PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON MONDAY 20 SEPTEMBER 2021

ROYAL HOBART HOSPITAL INTENSIVE CARE UNIT EXPANSION PROJECT

Mr RICK SASSIN, PROGRAM MANAGER, DEPARTMENT OF HEALTH AND HUMAN SERVICES, **Ms GLENDA SORRELL**, PROJECT MANAGER, MATRIX MANAGEMENT, **Mr DARREN JONES**, ARCHITECT, BPSM ARCHITECTS, AND **Mr MARK KUKOLA**, SENIOR ASSOCIATE, PHILP LIGHTON ARCHITECTS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr VALENTINE) - Welcome. I need to read a statement to you. This is a formal hearing and it is being broadcast.

Thank you for appearing before the committee. It is important that we hear evidence in relation to these projects. Just before you begin your evidence I want to inform you that there are some aspects of committee proceedings.

A committee hearing is a proceeding in parliament which means it receives the protection of parliamentary privilege. That's an important legal protection and it allows individuals giving evidence to a parliamentary committee to speak with complete freedom, without fear of being of being sued or questioned in court or a place out of parliament. It applies to ensure that 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 proceedings.

As I said before, it is a public hearing. Members of the public and journalists may be present and this means your evidence may be reported and is being broadcast. I welcome members of the public who may be listening in or watching today.

Do you understand? I need an acknowledgement.

Messrs KUKOLA, JONES, SASSIN and Ms SORRELL - Yes.

CHAIR - Thank you.

Would you care to make an opening statement, Mr Sassin?

Mr SASSIN - Thank you, Chair. Good afternoon to members of the Joint Standing Committee on Public Works. My name is Rick Sassin and I am the program manager with the Department of Health, Infrastructure Services Programming and Delivery.

With me today are our project team: Glenda Sorrell, our project manager; Darren Jones, our architect, from BPSM; and Mark Kukola, from Philp Lighton Architects.

We are seeking in this hearing approval of the Intensive Care Unit expansion project at the Royal Hobart Hospital, as part of the Stage 2 redevelopment program. This morning's inspection on site and the documents submitted to you are to inform the Parliamentary Standing Committee on Public Works of the need for the proposed project and how the design of the works will address this need.

I thank you all for coming out today, and our clinicians who attended, whom I hope answered some of the very particular questions of a specialist nature. I had a few more words to say but this morning we covered quite a bit, so I will hand over to you, Chair.

CHAIR - That's fine. We thank you for the time you gave us on site. It's always important to be able to view these things in the flesh. The documentation was very significant and the plans and everything provided with the submission left us with no uncertainty as to what is envisaged. We thank you for that.

I will leave it open for members to commence with questioning.

Ms RATTRAY - Thank you. I have one question. This may not be the right forum, but reflecting on what we saw this morning - and it was my first visit to the sections we went to so I wasn't familiar with the site - 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 or is this the wrong forum to ask?

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.

Ms RATTRAY - Thank you. That was worth asking the question, because I know how expensive it is when it comes to bathrooms, ensuites, plumbing and the like. I thought, we are taking it away, then are we putting it in. I appreciate that.

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 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.

CHAIR - Thanks for that. That's really clear.

We will go to page 4 of the submission and work our way through. I won't deal with the executive summary because everything will be covered as we go through - unless a member has something in the executive summary that they want to specifically cover?

Ms BUTLER - I understand that the expansion of the ICU is part of the stage 2 of the RHH redevelopment, so that is in H Block?

Mr JONES - The project is within the existing H Block.

Ms BUTLER - There's also L Block in stage 4 with ICU. Are they two different things? Is that just me getting jumbled or will it go from H Block to L Block eventually?

Mr JONES - I can't comment on L Block in that the work I am undertaking at the moment is purely the ICU. On the assumption that the master plan proceeds over the next 10 to

15 to 20 to 25 years, ultimately there will be an L Block at which point in time ICU will move across to there.

Ms BUTLER - The ICU will go into that?

Mr JONES - Yes.

Ms BUTLER - Perfect. I thought I was getting them jumbled; they are two completely different blocks. The expansion of the ICU is a step towards - but eventually in a perfect world the ICU will be in the new L Block.

Mr JONES - Yes.

Ms BUTLER - By the end of?

Mr JONES - Maybe 10 years.

Ms BUTLER - It's 2050 according to the master plan. That's correct.

CHAIR - You may not be able to give me this because we don't have the clinical staff, but page 4 says:

> There is competing and increased in bed demand for high acuiety patients …

This is under the background,

> … that require ICU level of care which has a flow-on effect on scheduled elective surgery with the risk of surgery cancellations if ICU beds are not available.

Do we have any figures on surgery cancellations at the moment? How much might this be relieving those?

Mr SASSIN - I will have to take that on notice.

CHAIR - I don't expect that you're going to have that. It is only an incidental question.

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.

CHAIR - Any other questions? No, we'll go to page 5.

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. Hansard can't see the plan we have in front of us, but I understood when we spoke that the corner office would be used as a notes room, yet it has 'Sitting'.

Mr JONES - You would be looking at the existing floor plan. The one in front of you is the demolition plan. The one on the right, the workroom. There is a drawing number.

Ms RATTRAY - Drawing number A22-001. It has a workroom. 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 park.

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.

Ms RATTRAY - That is understandable. If I was coming up there I would be wondering why they had not gone further around and used that area. It is on the record. Thank you.

CHAIR - Australasian Health Facility Guidelines for sizing and access to natural light: how much natural light are these spaces expected to have under those guidelines? Someone reading this might think that is well and good but what does it mean.

Mr JONES - The Australasian Health Facility Guidelines are best described as a set of documents that outline at a basic level a series of what is called health planning unit guidelines. That sets out how you would go about planning a health unit. ICUs, a pharmacy, paediatrics outpatients or a cardiothoracic unit are what is defined as health planning units under the Australasian Health Facility Guidelines.

Then it sets out how that might work in terms of relationships, the types of functions and special arrangements needed. The Health Facility Guidelines also have individual room information sheets. Those information sheets comprise a room layout. This identifies what it perceives to be the ideal arrangement of that relevant room in terms of planning but also other elements, even down to furniture arrangements, light switches, nurse call buttons, et cetera. It also has an attached room data sheet. The room data sheet also sets out those same elements but in a tabulated format. It is an easy ready reference guide for anybody reviewing the documentation.

In terms of light levels, it explicitly says light. It does not quantify the amount of light such that it provides 10 per cent of the floor area or 15 per cent of the floor area, it just states that natural light is a desired characteristic of an ICU bedroom.

CHAIR - It does not say at a certain level?

Mr JONES - No.

Ms RATTRAY - The windows are not being replaced, so there is no extra window opening?

Mr JONES - No.

Ms RATTRAY - You are building the wall inwards to facilitate services, if you like.

Mr JONES - Yes, but only below the existing window. The windows that you saw this morning on Argyle Street will all remain as is. We build a supplemental wall up to the window sill for running services and providing additional acoustic and thermal insulation. We are also providing a second glazed skin to enhance the thermal and acoustic performance of those existing windows, which allows us to install venetian blinds for light control and privacy. Fundamentally what you see there is what is maintained in each room.

CHAIR - Is that a sealed environment, or is it just an extra window?

Mr JONES - No, the new window that will go in is its own double-glazed unit with an integrated venetian blind.

CHAIR - Okay.

Mr JONES - It is a sealed unit.

CHAIR - It is a sealed unit. That answers the question. Thank you for that.

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 - As you know yourself, from your own houses, how much or how little. 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.

CHAIR - iGlass?

Mr JONES - Yes, iGlass. It can be switched on, switched off to provide either total privacy or total transparency.

CHAIR - That will still be activated in the event of a power outage, along with the back-up systems? There is no way that ceases to operate?

Mr JONES - No. Most of the different systems associated with iGlass operate on the basis of on/off. When they are switched off is when they become opaque. To make them transparent, you physically switch them on. It needs power to actually be clear.

Mr SASSIN - Very minimal power -

CHAIR - That is interesting and very clever.

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.

Ms BUTLER - Thank you.

CHAIR - On page 5 you talk about communication strategy involving safety huddles with medical teams, allied health, ward clerk and hospital aides as currently occurs will be improved with the use of a journey board. Can you talk about the journey board? I am pretty sure I know what it is but for the record what the journey board entails? Is it a software system through the display screen?

Mr JONES - We'll call it a glorified TV but it's a little bit more complex than that. Typically, what you'll find in the nurses' station is that a journey board will be the equivalent of a 55-inch smart TV connected to the patient-flow system within the hospital software. Basically, it provides the information relating to the patients within the unit, their status and other relevant little pieces of pertinent information that enable the staff, either in the staff base or in this case also in the workroom, because there will be a journey board located in the workroom too for any of the doctors or nursing staff who are in there making notes on patients. Effectively it's a ready reckoner device.

CHAIR - And everyone has the same information?

Mr JONES - Yes, everyone has the same information.

CHAIR - And as soon as it's updated somewhere it gets reflected through?

Mr JONES - It does, yes.

CHAIR - Is that something that exists now in the ICU area or something that's going to be introduced during this?

Mr JONES - No, it's something that already exists and most of the units across the hospital all utilise and employ journey boards. The journey board is also a concept that gets taken down to an individual patient level, such that within the patient rooms you will quite often find a journey board which sets out the individual notes that are relevant and pertinent to that patient.

CHAIR - So, it's a patient tracking and treatment recording system?

Mr JONES - Yes.

CHAIR - Is there anything further on that page?

Ms RATTRAY - I might ask about the access for the workers. We also talked about that today and we will probably get over the page and there will be nothing left to ask, Chair, but that is an important feature of any redevelopment, particularly in a hospital setting.

Mr JONES - From my own perspective I've been doing projects now down on that site for the best of 25 years -

Ms RATTRAY - And we still haven't got it right.

Mr JONES - We still haven't got it right. No, you can't quite say that - it's an ever-evolving feast as things change and evolve.

Ms RATTRAY - And standards change and expectations change.

Mr JONES - On that basis, 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.

Ms RATTRAY - Thank you. Important information.

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.

Ms BUTLER - That is good news.

Mr SASSIN - To clarify, we cannot appoint or execute a contract until the Parliamentary Standing Committee on Public Works gives its approval.

Ms RATTRAY - It is very kind of you to recall that. Some have thought that we are not necessary, so it is nice to hear.

Mr SASSIN - We respect the process and we are trying to get ahead but not ahead.

CHAIR - We read where you mention the PSCPW in the submission.

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.

CHAIR - Page 6.

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.

CHAIR - Other questions on page 6?

Ms RATTRAY - Just a comment really around the need for the project. Not such good stats, are they?

CHAIR - No, they are not great stats.

Ms RATTRAY - About Tasmanians.

CHAIR - It is interesting. I have written on the edge of the page 'baby boomer bubble'. It really is coming through in the increasing use of the ICU.

Ms RATTRAY - And 57.1 per cent of the population in Tasmanian are living in the two lower socio-economic quintiles.

CHAIR - And 36 per cent are overweight, 34.8 per cent are obese.

Ms RATTRAY - We are above the national average with high blood pressure.

CHAIR - I queried that national average. It says 67 per cent and 31.3 per cent; that must be wrong. It can't be that 67 per cent of the nation are overweight, surely.

Ms RATTRAY - It could be.

Mr ELLIS - I think it's 67 in total. If you look at the two numbers. they are about 70 per cent.

CHAIR - If you add the 36 and 34.8 together.

Mr ELLIS - Yes.

CHAIR - Is that what you are assuming?

Mr ELLIS - That is about 70 per cent.

CHAIR - Okay, well that is interesting. I just wonder why they have 67 and 31.3 in brackets. They have two figures outside. I am thinking one of them has to be wrong.

Ms RATTRAY - They are interesting and quite alarming statistics about the need for the project, but I don't have a question relating to it; a comment only.

CHAIR - No, okay, any other questions on that. Page 7.

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 Manager -

Ms RATTRAY - We met this morning.

Mr JONES - Whom you met this morning 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. Thank you.

CHAIR - Do we have the membership of the Project Reference Group?

Mr KUKOLA - May I be excused briefly?

CHAIR - Yes, by all means.

Does the membership of the reference group include community members?

Ms SORRELL - I wasn't involved in the project at that point.

CHAIR - That's okay.

Mr JONES - I'm not involved at that level either.

CHAIR - It says: 'clinical and consumer stakeholders'.

Ms RATTRAY - Where are you in the drawing?

CHAIR - Down the bottom.

Mr JONES - I am trying to find myself as well.

CHAIR - You're at the project steering committee.

Mr JONES - No, I'm at the project team level. 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 - We will move over to page 8. Are there any questions on page 8? 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.

Mr JONES - Quite literally.

CHAIR - 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.

CHAIR - Coming from emergency, where quite a few of these patients are likely to come from, to the ICU, is it circuitous route or is it a straightforward transfer?

Ms SORRELL - Isn't it straight off the lift at the back?

CHAIR - That's what I thought was said, but I would like it for the record.

Mr JONES - I am just trying to think where that lift comes out.

CHAIR - Is it near the workroom?

Ms SORRELL - No, it's at the other end. It's in the lift lobby in the centre near the stairs. It seems the ICU leads into that lift lobby so they can come straight through there.

CHAIR - So it's not circuitous?

Ms SORRELL - No.

CHAIR - It's not internal to emergency and ICU, it goes out into a public space, does it?

Ms SORRELL - Yes, it does as you come down the corridor, it does. Isn't it straight up the lift at the back?

CHAIR - Well, that's what I thought -

Ms SORRELL - Yes.

CHAIR - was said but I would just like it for the record. Is it near the workroom?

Mr JONES - Yes, so I am just trying to think where that lift comes out.

Ms SORRELL - No. No sorry, it is at the other end. So it is in the lift lobby. The lift lobby in the centre near the stairs.

CHAIR - Yes.

Ms SORRELL - And it seems that that is - the ICU leads into the lift lobby so they can come straight through there and up where we walk down to paediatrics

CHAIR - So it is not circuitous?

Ms SORRELL - No.

CHAIR - And it's not internal to emergency and ICU? It goes out into public space though, does it?

Ms SORRELL - Yes it does go out, as you come down the corridor.

Mr JONES - Down the track that will be improved, particularly once the emergency department expands into the lower ground floor of H block. There is a lift further down that will provide direct access between the two floors.

CHAIR - Is that taking over part of where paediatrics currently is?

Mr JONES - Yes.

Mr SASSIN - The expansion area is in a direct pathway to medical imaging. That connectivity to medical imaging is important.

Ms BUTLER - I know from previous audits of the Royal there have been problems with securing the switch rooms. They have been easy to access by members of the public. Would there be appropriate security at the IT switch room?

Mr JONES - The current room is an existing room located just off the lift lobby. It's secured by access control. The door is provided with a swipe-card reader. Only those issued

with the appropriate access provisions within their swipe-card can access that room. As part of this project we will be expanding that room to incorporate some additional infrastructure. We will be maintaining that existing access control.

Ms BUTLER - Chair, you mentioned ICT this morning in some questions you provided.

CHAIR - Yes. I was just interested to know about the cabling and shielding for ICT's category 6. Do we still have the problem of mobile phones being used in hospitals?

Mr JONES - Over the past 10 or so years has gone the need to switch off the phone as you enter a part of the hospital. These days even surgical staff in the middle of an operating theatre will have their mobile phone on. We use category 6 cabling for all of our ethernet-based equipment. We also used fibre optics.

CHAIR - And that saves any cross-talk?

Mr JONES - It does, as well as maintaining minimum required separation distances between that and electrical cabling.

CHAIR - Will the cabling in the building be renewed or have a different termination on old cables? There might have been upgrades to cabling over the past few years.

Mr JONES - Within the new part of the building the cabling will be replaced, for no other reason than we can't guarantee the quality or compliance of any existing cabling that may be there.

CHAIR - That is fair enough. Back-up power to the switch gear and computing services is all sorted? You have an uninterruptable power supply. How long can that run for and then the diesel generators take over? Can you describe that?

Mr JONES - As part of the whole electrical system we will be installing a new main switchboard. The existing switchboard's current wiring standards are no longer compliant. Because we are making changes to it we have to upgrade it to a new compliant switchboard. We are also -

CHAIR - And that is earth-leakage detection -

Mr JONES - Earth-leakage detection. For example, the ICU will be cardiac-protected as part of its installation. It relates to the number of circuits permitted on a residual current device. Because it is cardiac protection we require a higher level of protection in terms of the residual current device so it reduces the number of outlets we can put on a circuit. That increases the number of circuits, increases the size of the board. We are also going to run new mains cabling from the new board back to the main main switch room which, from memory, is located on the ground floor of the junction of D and H Blocks.

As part of that, we are also providing a UPS which gives us the ability to keep everything running in the event of a power outage sufficiently long enough for any one of the generators to be manually connected.

Ms BUTLER - I am not sure who to ask this question of, but around the staffing capabilities - I'm not sure if it is appropriate to this project, but with the increase in intensive care beds, is there a concerted effort to ensure we have the right number of intensive care nurses to be able to look after those beds? I picked that up today when we were visiting, where the good doctor was talking about intensive care patients being about the one-on-one, having that one nurse there the whole time with that one patient. Do we have the capabilities to staff this?

Mr SASSIN - That is a clinical question that we could take on notice, if you wouldn't mind?

Ms BUTLER - That would be great.

CHAIR - In terms of the actual development itself, it is probably outside that, but that doesn't stop an answer being provided. It probably wouldn't be necessary for us to say yea or nay to.

Mr JONES - It is one of those issues that would fall into operational expenditure, rather than a capital expenditure.

Ms RATTRAY - With regard to repurposing any of the existing infrastructure around this development, I asked the question in the hallway.

Mr JONES - Certainly. Where we possibly can, we always endeavour to try to reuse elements from the existing fabric. But as I alluded to in our earlier conversation around the existing maternity in 3D, when you are trying to take what is maybe 20, 25 or even 30 years old and trying to repurpose it, it is very difficult to achieve that and meet current standards. In terms of the previous discussion around services, you can't guarantee compliance, particularly around meeting current wiring standards, meeting current IT standards, meeting medical gas standards, because all of these are governed by the Australian Standards, which are referenced.

With our national construction code, we actually reference, and what takes precedence is a lot of these Australians Standards. Whenever we undertake a new development, we have to achieve compliance with what are deemed to be the current standards. When you have an existing building fabric that is 25, 30 or 40 years old, it can be virtually impossible to reuse a lot of what is there, as well as the fact that, while it is ideally great on one level to be able to recycle elements, from a cost perspective, both time and value-for-money aspect, you don't achieve value for money.

Mr KUKOLA - It has the potential for disruption when it inevitably has to be replaced earlier than the rest of the facility. Another example would be the reuse of hand-wash basins. You can't reuse them because generally older type basins, although still functional, have an overflow hole in their basins. That makes an area that is not accessible to be cleaned properly. That was fine 15 or 20 years ago, but we can't reuse those types of basins any more.

Ms RATTRAY - Effectively, the space that is going to be used for this redevelopment, is going to be gutted?

Mr JONES - It becomes a clean slate. It also gives us the opportunity to try and remove as much as we possibly can any of the hidden nasties, such as asbestos.

CHAIR - In relation to the question the member just asked, while you mightn't be able to recycle much of the fabric into the new development, is it envisaged that it goes to a recycling facility so it can be considered by others who may wish to use waste? I am thinking of years ago we had this Waster Information Resource Exchange. I don't know whether that still exists today but it was a database of the demolitions and what material was available.

Mr JONES - I guess what we do is we go through and identify certain things that can be removed from the works and hand it back to the hospital, particularly where -

CHAIR - Windows or whatever?

Mr JONES - Not necessarily windows but there are certain elements, sometimes even just all hardware. We will go through and we will pull off door hardware, doors that are in good condition, give those back to the hospital and they will go into their facilities and maintenance store.

CHAIR - As spare parts?

Mr JONES - Yes, so they can be utilised, or even tapware that still would be considered compliant, we will take that off and hand it back to them.

From a maintenance point of view, we always install new so that, particularly in terms of defects and warranties, it is all consistent across the board.

Most contractors certified at the third-party quality assurance level all have a waste management strategy which involves separation of different types of elements so when it is disposed of, some goes to recycling, some goes into storage, some goes into various other different elements of the waste process.

CHAIR - It raises another question, as I think about it now. I believe that some newer brass elements contain higher percentages of lead than the old brass fittings that used to be. Do we look at making sure that tapware and those sorts of things don't leach lead into the system? That's a concern. I don't know whether you have any detail on that but it is certainly something that may have occurred in the past. It could cause an issue.

Mr JONES - I can only comment from my perspective, at a personal level, on a project basis. One of the issues we have is in terms of where goods are sourced from. Obviously, goods manufactured in Australia are required to comply with Australian standards.

Ms RATTRAY - There are not many of those.

Mr JONES - Unfortunately, there are not as many as we would like to have these days.

CHAIR - I think there is an attempt to increase it.

Mr JONES - There's certainly an attempt to increase it. At a personal level, I have a philosophy that I try for a variety of reasons, whether it be supply chain, timing or anything else, to source local products.

CHAIR - Local first, national second.

Mr JONES - International when we are desperate. It is where you end up being either forced - I shouldn't say forced - but you end up in that set of circumstances where something does come internationally. It is less likely because it is less governed and it becomes harder to make the relevant Australian standard apply to it. For example, if the tap is manufactured in Australia, it has to comply with the Australian standard, which has leaching levels, whereas if the relevant tapware comes from somewhere else, it is harder to apply that standard.

Mr KUKOLA - I think the standards for tapware and anything involving potable water are quite stringent.

Mr ELLIS - It's worth noting that the Perth Children's Hospital was delayed opening because of lead contamination from tapware and thermostat mixing valves, and that was 2018.

Mr JONES - The comment I make is if you look at where some of those elements have occurred, it has come about because of a procurement process. There's a particular procurement process, and very much a personal observation, that leads to sometimes less than desirable outcomes, and this is where you do run into some of these problems.

Ms BUTLER - There is always the problem as well, sometimes, that what is stated on the MSDS might actually be correct, so it is hard to know.

Mr JONES - In a lot of what we do we are relying upon the fact that the person standing in front of us, handing us the piece of paper, is being upfront and honest about what they're telling us.

CHAIR - An observation on page 9, where we are talking about the iGlass, it is half way down, Visual Privacy: 'Visual privacy for each patient is achieved through the use of electronic glass in the sliding doors, which is fully transparent when switched off and opaque when switched on'. You told me earlier that it was the other way around I think.

Mr JONES - Yes, it is, that is a typo.

CHAIR - That is a typo, so it should read 'opaque when switched off and transparent when switched on'.

Anything else on page 9? Page 10.

Ms BUTLER - We have been through a lot of this already.

CHAIR - We pretty well have. We have talked about the isolation rooms, the air-conditioning system, medical gases.

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.

CHAIR - Okay, anything else on page 10? 11? No. Page 12?

Ms RATTRAY - Chair, I have my perennial question, on project cost. I have one about Other Client Costs of $489 000. Can I have some indication of what Other Client Costs might entail?

CHAIR - Second from the bottom there?

Mr JONES - Yes. Not sure what that includes.

Ms RATTRAY - I'm happy to take it on notice. That's fine. My next perennial question is around the Tasmanian Arts Scheme. I always cite the wonderful Arts Site Scheme initiative at the St Marys District School. A piece of furniture was incorporated into the library. It was a beautiful piece of Tasmanian timber and was part of the arts scheme.

I am interested in what might be envisaged for the $80 000 in the arts scheme, what it might look like and how that process is going to be undertaken. Is it envisaged that it might be incorporated in the build of the redevelopment and not necessarily an add-on at the end?

Mr JONES - The nature of the space and the fact that it requires a very clean clinical environment does limit our opportunities from an infection control point of view to provide artistic surface treatments within the rooms or within the main treatment spaces. I guess a mural or something or some form of artwork, whether it be a chair or something like that -

Ms RATTRAY - Or a beautifully etched piece of glass.

Mr JONES - Probably the two principal spaces that would benefit from it would be the outdoor patient area, or the family lounge waiting space. They would be the two most likely locations. They would go through Arts Tasmania, no doubt undertaking the registration expression of interest with some local artists.

Ms RATTRAY - You might turn around and have a look at the beautiful art work we have in timber on the back wall in this room. You are looking at dividers that are looking like they are slats and that's not going to work, but that may give you some indication of how you can incorporate art into a build.

Mr SASSIN - It is very strongly dictated by the infection control issues.

Ms RATTRAY - There are different ways of being able to incorporate art. Given that $80 000 is a lot of money and we like to keep it in Tasmania - from my perspective. I am only

letting you know there are some things you could do. You will make some contact with someone in Arts Tasmania?

Mr JONES - Yes. Normally that would be Glenda's role as the project manager to make contact with Arts Tasmania to instigate the process.

Ms SORRELL - We will be making contact with them soon because this project is pretty far down the line now, but not until we have an agreement so we can go ahead and appoint a builder.

Ms RATTRAY - You don't want to get the art in place without having the project started. I understand that, thank you.

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 RATTRAY - It is normally 10 per cent isn't it?

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.

CHAIR - That one is close to 6 per cent.

Ms SORRELL - There has been a round up.

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.

CHAIR - It will be interesting to see what that Other Client Costs are. It is quite high.

Ms BUTLER - We have construction starting in October 2021 -

CHAIR - Does anyone else have any other questions on that page?

Ms BUTLER - For the record, I asked this earlier: around the construction start, we have October 2021. That's next month. So, to reclarify that we are on track for this to start in October 2021?

Ms SORRELL - It probably will not be based on the fact that we have to wait for the decision of the Parliamentary Standing Committee.

Ms BUTLER - My next question is the 'subject to approval', is that just our approval or are there any other approvals you need to receive?

Ms SORRELL - We need the RPC approval as well.

Ms BUTLER - What's the process with that approval?

Ms SORRELL - The report went up there this morning. They get it two weeks ahead of when they have their meeting. They then assess the project. As long as the project is on budget, we have funding for the project, then they will write a report, which probably takes another two weeks after that. Then they will send that report down, at which point we wait for the parliamentary committee to make their decision then we can go to Procurements to ask them to please start to commence the documentation.

Mr SASSIN - To negotiate the contract. We won't do that until we get our approval.

CHAIR - Any further questions on the Intensive Care Unit project?

Mr JONES - On the approvals process, there are still all the relevant statutory approvals that have to be put in place. As far as this project is concerned, the building permit is in place. We are just waiting on finalisation of the plumbing permit.

CHAIR - Does it need a DA?

Mr JONES - No, it's planning-exempt.

CHAIR - Is that because it's an existing building?

Mr JONES - Yes, there are two factors. One, is that it's an existing building and existing use rights; we're not changing use.

CHAIR - And there aren't any neighbours, apart from the workers.

Mr JONES - No.

Mr SASSIN - We just need plumbing permits, perhaps.

Mr JONES - Yes, permits.

CHAIR - All of those sorts of things. A query to the secretary: do we ask these questions twice or only once?

SECRETARY - Twice.

CHAIR - As we wrap this one up, we have a number of questions:

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. They're minimum viable products

Mr JONES - It's not minimum viable; 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.

Ms RATTRAY - One of the former members of this committee asked that question every time.

CHAIR - You're taking his place.

Ms RATTRAY - I'm here to help.

CHAIR - 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.

Paediatric Outpatient Clinic - Relocation

CHAIR - Thank you. We will move on to the second project. That is the Paediatric Outpatient Clinic's relocation. Do you wish to have any opening statement with regard to that in particular?

Mr SASSIN - I am going to say the same sort of thing, other than to say that our project architect, Mark Kukola, senior associate from Philp Lighton, will answer any details on that one, Glenda Sorrell, who is project manager, myself, program manager, and Darren has agreed to stay on for any overall hospital technical clarifications.

We went out this morning - and, again, we appreciate the committee's attendance - and with our clinicians, Sean Beggs, who is clinical director, Women and Children's Services; and Cassandra Tichanow, who is the clinical nurse consultant, hopefully gave clarity to you on site for some of the clinically based questions.

Thank you, Chair.

CHAIR - No worries. I will go straight to page 5, if members are happy for that, and we can work our way through. Any questions on page 5?

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 -

CHAIR - That is the emergency department.

Mr SASSIN - Yes, the emergency department would have 25 beds designed and installed in lower ground H.

Ms RATTRAY - I think they are having trouble picking you up, Rick, so thank you. You almost have to eat it, like this.

CHAIR - Especially when you have a soft voice, Rick.

Mr SASSIN - 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.

CHAIR - I can imagine it's a nightmare.

Ms SORRELL - This particular one could not be started until somebody else had been decanted, so that has also been knocked out now.

CHAIR - It is a bit like buying houses - subject to sale of your house.

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 time frame 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.

CHAIR - Yes.

Mr SASSIN - 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.

CHAIR - We don't get a second bite. Public Accounts gets the opportunity.

Ms RATTRAY - Somebody else looks at it. 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 - I understand that. My concern is that it will completely change the time frame and the budget. That is what we are here for.

CHAIR - That's true. The budget side of it is important.

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 -

Ms RATTRAY - You didn't make the announcement of 25 extra beds -

Mr JONES - No. I've had a mental blank on that one. 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.

I am probably speaking out of turn here, but 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.

Ms RATTRAY - All you have had to do is move the jack jumper program.

Mr JONES - 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 and Cassandra.

CHAIR - He said they would cope. There is not a lot of choice.

Mr SASSIN - Through the Chair. 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.

CHAIR - Something we didn't deal with in the previous project but that needs to be put on the record is the jack jumper unit. Can you describe what that is?

Mr JONES - The jack jumper unit that you saw this morning, is the -

Ms RATTRAY - only one in Tasmania.

Mr JONES - Only one in Tasmania. The program deals with developing treatments for the jack jumper allergy, which can be fatal for some people.

After neurology moved out of 1H into 8K West when K Block was opened, jack jumper temporarily moved into that space. They provide direct client services to the general public. When undertaking the works of the ICU we need to relocate them. There has been a space identified for them in 3C. So level 3 of C Block. Included in the project cost of $11.5 million is a $550 000 allowance to undertake the relocation works.

CHAIR - I wanted to make sure that was on the record. I know it is not this project but it involves it to some degree.

Ms RATTRAY - So nobody thought my idea of sending them out to the DEC was a good one at the time.

CHAIR - I'm not sure it refers to basketball.

Ms RATTRAY - No, but the good doctor has a membership.

CHAIR - Anything further on page 5? No. I asked a question on adolescent mental health. Is it involved with this project? The answer came back that, no it was not. But maybe someone could expand on that.

Ms BUTLER - Is that the eating disorders?

Ms SORRELL - It is. The only reason I know is because I happen to be working on the other project where the eating disorders is being handled. It is not this project, but it is another project under the Department of Health.

CHAIR - So it is not seeking to go into the adolescent mental health area. Over to page 6. No. 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.

CHAIR - And the issue of oncology patients returning from Melbourne with isolation required? I think Mr Tucker asked that question this morning. Isolation is provided for?

Mr KUKOLA - I am not sure about that, I can't answer that question.

CHAIR - It was mentioned by -

Mr TUCKER - It was one room -

Mr KUKOLA - Yes, that is right. The isolation room close to the entry area -

Ms RATTRAY - For hot cases.

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

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.

CHAIR - Thank you. 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.

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.

Ms RATTRAY - But the ones that were there were more cartoon-y.

Mr KUKOLA - Sorry, that relates to the new K Block the inpatient paediatric wards, not to the existing paediatric facility.

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.

Ms RATTRAY - We didn't see the other one. I have no idea what you are talking about.

Ms SORRELL - For clarification it is the new K Block that has been built and completed last year -

Ms RATTRAY - It doesn't actually read like that here.

Mr KUKOLA - 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, I suppose.

CHAIR - Page 11. This lovely term 'existing and new interstitial' external window blinds. Interstitial meaning between glass? Is that what it means?

Mr KUKOLA - Yes.

CHAIR - I wanted to make sure it was understood, because I wondered.

Mr KUKOLA - We shouldn't really have blinds that aren't contained for infects control.

Ms RATTRAY - Is that for the same for the previous reference? That the venetians will be on the inside?

Ms SORRELL - Between the glass.

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.

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.

Ms BUTLER - Currently there is no gymnasium but there will be a gymnasium. Was that done through consultation? Was that put forward as part of the project out of need?

Mr KUKOLA - I think it was part of the original brief.

Ms BUTLER - Okay.

Mr KUKOLA - I came onboard a little bit later in the process but I think that was the case.

Ms BUTLER - Thank you.

CHAIR - Any other questions on page 11? Page 12?

> Luminaires will be provided with lay-in diffusers to meet infection control requirements.
>
> Describe that for me.

Mr KUKOLA - They are LED lights that -

CHAIR - Are they concave ones?

Mr KUKOLA - I don't think they are concave anymore. They are within a ceiling grid and they are quite thin now.

Ms SORRELL - A lay-in diffuser is not the luminaire itself. It is the diffuser under the luminaire.

Mr KUKOLA - It scatters the light.

CHAIR - It scatters the light but it does not allow dust and dirt to collect.

Mr KUKOLA - It's put within a tiled ceiling grid.

CHAIR - Okay, so it reduces the ledges and gaps.

> Lighting control system will be integrated with both the nurse call and duress system.

Is that something innovative or is it something that occurs right throughout the hospital?

Mr JONES - Not throughout the hospital.

The standard nurse call system operates on the basis that there is a nurse call button at a chair or a treatment point. Nurse call is a generic term we use for the whole system. Then there is a nurse call button so a patient can call a nurse, a staff assist button so nursing staff or a treatment staff member can call for assistance, and then an emergency call button for an emergency such a code red or blue or black.

The normal standard approach is that within a work room - a nurse space, a nurse station - there is an annunciator panel. If you are in room 3 and hit the nurse call button, the room 3 nurse call appears on annunciator panel in the work room so nursing staff know that the patient in room 3 requires attention. Typically, there is a little light outside that room for easy visual identification. Plus you will have annunciator panels located in the corridor so any nursing staff are just generally walking the beat, so to speak, can instantly see.

You have green for nurse call, yellow for staff assistance and red for emergency calls. That is the normal standard approach and depending upon the functional nature of the unit, you have a variety of different other buttons such as orderly assist which is prevalent in theatres where you want to call for an orderly to transport the patient on the trolley back to recovery or from recovery to their ward. That is your normal standard use of nurse call. However, in this particular set of circumstances I cannot directly comment.

CHAIR - That is okay. Any other questions on page 13? Fire Services seems straight forward. No particular comment on that, anything unusual about the fire service system.

Mr KUKOLA - Only that D block does not have an existing sprinkler system so the agreement with Tas Fire is as we progress through updating the spaces they will install a compliant sprinkler system.

CHAIR - Okay, no other questions on that page, page 14? Costs.

Ms RATTRAY - In regard to the Tas Arts Scheme, is this the same as the previous reference for the ICU upgrade? There has been no decision made around the scheme. I found it interesting that they are both at $80 000. Is that the minimum requirement now? Because one is $16 million and one is a not quite $14 million overall project? I thought it was a percentage.

Ms SORRELL - No, it is not a percentage. The maximum is $80 000.

Ms RATTRAY - So, you might not necessarily spend $80 000?

Ms SORRELL - No, you have to spend the $80 000 because it is over $5 million. It is a percentage up to $5 million and over $5 million; it is set at a maximum of $80 000.

Mr SASSIN - Projects over $250 000 to a maximum of $5 million.

Ms BUTLER - A Jim Bacon innovation, Tania?

Ms RATTRAY - I thought it was 2 per cent of the project cost.

CHAIR - It used to have a percentage on it.

Ms RATTRAY - I am going back a few years now. I am going back to Jim Bacon's time.

Mr SASSIN - It is 2 per cent. It is a percentage basis to a maximum of 80 per cent under the Treasury instruction, so you are correct.

CHAIR - To a maximum of $80 000.

Mr SASSIN - You are correct. But it's based on 2 per cent.

Mr KUKOLA - Further to that, we do have some ideas on how we would like to spend some of that.

Ms RATTRAY - Could you share them please, Mark?

Mr KUKOLA - One of those would be the image -

Ms RATTRAY - The whales on the wall?

Mr KUKOLA - No, that is graphics from the K Block, the existing images. In the play area for the young children we have a tree. That is a sculptural element. We would like to use local timber on that and it would be great if we could get the input from a local artist on that piece.

Ms RATTRAY - Even metal?

Mr KUKOLA - Yes, all sorts of potential, absolutely.

Ms RATTRAY - I know where you can get some fantastic metal artwork, at Longford. Esk Ridge, amazing.

Mr KUKOLA - It has a lot of potential. It is an important area that needs to have some joy and life to it. Around that area, potentially, Sean Beggs would like to see some interactive screens, so the kids would sit on a stool and play some games, and potentially some educational things as well. Perhaps we could integrate some of those screens, as part of the arts and digital art as well.

Ms RATTRAY - My second question is around client costs. They are quite significant, about half the cost of the previous reference for the ICU other client cost, so I am interested in what client costs of $235 000 relate to for this reference.

Ms SORRELL - I think I've worked out what it is. It is the actual staffing costs of the department, so that each project now has to carry its own cost of staff of the Infrastructure Projects division. I think that is what it is, but I will go back and check that out.

CHAIR - So that enables the department to be a little more flexible, does it? If you are saying departmental staff are put onto these projects, it is so the project costs cover that?

Ms SORRELL - Project covers the cost of that staff, yes.

Mr SASSIN - It could be infection control and ICT.

Ms SORRELL - So you would have to go to the Infection Control department, they would have a cost. You would have to go to Facilities and Maintenance, they would have a cost, so it all gets pulled back to the cost of the 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.

CHAIR - It is about 5.2 per cent. The same as the other, in the ball park. Any other questions on the costs? That is it unless members have other questions? I will ask the standard questions on this one too, Mr Sassin.

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.

CHAIR - Thank you very much for that. Before you go I need to remind you that 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 that privilege does not attached to comments you may make any more to anyone, including the media, even if you are just repeating what you said to us. Do you all understand that?

Mr KULOLA - Yes.

Mr JONES - Yes.

Mr SASSIN - Yes.

Ms SORRELL - Yes.

CHAIR - Thank you for appearing.

Ms RATTRAY - Good detail. For someone who has no real affiliation with the RHH, it was easy to read.

CHAIR - One thing with this role that we play is that we learn a lot.

THE WITNESSES WITHDREW.