really tight. A much better solution.*
>
> ***Ms RATTRAY*** *- We also heard that it will allow for more services in the one room, where you need more than one service for a patient.*
>
> ***Mr KUKOLA*** *- Yes. They are also combining allied health services in that whole space. The use of the gymnasium as well. The level of service they can offer will be enhanced.*

Temporary Relocation of the Paediatric Outpatients Clinics

4.16 The Committee understood that the initial plan was for the new POCs to be constructed in Level 3-D Block, with the POCs continuing to operate from their current location. However, since the project was submitted to the Committee for consideration, the State Government had announced that the planned expansion of the ED was being brought forward. The ED expansion will be taking over space currently occupied by the POCs, resulting in a need for the POCs to relocate temporarily, potentially more than once, prior to construction of the new facilities.

4.17 The Committee did have some concerns with the potential double relocation and sought further information from the witnesses on how this would be managed:

> ***Ms RATTRAY*** *- I would like to ask the question that I asked and the answer was provided around the relocation, or the temporary relocation, of the current Paediatrics services while their purpose-built facility is being prepared. Obviously, it is a crucial element of care, particularly paediatric check care, so I would like a response to that, thank you.*
>
> ***Mr SASSIN*** *- In all intents and purposes, this project was prepared in light of a full renovation of 3D and Paediatrics would move within that facility, that floor. That was the intention of the project from its outset. Recently an announcement was made that lower ground, or ED, shall have 25 beds… … designed and installed in lower ground H*
>
> *… …We are all a little bit on the back foot, and we have been very open with you, that only recently an announcement was made that 25 beds would be fast-tracked, or early works program for the emergency department, which would require Paediatrics almost immediately to be relocated out of the current location in lower ground H to make way for those 25 beds, which are due to be opened by the end of 2022.*
>
> *Until confirmation is given, discussions are still in place, but our understanding is that it's easiest at this time to move Paediatrics from lower ground H into the 3D location, which is where this particular project we are discussing today would likely be. This ultimately means a double decant, if that makes any clarification to you.*
>
> *Basically, they would move in, an alternate location would be found in that process of moving out of lower ground H into 3D, unless another idea comes within the next week or so. I know there is some discussion going on in senior management at the hospital. Subject to those decisions being made, we are under the belief that that's what will happen in the short term. Paediatrics will move from lower ground H into 3D and then, subject to another location, they would then decamp into that location. Then the Paediatrics project will commence and complete. They would move back. And that's, I think, how we understand it.*
>
> ***Ms SORRELL*** *- Overall there is a master schedule for the entire project and every single one of these projects is scheduled onto that master program. The moment you change one element of that master program, it -.*
>
> ***CHAIR*** *- A domino effect.*
>
> ***Ms SORRELL*** *- Yes, and that's what has happened. While this was decided, that this project would be started and built while they were still on the lower ground floor, it now has to change because they have changed the domino effect of the Department of Emergency Medicine, which has now knocked out the rest. We are currently working around what that means to the total master schedule, because there are about six or seven projects all going on at the same time, and each has a knock-on effect because people have to be decanted from one building into another… …This particular one could not be started until somebody else had been decanted, so that has also been knocked out now.*
>
> ***Ms RATTRAY*** *- What I am hearing, Chair, is that it is not settled where Paediatrics might have to be temporarily located for this to even progress in the timeframe that's been provided in this document.*
>
> ***Mr SASSIN*** *- That would be a fair comment. We would like to go through the process, if that's okay… …And present the design as it is. It will be constructed as is; there won't be, other than maybe some possible staging - we haven't looked into that in too much detail. But we would appreciate if we could have the hearing, and probably on notice we could come back to you at a later date with any clarifications.*

Ms RATTRAY *- We don't get a second bite at these. This is it for us……We only have this opportunity. Once we say yes or no, we don't have input any longer.*

CHAIR *- We don't have any more say. It is a matter of knowing that it will end up being constructed as per the plans.*

Ms RATTRAY *- …… My concern is that it will completely change the timeframe and the budget. That is what we are here for.*

Mr JONES - *…… If I may, wearing several other hats as I do down at the hospital, I am involved in several other projects outside of ICU…..I have several other projects I am responsible for, a couple of which are decant wards that I am currently in the phases of designing ready to have in place.*

…… as I understand it the intent is that will be as is. With regard to decanting to other wards, there are several things that need to be looked at, whether a staged construction process needs to be undertaken to enable it to remain in occupation while the new facility is being constructed?

For me, that is a regular occurrence down at the hospital. ICU is a rare beast where we can pretty much knock it over in one hit.

…… Normally, most of the projects I am involved in require multiple stages, because we can't decant the service into another part of the hospital or off-site, either for funding reasons or because that unit needs to be on site to operate. Therefore, we stage it.

Ms RATTRAY *- We heard this morning that the paediatric component, or this area, has to stay on the site it is. It cannot move off-site.*

Mr JONES - *Knowing in the background, because I am involved in them, there are several space opportunities becoming available down the track. I am flagging the opportunity for paediatrics, if it needs to, to temporarily relocate into those other spaces without it impacting upon the cost of this project because those decanting spaces are being funded from other parts of the stage 2 budget.*

CHAIR *- You are saying that the cost is unlikely to change dramatically?*

Mr JONES - *Yes, that is what I am saying.*

Ms RATTRAY *- I am concerned for the department. I heard that concern this morning, Chair, from the good doctor Sean* [Beggs] *and Cassandra.*

Mr SASSIN *- ……I talked to Mr Beggs afterwards. He has not spoken to the senior management of the hospital. It has all happened very quickly. I understand there is a meeting or meetings happening this week, so he will be made aware and he will participate in the hospital's discussion.*

4.18 The Committee subsequently received further information from the Department on the proposed arrangements for the temporary relocation of the POCs:

Following an announce by the Health Minster on 6 September (2021) where he committed to the accelerated opening of 25 new Emergency Department beds by the end of 2022, Paediatric Outpatients Unit, which is currently located in in Lower Ground H-Block, will be relocated temporarily to Level 3 in D-Block. This move will allow the refurbishment of Lower Ground H-Block, thereby providing additional floor space to

accommodate the 25 additional beds outlined in the Ministers announcement. This work is planned to commence in early 2022.

Paediatric Outpatients Unit will subsequently be required to relocate, most likely to vacated space in the Wellington Centre, by mid-2022. This will enable construction works in 3D to establish the new Paediatric Outpatient Clinic (as per details contained in the PSCPW submission). This work is scheduled to be completed July 2023.[1]

Accessibility

4.19 The Committee recognised that many patients visiting the POCs may have special needs and sought to understand what measures had been taken to ensure the facility would be accessible:

> ***CHAIR*** *- … … Can you place on the record what consideration has been given to that area and people with a disability? Navigating that space if they are blind or in a wheelchair.*
>
> ***Mr KUKOLA*** *- The whole space is fully compliant equal access, also for people who are ambulant. That entails coloured contrasts between walls and doors so that people who don't have full sight are able to distinguish the entry door. It doesn't show it on here because this has been a revision in the past week. We have clear colour-coding shapes on the floor from reception to the main treatment halls so patients can easily find their way to one treatment hall or the other. It's a clear blue-green that tends to work well. It complies in every other regard such as the number of equal access toilets, et cetera.*
>
> ***CHAIR*** *- And Braille plates on buttons, lifts and those sorts of things?*
>
> ***Mr KUKOLA*** *- Full compliance with that. Access to the lifts is complied with. The lifts are existing.*
>
> ***Ms BUTLER*** *- Is one of the reasons why you have that coloured coding and lines to do with people who are illiterate and don't understand normal signage?*
>
> ***Mr KUKOLA*** *- It helps everybody. It's an easy way to know that you're on the right path to where you need to go. Hospitals can be confusing places. There are lots of doors. Children will be accompanied by their parents, but there are older adolescents as well. It's a good way to get them to where they need to be.*

Provision of an Isolation room

4.20 The Committee understood that the new POCs facility would include an isolation room and sought further information on the purpose of this:

> ***CHAIR*** *- And the issue of oncology patients returning from Melbourne with isolation required? … … Isolation is provided for?*
>
> ***Mr KUKOLA -*** *… … Yes, that is right. The isolation room close to the entry area -*
>
> ***Ms RATTRAY*** *- For hot cases.*
>
> ***Mr KUKOLA*** *- Yes, the hot case. I think the main purpose was because there are patients who are immunocompromised, even things like the common cold they try to isolate those patients*

[1] Response to Questions Taken on Notice, Department of Health, via email Thursday 30 September 2021

from them. It's not to the level of isolation in the ICU. That's a step up from what's required here.

Provision of a Quiet room

4.21 The Committee noted that the new POCs would include a quiet room and sought to understand what this might be used for:

> ***CHAIR*** *- What is the quiet room?*
>
> ***Mr KUKOLA -*** *The quiet room is a space for children and adolescents who are on the spectrum. It's a space towards the rear of the waiting area, where they can be away from the din of that space, especially with young children. That really helps in reducing their anxiety levels. There will be a visual connection between the reception office area into that space so they can see what is going on but it will be closed off from the main waiting area, and on the other side from the young children's play area as that would the noisiest.*

Gymnasium

4.22 The Committee noted that the current POCs facility did not have a gymnasium, but the new facility would have. The Committee was keen to know why a gymnasium had been included and what benefits it would provide:

> ***Ms BUTLER*** *- What is going to be in the gymnasium? What are some of the purposes for the gymnasium?*
>
> ***Mr KUKOLA -*** *My knowledge is that it will contain things like parallel bars, a plinth, which is like a bed - exercise equipment. It is for the physical rehabilitation of children with disabilities.*
>
> ***Ms BUTLER*** *- Currently, there is no gymnasium, so this is a step up? It is like an addition to the project?*
>
> ***Mr KUKOLA -*** *There isn't. I think that is done elsewhere.*
>
> ***CHAIR*** *- So it is for allied health purposes?*
>
> ***Mr KUKOLA -*** *Correct, yes, that is right. That is why it was important to bring them together and have them all in one space so children with complex physical issues can be treated in one area and doctors can move between those areas.*

Area for Staff to Change Personal Protective Equipment

4.23 The Committee was aware that early plans had included a specific room for staff to change in and out of personal protective equipment (PPE), but current plans had removed this area. The Committee sough clarification on what arrangements would be in place for the donning and doffing PPE:

> ***Mr TUCKER*** *- When we were talking about the isolation room, there was meant to be an area for the staff to change in and out of the PPE equipment. Do you want to put some of that on the record?*
>
> ***Mr KUKOLA*** *- Through the process of working through the rooms, we originally had a separate room where the medical staff could don their PPE gear before they entered the main room. After quite a bit of discussion it was thought that it wasn't required, that they would prefer*

to put on their gear before they entered the room. That space could be better used for other things.

***Mr TUCKER** - They mentioned that the space where there are three waiting chairs next to the isolation room was a good area for them to do that. I could see the reasoning. They mentioned that the likelihood of having three patients there while one was in the isolation room was unlikely.*

***Mr KUKOLA** - Yes, that's right. That's what I believe too.*

Design Theme

4.24 The Committee noted the design in the current POCs was very outdated and focused heavily on early childhood. The Committee also understood that the new POCs would incorporate a different design and sought further information from the witnesses:

***Ms RATTRAY** - The executive summary says the current Antarctic theme has been adopted and you're going to follow that through. The theme that we saw as we did a walk-around today appears to be quite dated and aimed at very young people. When you have such a range of tinies, through to the half grown-ups who think they are fully grown up, how do you meet their aspirations?*

***Mr KUKOLA** - It is a challenge. Their needs are quite different. The brief was to utilise the Antarctic and Aurora colours theme that is now in K Block.*

***CHAIR** - ... ... You are talking about continuity between the birthing area and the adolescent?*

***Mr KUKOLA** - That's right. We have taken the design themes from the new paediatric facilities and maternity facilities in K Block and utilised them for the paediatric outpatients. The graphics and the colour schemes are quite dated in the existing paediatric outpatient department.*

***... ...** As an example to help you, have you seen the images of the entry area with the beautiful coloured lighting on the lift lobby?*

***Ms RATTRAY** - We did see that.*

***Mr KUKOLA** - There are whale picturegrams on the walls. Those sorts of themes and those sorts of colours are what is our inspiration... ...*

Project Contingencies

4.25 The Committee sought further information from the witnesses on the differing contingencies for this project, compared with the ICU Expansion Project:

***CHAIR** - I am looking at the 20 per cent allowance of current market conditions over the tender estimate of $1.8 million in a $7.7 million project yet the other one, which was $11 million, has only got $685 000.*

***Ms SORRELL -** I can comment. The other one did have a 20 per cent but we didn't actually use it, so when it came back from tender, we were spot on the budget and did not need to use the 20 per cent. We were fortunate.*

***CHAIR** - This is after tender and this is before tender.*

Ms SORRELL - *This is before tender and it is probably the COVID-19 factor that everybody is factoring where you can't get materials. We may or may not need it. If there are too many tenders out there at the time we will have a problem.*

Ms RATTRAY *- This one has not been tendered?*

Ms SORRELL *- Not yet.*

CHAIR *- What percentage is the construction design contingency?*

Ms RATTRAY *- This one is $405 000 on almost $14 million. The other one was $685 000.*

Ms SORRELL *- That construction design contingency will be on the $7.7 million.*

Ms RATTRAY *- Not the total cost?*

Ms SORRELL - *Not the total cost.*

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

4.26 In assessing any proposed public work, the Committee seeks assurance that each project is a good use of public funds and meets identified needs. The Committee questioned Mr Sassin who confirmed that the project was a good use of public funds and would deliver a fit-for-purpose facility designed to meet an identified need:

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

Mr SASSIN *- Yes.*

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

Mr SASSIN *- Yes.*

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

Mr SASSIN *- Yes.*

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

Mr SASSIN *- Yes.*

CHAIR *- They are not gold plated?*

Mr SASSIN *- No.*

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

Mr SASSIN *- Yes.*

5 DOCUMENTS TAKEN INTO EVIDENCE

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

- *Royal Hobart Hospital (RHH) Intensive Care Unit (ICU) Expansion*, Submission to the Parliamentary Standing Committee on Public Works, Department of Health, August 2021; and
- *Royal Hobart Hospital (RHH) Paediatric Outpatient Clinics Relocation*, Submission, to the Parliamentary Standing Committee on Public Works, Department of Health, August 2021.

6 CONCLUSION AND RECOMMENDATION

6.1 The Committee is satisfied that the need for the proposed works has been established. The Committee recognises these projects are important components in the ongoing redevelopment of the Royal Hobart Hospital, with the aim of meeting increased demand and changing expectations in the range and delivery of health services.

6.2 Once these projects are completed:

- the expanded Intensive Care Unit will provide enhanced capability to cater for the expected increase in demand for ICU services, with the addition of 12 beds with pandemic capability; and
- the new Paediatric Outpatients Clinics will provide an improved facility in which to provide expanded health services to children and adolescents.

6.3 Accordingly, the Committee recommends the Royal Hobart Hospital Intensive Care Unit Expansion Project and Paediatric Outpatients Relocation Project, at a combined estimated cost of $30.5 million, in accordance with the documentation submitted.

Parliament House
Hobart
5 October 2021

Hon Rob Valentine MLC
Chair