PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT THE LAUNCESTON LIBRARY HIGH STREET CENTRE - ROOM 2, LAUNCESTON, ON WEDNESDAY 4 FEBRUARY 2026.

NORTHERN HEART CENTRE

The Committee met at 2.02 p.m.

CHAIR (Ms Butler) - Welcome everyone. Before we commence the hearing, I will introduce the members of our Committee. To my left, we have Tania Rattray, Mark Shelton, Dean Harriss, Helen Burnet; we also have Karen from Hansard; and Georgia Gray and Scott Hennessy as our Secretaries. There are no apologies for the hearing today.

Secretary, would you please read out the message from Her Excellency the Governor-in-Council referring the project to the Committee for inquiry?

SECRETARY –

Pursuant to section 16(2) of the *Public Works Committee Act 1914*, the Governor refers undermentioned proposed public work to the Parliamentary Standing Committee on Public Works to consider and report thereon:

Northern Heart Centre.

Pursuant to section 16(3) of the Act, the estimated cost of such work when completed is $120 million.

CHAIR - The Committee is in receipt of two submissions from the Department of Health and from the Heart Foundation. Could I ask a member to move that the submissions be received, taken into evidence and published?

Motion agreed to.

CHAIR - The witnesses appearing before the Committee today are representing the proponent, the Department of Health. Could I ask each of you to state your name, your position and organisation, and then make the statutory declaration?

Ms FIONA KATHERINE LIEUTIER, CHIEF EXECUTIVE HOSPITALS NORTH, **Mr ADAM MARTIN**, PROJECT MANAGER, INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; **Ms RACHAEL DOBSON**, SENIOR PROJECT MANAGER, PROGRAMMING AND DELIVERY, DEPARTMENT OF HEALTH; **Mr SIMON DUNNE**, DIRECTOR PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; **Dr MATTHEW LEE-ARCHER**, DIRECTOR OF MEDICINE, LAUNCESTON GENERAL HOSPITAL; **Dr PAUL MacINTYRE**, DIRECTOR OF CARDIOLOGY, DEPARTMENT OF HEALTH; AND **Mr ALISDAIR JOHN McPHEE**, ARCHITECT AND LEAD DESIGN CONSULTANT, ARTAS; WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you for appearing before the Committee. The Committee is pleased to hear your evidence today. Just before you begin giving your evidence, I would like to ask whether you received and read the guide sent to you by the Committee Secretary? If so, I'd like to reiterate some important aspects of that document.

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

This is a public hearing, members of the public and journalists may be present and this means your evidence may be reported. It is important that should you wish all, or part, of your evidence to be heard in -

SECRETARY - I think that's the wrong script.

CHAIR - Oh, right.

Ms RATTRAY - There's a lot of scripts that go with a lot of things.

CHAIR - This is a public hearing. Members of the public and journalists may be present and this means your evidence may be reported. Do you understand?

Witnesses - Yes.

CHAIR - Ms Lieutier, would you or one of your colleagues like to make an opening statement?

Ms LIEUTIER - I will pass that to Mr Martin.

Mr MARTIN - Thank you, Chair. If it's okay with the Committee, I'm just going to read directly from the report.

The proposed Launceston General Hospital Northern Heart Centre is a significant initiative aimed at improving health outcomes for northern Tasmanians suffering from heart disease. Funded entirely by the Australian Government through a federal funding agreement, the Australian Government has committed $120 million towards the establishment of the Northern Heart Centre.

The project is part of a broader effort to address the gaps in cardiac medical and surgical services as identified in the Long-Term Plan for Healthcare in Tasmania 2040 and is aligned with the recommendations from the statewide Cardiac Cath Lab Capacity Planning Clinical Engagement Report 2023, otherwise known as the Cardiac Report, and the Tasmanian Cardiac Strategy 2025.

Key components of the project include the creation of a new coronary care unit featuring 18 inpatient cardiac ward beds and six coronary care unit (CCU) beds. There are 24 beds in total. The establishment of two cath labs equipped with dedicated recovery and holding bays, allowing for direct access for a patient requiring procedures without needing to go through the emergency department; provision of dedicated diagnostic testing facilities for echocardiography and outpatient services, which will include five echo-testing rooms, one exercise testing room, and six outpatient consultation rooms. Also there's direct access to ICU, the emergency department, and medical imaging services.

CHAIR - Thank you very much for your time today and providing our Committee with the opportunity to have an onsite visit. We were able to pick up from our onsite visit how congested and busy that area is. Thank you very much for your time.

I suppose the most prudent question to open with is: could you provide the Committee with information about the - I suppose, the hardest part of this project will be how you triage services and still operate the LGH [Launceston General Hospital] effectively during the construction of the proposed heart centre. Could you provide us with some detail, an overview of some of those challenges and how you may overcome them as a team?

Mr MARTIN - If it's okay, Chair, we might just bounce between the lead consultant and myself. I consider the heart centre project almost having almost two personalities. We have the main heart centre scope of work, which is effectively the main scope in terms of the clinical cardiac response. Then we have a heavy and significant disruption component, which is really around the project, in terms of how it impacts existing services within the hospital. As the scope of the project has expanded from very much a concept through to design development, schematic design, the understanding, or comprehension, of the disruption footprint - of what this project is going to implicate for the LGH precinct - is developing constantly. It's gone from very much a high-level understanding to now a pretty well detailed comprehensive strategy and design response.

The disruption to the services at the hospital range from backhouse services - laundry, sterile stock, and access to the principal loading/unloading areas. We understand that there is disruption to mortuary in terms of how those services access their current functions and facilities. There is a bigger piece of work that's being understood around disruption to clinical services, that being in the capacity of CT services within the Department of Emergency Medicine. They've all required a level of triage. They've all required - and still have an ongoing - level of risk rating applied to them. That risk rating is adjusted through mechanisms like ongoing stakeholder engagement with those core cohorts of stakeholders within the hospital.

The CT disruption element of the project has required that stakeholder group to broaden. For example, we wouldn't necessarily liaise with, say, medical imaging or radiology to the extent that we have, but they've now had to form part of the project working group to understand the clinical requirements risks.

Not to speak on behalf of the sponsor of the project, but it has required an extensive deep dive into understanding clinical risk, not just operational risk. They all have a different profile of risks. They're evolving at different speeds, but I feel as though, in support and consultation of the lead design and sub consultants, we have a very good read on disruption. I think we have

a very good read through the continuous stakeholder engagement that all key stakeholders are ready and prepared.

I acknowledge the fact that some of these solutions on the table aren't necessarily ideal, but compromises had to be afforded from both parties. I think that if we zoom out and look at what this project is trying to do, it's going to be long lasting and deep reaching. For the challenge of trying to keep the hospital operational for three-plus years, that compromise is worth it.

Ms RATTRAY - My questions may well be to the medical experts here. I appreciated the opportunity this morning. A submission from the Heart Foundation talked about people living in the north and north west having a higher rate of heart disease than anywhere else in the state. I think, for the public record, it would be really good to have an understanding of if there is any rationale behind that and, obviously, this particular project will have a positive benefit on that, is what I'm expecting.

Dr MacINTYRE - Absolutely. The north west of Tasmania, you see, has the highest incidence and prevalence of cardiovascular disease in the state and, except for some Indigenous communities, is probably up there in Australia. The reasons for that would be about the level of cardiovascular risk factors in that environment, plus the genetic component where people living with heart disease pass on that genetic present to the offspring.

The other thing that you're alluding to is, I suspect, around equity of access to cardiac services for people from the north west of Tasmania. There are definite barriers to us getting timely care to these patients suffering from acute coronary syndromes and other complex cardiac conditions. There's a geographical component to that. There is also a model of care component to that, which we hope to address within the project. We see the Northern Heart Centre as unlocking the issues around equity of access for the north west of Tasmania, and that includes the Mersey Hospital and North West Regional Hospital in Burnie.

We see the Northern Heart Centre as being the nucleus of a northern hub of cardiac services that is integrated across the northern corridor. There will be a southern hub, but the northern hub will consist of those three hospitals and there will be outreach facilities into the north west from the Northern Cardiac Centre. There will also be much better access to acute interventional services as a result of this build.

To take you back - I may be going too far - to how this came about, we commissioned an independent external report that was conducted by Professor Andrew MacIsaac, who was the previous Chairman of the Cardiac Society. He came from St Vincent's in Melbourne with very much a public sector focus. Myself and others were involved in that review, and we toured Tasmania looking at cardiac services, trying to work out what was required for the future. He visited Launceston as part of the group and we interviewed a whole variety of people.

We went on the patient journey from ED through to the cath lab and the first comment was that he was absolutely appalled with the infrastructure that the current cardiology group were working in and delivering, in some cases, very good services, particularly around the cath lab activity which had been set up over a number of years, but recognised there were major gaps in the service and that we weren't delivering the broader range of cardiac services from LGH. There was no dedicated cardiac ward and there were various issues around the model of care being delivered in that current environment.

He produced a report which was submitted to the Secretary of the Department of Health and the Health Minister and the Premier. I'm sure it's not news to you that that report was not released publicly. The understanding behind that was that the public confidence would be diminished for the current service. Instead, it was turned on its head, which I think was the correct decision, focusing on the very positive recommendations that have been incorporated into our cardiac strategy, which was published last year, and that's what we're now trying to implement.

The Northern Heart Centre is a key component of the deliverables within the capex strategy. We were incredibly fortunate to get federal government funding. There was a point where I thought it was not going to happen, but fortunately we have the money that we need to build the Northern Heart Centre. It's an absolutely key development for heart disease in the north of the state.

Ms RATTRAY - Is there anything you'd like to add to that, Dr Lee-Archer?

Dr LEE-ARCHER - The only thing I'd like to say is that I'm very excited about this project because there's such an incredible clinical need because of the prevalence of heart disease, and it really is important for equity of access for all our people in the north and north west.

Ms RATTRAY - Is it expected that having this centre in the north for the equity of access right across the north will take some pressure off the southern aspect? It won't make any difference?

Dr MacINTYRE - Not really. It will be a two-hub model. There is some flow of level 6 services, based on the Tasmanian role delineation framework, that need to come to Hobart. We do cardiothoracic surgery, elect physiology, and we perform trans-aortic valve implants in Hobart, which should be defined as level 6 services, which are not occurring in the north, and they will still have to come south. What we're looking for is to develop robust level 5 services across the board, which is to expand the existing intervention service, but also to fill in the gaps in the broader cardiology services that exist in the north of the state.

Ms RATTRAY - My final, if I might, Chair: it's talking about 24 beds in total, 18 inpatient cardiac and six coronary care, which Adam read out to us earlier. Is that an increase on what's already available?

Dr MacINTYRE - Yes, a massive increase. Yes.

Ms RATTRAY - What is the current availability?

Dr MacINTYRE - Eight.

Ms RATTRAY - Eight in total?

Dr MacINTYRE - Yes.

Ms RATTRAY - So it will be a total of an increase -

Dr LEE-ARCHER - Sixteen.

Ms RATTRAY - Wow. Well done on your maths.

CHAIR - Subsequent to your question, Ms Rattray, hopefully that will also provide some relief for the ED with representations; is that correct?

Dr MacINTYRE - Yes, depending on the model of care. We'd be looking to bring patients straight to that facility and bypass ED. I think that would be a major achievement because of an increase in capacity and an improvement in the model of care, the idea of ambulances coming straight to the Northern Heart Centre with patients who need to go to the cath lab. It will fast track that process.

CHAIR - There will also be, I understand, less of a reliance on that interstate travel that patients may have to currently use to -

Dr MacINTYRE - Absolutely.

CHAIR - That should minimise costs, but it's also much better for those patients if they can be treated in a timely fashion here; is that correct?

Dr MacINTYRE - Correct.

CHAIR - Can you run us through what that looks like from clinical care?

Dr MacINTYRE - You're talking about transfer of patients predominantly to Melbourne. That happens because the services cannot be provided locally and therefore there is a desire to send patients to Melbourne. It's about trying to develop, or to address the gaps in the level 5 services, such that they don't need to be sent elsewhere. There are significant gaps in the current service in the north of the state. A lot of that traffic at the moment is coming from private providers, who are then going privately to Melbourne.

However, you will be aware of the patient transport assistance scheme (PTAS) - we cannot fund patients to go to Victoria if we can provide the service here. It's really about filling the gaps in and the services that are missing in the north, in the broader sense, not necessarily intervention.

There will always be a small number of services that we can't provide in Tasmania and that will have to go to Melbourne, such as heart transplants, as the obvious example. There are other complex things that they do as a high-volume centre that we should not be doing in Tasmania and should be sent, but the idea would be to minimise that flow.

I think that what you might see is a rebalancing of the public/private cardiology services in the north of the state. We are very keen that public patients who cannot afford to go privately are treated within the public hospital in Tasmania, and there's an adequate service provided so that they don't have to, and are not forced to, go privately for access issues.

CHAIR - It shouldn't be based on your income level.

Dr MacINTYRE - Exactly.

CHAIR - There was a question this morning around location. I believe Mr Harriss and you raised it as well. We might go back to Ms Burnet.

Ms BURNET - I'm curious to know: we have the highest incidence, presumably that's high in the south of the state as well, but why is it so high?

Dr MacINTYRE - In the north?

Ms BURNET - Yes. Why do we have such a high incidence?

Dr MacINTYRE - The major risk factor for cardiovascular disease is social deprivation and we've got higher levels of social deprivation in Tasmania than we have in most other states. Obviously, there's pockets on the mainland, but we have a very high-level of social deprivation. That is, the social determinants of health drives cardiovascular risk factors, drives cardiovascular disease and increases the incidence and prevalence of cardiovascular disease. I suspect there is a genetic component. We went to Agfest last year to do cardiovascular risk screening with the Heart Foundation. We measure -

CHAIR - I dropped into you too.

Dr MacINTYRE - Did you? We measured cholesterol levels, measured blood pressure. The incidence of hypertension and the incidence of hypercholesterolaemia was unbelievable in that population. I would probably suspect that access to primary care services is also an issue in terms of prevention of coronary heart disease, and the overall investment in upstream prevention is significantly deficient, but it is a geopolitical issue in terms of social deprivation, and how do you turn that around in a modern world.

Ms BURNET - Presumably, because it's an important - I know we're talking about a heart centre, but that's certainly part of the picture -

Dr MacINTYRE - Absolutely.

Ms BURNET - that preventative health - I know that the Minister has been talking about the plan to roll out greater preventive health; do people who have one episode often have recurring episodes?

Dr MacINTYRE - Absolutely. That's where your cardiac rehabilitation process is key. Knowing that you've had an event, being supported properly through that rehabilitation process and what we call secondary prevention. Preventing that second event by adequate treatment to target cholesterol, blood pressure and diabetic measures, haemoglobin A1C. Knowing that the patients are being adequately treated and then addressing lifestyle issues on top of that, health coaching to get patients healthier and prevent that second event down the line.

The overall objective in prevention is to try to find premature coronary heart disease. When you have a myocardial infarction in your forties, it's not just about that event, it's about what's ahead of you until you die at 75 or whenever. It's the whole spectrum of cardiac conditions that you will get on the way and the resources required, as opposed to living a healthy lifestyle and dying at 85 within a year of your first major illness, which is what we want for everybody.

Mr HARRISS - Through our visit this morning, we touched on some of the complexities with location and site selection. I'm interested to understand the final site location, I suppose, and how that came about.

Mr MARTIN - I can't speak to anything post the adoption of the Master Plan recommendations of 2022. That's the driver of the location of the proposed Northern Heart Centre. There is a potential - Fiona, I'm not sure if you're aware, but there could be a model or an option paper that was presented that led the Master Plan to be adjusted.

Ms LIEUTIER - The issue with the Launceston General Hospital, I think you're all acutely aware, is it's largely landlocked. There were different options put forward putting the Heart Centre initially down closer to the private urgent care clinic-type area. That was locked in or combined with the Northside Mental Health Facility being moved across the road in Franklin Street. That was revisited because we needed to make sure that we had the Heart Centre close to the Intensive Care Unit and also close to the Emergency Department.

We felt the distance of travel was too great for the patients. I think it was 2023 we revisited the location and it was decided the best location was actually that location on Franklin Street where it's closer to CT, although there will be disruption to radiology very close to the Intensive Care Unit and the Emergency Department. It will cause disruption, but that was the primary driver of that location.

Mr MARTIN - I suppose, Mr Harriss, in terms of the discussion this morning around the various options that then live within the ultimate decision around what is now - or we know the Heart Centre to look like was derived through various options. We spoke this morning around a modularised construction planning proposal versus a traditional design construct. We know that through the optioneering and the acceptance of going with a traditional design that, I suppose, the allowances or some of the amnesty in terms of size that the modular options provided the Heart Centre in terms of its size and scale had to pivot and change because that was heavily reliant on departures of AusHFG (Australasian Health Facility Guidelines) requirements.

We spoke about bed bays versus bedrooms. Ultimately, all those decisions have led to what we now know the Heart Centre to be. It's had to grow in terms of its size and scale. It hasn't grown much, but we've had to maximise its footprint to be able to accommodate what we need to accommodate. I guess that is a contributor to a number of the disruptions and enabling requirements of the scope.

Mr HARRISS - With that location and touched on size, then - I don't know, somewhere it says that cardiac procedures are predicted to increase by around 37 per cent by 2033. Are we futureproofing, I suppose? Has that been taken into account for that?

Mr MARTIN - I'm going to defer to Dr MacIntyre.

Dr MacINTYRE - We had our report commissioned by KP Health that looked at current activity and then projecting over a 10-year period to find it - really, I think it was even 20 years and then onto - and it is futureproofed for that. I think if we build this in the north and we have a second cath lab coming on as part of the strategy in the south, then we should be futureproofed for the growth in population, and the prevalence and instance of heart disease. There are some

specific services that we need to expand such as electrophysiology. There's a big growth area in that, but I think that we can achieve that by four cath labs in the public sector in Tasmania.

Ms RATTRAY - That segues nicely into my next question around the staff required. I've been able to digest the increase from eight to 24 beds available. What about the staffing component? I know this might seem somewhat outside our scope, Chair, but we know that having a wonderful facility, when we don't have adequate staff, or the right complement of staff, that's another issue that's not going to be picked up in a contingency or anything else. Do you have something that you might be able to share with me and Committee members and the rest of our Tasmanian community?

Dr MACINTYRE - There's a staged process map - I want to come into this - that would create a dedicated ward that will have 14 beds and that will be fully staffed. That process is ongoing at the moment. We're hoping that that dedicated ward will open early in this year. That then cohorts all the patients with cardiac problems together. It's 14, it's not 24, but it's as much as we can do at the moment.

As we move into the Northern Heart Centre, we recognise that we will have to staff the Northern Heart Centre appropriately, and there will be a bigger increase in staffing. That's recognised within the Department of Health. There will be a separate business case to deliver that staff, but we're not going to open up a facility and not have it staffed. There are assurances that it will be staffed closer to the point where it's built.

Ms RATTRAY - Do we have access to those staff, or are we able to attract them to our state?

Dr MACINTYRE - Training and education is part of that equation. We can do that from a nursing staff perspective. We've also got to do it from an allied healthcare perspective, which gives us some challenges. We see the Northern Heart Centre as being a massive attraction to people to come and work in Tasmania. There are always challenges of getting people from the mainland, but training and education is going to be part of this process so that we are adequately staffed to the right level in the Northern Heart Centre going forward. We're providing that service as an outreach service across the north west as part of the integrated model I described. Matt, do you want to add to that?

Dr LEE-ARCHER - I wanted to share that late last year we had a vacancy for an interventional cardiologist, so the person who saves your life during a heart attack. We had a lot of people apply from all over Australia, and even internationally. We shortlisted down to five. All five of those at interview spoke of the Heart Centre and how exciting this is for northern Tasmania. So I think this project does give a lot of optimism and excitement about coming to Tassie to work from a medical point of view.

Paul and I in particular have talked at length about some of our allied health staff, and who we call echo-sonographers, people who do ultrasounds of the heart. We want to work on ways to train people locally and give them a pathway from the university degree that they will do and into staying and working with us. We're confident that there will be a lot of interest. It's a great, very exciting thing.

Ms RATTRAY - We're going to have a first-class facility and going be able to park fairly close to the hospital as well?

Dr LEE-ARCHER - Of course, we should all be riding our bikes and walking for our hearts.

Ms RATTRAY - This is Tasmania.

Dr MACINTYRE - You're talking to two cyclists.

Ms RATTRAY - Of course I am.

CHAIR - Do you have another question?

Ms RATTRAY - I think that was the best question of the day, so far.

CHAIR - Subsequent to your question, in follow up with your question, because of the duration between the turning of the sod of the Heart Centre to it actually being operational, and I believe that's 2030 -

Dr MACINTYRE - We're thinking 2028.

Dr LEE-ARCHER - 2028-29.

Ms RATTRAY - I think it will be a jackhammer in the concrete. I don't think it will be a turning of any sod. I didn't see any dirt.

CHAIR - Would that provide an opportunity to develop or enhance those stronger training relationships, say, between UTAS and different institutions around the country, to attract and start training up more staff? Does that give you more of an opportunity if you know that it's not like we need these people tomorrow, we need them in three years' time?

Dr MACINTYRE - As Mark said, when we appointed the new interventional cardiologist, that was part of the sell, that we've got this facility coming on board. We've got potentially some finance to attach to the strategy that will address some of the gaps in the existing service, particularly at consulting level and also nurse practitioner level. There's some resource now to try to make appointments to fill in the gaps of the service in advance of the Northern Heart Centre.

There's a training program. We're part of the national training program where we get registrars. We train them. There's a college process attached to that. We could always expand that. We can expand that in Hobart as well, and that might be one of our objectives to try to get additional registrars into that facility. It's about, I think, showing off to would-be cardiologists that this is coming, it's coming in the north of Tasmania. Would they be interested in being part of that going forward?

Ms LIEUTIER - If you couple it, too, with the fact that we've got the new research and innovation centre which is literally right within 10 millimetres of your cardiac centre, that also provides an attractiveness for cardiologists to come to the northern part of Tasmania.

CHAIR - Fantastic.

Ms BURNET - There's clearly a lot of inefficiencies in how people move through hospitals. If somebody's coming through the Emergency Department, what happens to be put onto a ward? Say if they come in with chest pain - can you just take us through that, and then what you envisage with the Heart Centre?

Dr MacINTYRE - At the moment the interventional service is fairly robust. So, if you present with what's called an ST elevation MI, an acute occlusion of your coronary artery, then the modern treatment for that is to try to open up that artery and stent across any residual narrowing once you've opened up the artery itself. That's called angioplasty and stenting. That's the gold standard treatment and Launceston delivers that very well. It's on the back of work that we did from the CabEd network to try to improve access from the north west to those services where there's a diagnosed ST elevation, MI, definite heart attack goes straight more or less to the cath lab and the ambulance service can notify the staff in advance that they're bringing a STeMI to the cath lab and the patients fly through ED and they go to the cath lab and everything is cleared.

There's only one cath lab. So, if there's a patient on the table, there can be some slight delays around that. But, usually, our patient's are treated very quickly, the artery's opened, famous expression time is myocardium, so the quicker you open the artery the more muscle of the heart you save. So that's the kind of pointy end to the cath lab.

Ms BURNET - What's the procedure there?

Dr MacINTYRE - That's an angioplasty and stent to open up a coronary artery in somebody who's having the traditional heart attack. That's the pointy end.

The less pointy end to that is patients who present with cardiac-centric chest pain, have a small amount of damage. We can measure that in the bloodstream, but they're not having a complete occlusion, and that would normally be called a non-ST elevation MI. So, it's not a complete occlusion; it's a very tight narrowing. We want these patients to undergo angiography within a 24-hour period and have their arteries opened if necessary. That's where we struggle to get the patients down from the north west in a timely fashion, get that investigation done, get them treated, get them back. Those patients can walk in off the street and in the north of the state, Mersey, for example, 45 per cent of patients with a non-stemi will walk in off the street and then they have to be transferred.

There are delays around these processes that this will address. We're hoping wherever possible to bypass ED, but remember the patients do walk in, get assessed by ED and then they're differentiated into, 'This patient needs to go to the cath lab'. So, it won't completely stop patients being processed through ED where there are challenges, but it will fast-track it because we've got the capacity to take these patients to two cath labs, not one, and process them much quicker.

Ms BURNET - As far as the diagnosis, does all that diagnostic testing happen in the Emergency Department?

Dr MacINTYRE - Yes.

Ms BURNET - What do you need to do there?

Dr MacINTYRE - For an ST elevation MI, then we're looking for the ambulance service to diagnose that in the community when they meet the patient. They do an ECG and it becomes obvious that this is a barn-door heart attack, needs to go straight to the cath lab and that happens north and south. We have a two-hub model with a 24/7 cover for that. That's actually a very robust service in Launceston as we speak.

The other group of patients who have chest pain, query cardiac, will end up going to an emergency department, whether it's North West Regional, Mersey or Launceston itself. They will have a blood test performed and an ECG done. On the back of those results there will be a call made, 'This is a patient who's got a non-ST elevation MI, needs to go cardiology and will need to have an angiogram and an angioplasty within 24 hours,' unless they deteriorate. If they start to get more chest pain and it becomes obvious that they're occluding the coronary artery, then they will convert to the pointy end of the scale and go straight to the cath lab. That's the way the service works now.

Ms BURNET - Now they're on general wards?

Dr MacINTYRE - At the moment in Launceston, they've got eight beds that turn over very quickly. We're going to expand that to 14, with a cohorted group of cardiology patients. But that's a broader group of cardiology patients than I have just described; that's patients with heart failure, arrhythmias or patients needing pacemakers. At the moment, cardiology has around 20 patients under their bed card all around the hospital and it's a very inefficient model and the patients get inferior care - I don't mean that in the nasty sense, but it's just less specialised care, they're not on a recognised specialist ward.

We know from data that seeing a cardiologist in a cardiology ward is your best form of care, as opposed to being parked in the gen-med or even the gen-surgical ward and have a cardiology problem because of the skills of the staff and various other reasons.

CHAIR - Just on that, Fiona, could you speak to how, once operational, the Heart Centre may help reduce bed-block within the Launceston General Hospital?

Ms LIEUTIER - As Dr Lee-Archer mentioned before, we're going through a two-stage process at the moment which hopefully will decrease the bed-block, particularly relating to cardiology patients, where we're going to actually cohort the cardiology patients on one ward rather than being dispersed across the hospital. That will make sure that we have the right patient being cared for in the right place. Therefore, we won't have beds being blocked in wards where medical patients need to go through straight from the ED.

Then, when the Heart Centre comes online, obviously we will have the additional beds. One of the difficulties we currently have at the LGH is managing the number of patients that are requiring beds versus the number of beds that we actually have. Again, it's not necessarily a funding issue; it's more the fact that we are landlocked. That will certainly help the bed-block.

The other thing that will assist is the movement of patients through will be a lot more efficient than it currently is. That contributes to our bed-block because we have people staying longer than they should, which means that our beds are actually held for longer than they need to be, which means that the risk is then converted back into the community and to the ED.

Matt, is there anything -

Dr LEE-ARCHER - Yes, I could make a comment because Paul and I were actually meeting with some quality and safety people at the Launceston General Hospital this morning and reviewing some data. Patients, after they have their procedure that we're talking about, the angioplasty and the stent, actually usually go home very quickly soon after. You can imagine one of our rate limiters is only having one laboratory trying to fit all the north and north west patients into one laboratory. With this infrastructure and increased capacity, they will get their angiogram quicker and then they're well enough to go home, usually, within about 24 hours. It will definitely help bed-block.

Ms RATTRAY - Brilliant thing.

Ms LIEUTIER - And it will help it out in the north west as well because at the moment we leave patients, in Mersey in particular, who have to wait for us to have the availability of the bed or the cath lab to bring them over to Launceston. So, with that throughput, we will be able to bring them, divert them out of the Mersey and bring them straight over.

Mr SHELTON - My question, and it's partly been talked about, we talked about the issues of connectivity for the different levels, and I want to go to that issue. With the five levels, it's a multi-storey building, and so, from the Committee point of view, why multi-storey? Obviously, you haven't got room to go one-storey. The comment that I'm interested in is the connectivity issue as you go up on each different level. We know where the problems are. We talked about the issues of the build - they're on the bottom two. The operational and the benefits - and the benefits always have to outweigh the negatives in order for it to get up. Therefore, the benefits that happen with this connectivity from each level that you have through and into the main hospital. If you can run through those benefits, because we know what the negatives are and the timelines.

Mr MCPHEE - Yes, sure. Thank you. The level 3 of the cardio cath labs are located on the same level as the Emergency Department with direct horizontal adjacency to medical imaging. The main patient lift, which connects all levels of the Northern Heart Centre to the rest of the LGH campus, is centrally located. Level 4, which is where the inpatient beds are, and the CCU, have direct horizontal adjacency to ICU, also. Level 5 is basically the diagnostics ward where we have consult rooms, echo rooms, stress-test rooms, things like that. That has directed adjacency to other parts of the LGH.

We have connections at both ends of the building, not only from a fire egress and safety egress, but also a medical response. So there's an ability to - correct me if I'm wrong here, Dr Lee-Archer, but the medical or the code blue team is situated in ICU which just quite nicely sits in the middle of the Northern Heart Centre. The response time from the code blue team is super rapid, super quick and they can access multiple parts of the Northern Heart Centre as well. From an Australasian Health Facility Guidelines perspective as well, they actually know from within the Guidelines that the horizontal and vertical adjacencies align pretty much spot on with what we've designed and the connectivity that we have as well.

It's tight, it's constrained. It's not necessarily always the right option to go with everything on the same level. We've worked within the constraints of the site. Miraculously, I've managed to fit in a full schedule of accommodation with minimal to no departures. We mentioned onsite earlier today that we've been working with tolerances that are within millimetres pretty much from concept design. When it's just blobs on a page, we were working in tolerances of

millimetres. That's how fine we've been pushing the boundaries here, with input from our full consultant team. We have upwards of 20 subconsultants on this project, everybody from cranage and lifting, structural engineers, risk advisers, safety and design with a full suite of consultants who've managed to coordinate all their requirements into a feasible built form. Now, we just need to start digging holes.

CHAIR - Just on that, may I ask what the interim - probably missed - construction impacts on the ICU, the ED and the medical imaging will be in the interim as you transition and as you're undertaking this build?

Mr MARTIN - If we start with ED, there are minor to somewhat intermediate -

CHAIR - Interruptions?

Mr MARTIN - Yes. We have structural incursions happening there around the links that will connect the heart centre to DEM. We spoke about those links this morning and where those occurrences are happening. In the nuts and bolts of that, the insertion of, say, structural columns, for example, will interrupt things like, say, the kitchenette within DEM, is a good example. That may be a six-month interruption, it may be shorter, may be longer. We then have another range of interruptions with DEM. The CT scanner safe room, for example, they are a bigger risk, bigger profile areas of disruption. I think that's -

CHAIR - ICU?

Mr MARTIN - The ICU is somewhat contained, although - it's probably out of the remit of this project, but the connection point between the Heart Centre and ICU, and also the confluence of where the northern mental health link bridge will connect the LGH and the mental health site, enable this sort of confluence of work that needs to happen in that transition point. ICU's current cleanup space will need to be rebuilt. Also, the DonateLife office, which is currently occupied in that area, will also need to be rebuilt. They will be done as part of the disruption enablement scope. So, effectively, their existing spaces will be maintained, and when the new spaces are finished, it will just be: move in, get on with doing the demo of the old spaces, so there will be very little disruption with that.

CHAIR - In our walkthrough this morning, I noted you mentioned that there will be changes to the mortuary procedure and also pathology access - so not pathology as such, but access to pathology and also access to the imaging.

Mr MARTIN - Correct.

CHAIR - For the record, could you provide that information?

Mr MARTIN - Okay. The footprint of the Heart Centre and its incursion on level 2 effectively severs public and clinical access from Franklin Street into any level 2 access, so that is mortuary access, the tunnel access to the loading dock, then the LGH mortuary is mentioned, and radiology. In terms of its clinical interface and public interface to the street, that will have to be disrupted for a period of construction time.

One of the points we spoke about this morning was the fact that until we actually get a contractor to site, we are optimistic that at some point during the construction process, we

can reintroduce clinical interface to some measured extent; public interface probably not, but we would be very hopeful that at some point when the structural conditions of the build are safe enough, and we have effectively a safe structural deck down, that we can start to introduce some clinical interface in those areas. Public would be off-limits.

CHAIR - Also, will Franklin Street require closures during the construction? I know it's how long is a piece of string, we don't have a crystal ball, but can you give us a general idea of what that might look like?

Mr MARTIN - We term it a partial closure. From Wellington Street up to Franklin Rise is still accessible, so minimal impact for residents from Franklin Rise. They can still access - noting that there's also concurrent construction activity happening with mental health as well, which is adding some strain to that. That street partial closure is effectively running from the eastern side of NICS (Northern Integrated Care Service) up to DEM (Department of Emergency Medicine) so it's about a 1500 square metre footprint of closure. It's been supported, validated, ratified through traffic modelling, and it's been approved by City of Launceston as part of a condition of the DA as well.

What we intend to do is make that a condition of the contractual conditions for the contractor. Upon forming a contract, we will effectively be able to hand over a zone of Franklin Street. We know that the private function of that closure is simply just a site; cranage, for example - the cranage complications of being able to not lift over live wards. Even the simplicity of being able to get a crane out if it's located somewhere else is very challenging. We still know the suspended concrete deck there, in the kitchen area in level 1, has minimal structural capacity to hold a crane that's required. The function of that closure is significant to the success of the project being tendered and built, but we are running on a worst-case scenario that that could be for the full duration of the build.

CHAIR - Can you run through the risk to the CT scanner from vibration and how you're going to mitigate that risk?

Mr MARTIN - There's two risk profiles associated with the CT service. One is vibration. From a vibration perspective in terms of how we're going to construct the Northern Heart Centre, in terms of the foundation structural methodology, we know that through the provisions that are being proposed by the subconsultant group have our vibration tolerances in alignment with the CT to be used up until the point that we can't use it any further.

The point that we can't use it any further is not vibration-related. It's to do with the structural works that are required to link the Heart Centre to level 3, 4 and 5; so those structural incursions need to happen either through or close to the existing CT space in DEM, that requires the risk to be too high. At that point we term it as mothballing, but we will effectively have another CT space conditioned ready to go, the relevant equipment ready to run, and we will effectively turn one on and turn the other off, which will basically maintain redundancy service provisions, but also enable the contractor to basically commence the true Heart Centre footprint build. That will stay like that until such time that the risk is such that the DEM CT can effectively be switched back on.

We will maintain the CT machine through the construction of the build. It can't be switched off for two-and-a-half-odd years. It needs weekly maintenance, effectively, to keep it operational. It will still be livened up, but it won't have any patient or clinical interface.

Ms RATTRAY - I'm waiting till we get to page 14, Chair.

Ms BURNET - Can I ask a question: the CT scanner, is it exclusively used for cardiac, or is it used for other things?

Dr MacINTYRE - No, it's not used for cardiac specifically. It's to service ED for whatever. That's a general CT scanner.

Ms BURNET - And there will be a second one in the Heart Centre itself?

Dr MacINTYRE - No.

Ms BURNET - It will just be the one still?

Dr MacINTYRE - It can be accessed for cardiac care, or there's another CT scanner at the hospital that they access for cardiac issues. There's no plan to have a CT scanner in the Heart Centre. There wasn't the space for it.

Mr MARTIN - The process of understanding the risk around CT disruption was really ultimately - and, Fiona, I don't want to speak on your behalf here - but understanding clinical risk around if we take a CT service away and not replace it, what does redundancy look like? What does outsourcing look like? Ultimately the risk factor there of whether a patient can still access the CT, predominantly an emergency department CT requirement, when needed? None of the risk profiling or optioneering around that provided us with enough assurance that redundancy was in place. The alternative there is to find another pocket of real estate on level 3 fitted out effectively to be a CT zone which will service the DEM capacity during the duration of the build.

Ms BURNET - Do you know what that capacity is now, like how much capacity -

Ms LIEUTIER - I think we'd have to take that on notice, unless, Dr Lee-Archer, you know?

Dr LEE-ARCHER - What exactly do you mean, sorry, Ms Burnet?

Ms BURNET - How much is the CT scanner used?

Dr LEE-ARCHER - A lot. Yes. It was a very robust process that Adam and Fiona led with all the clinicians. We need to put a CT in place while we mothball this one, which we are.

Mr MARTIN - It's a high number. It was effectively running pretty well 24/7.

Dr LEE-ARCHER - It's a 24-hour ED.

Dr MacINTYRE - It leaves us - correct me if I'm wrong, Adam, with an additional CT scanner at the end of the project.

CHAIR - That's a bonus, if that's the case. It would be a necessity rather than a bonus.

Mr MARTIN - It is hard to know, is there enough redundancy in the current system? When we talk about this CT machine in a temporary sense, because from a project perspective, that's my optics on it. I mean no disrespect about its temporary nature. What happens to that asset post the Heart Centre being operational and the DEM CT firing back up? I'd say the clinical need will still be there for it.

Ms LIEUTIER - Yes. I think we need to do a full assessment, but in terms of the current numbers, we can certainly provide those to you, but it does run 24/7. That's a high reliance on it. We delayed the whole process really of the project for about two to three months, wasn't it, Adam, just to make sure we have this right because we can't afford to get it wrong. I'm fairly comfortable that we've now got it right.

Ms BURNET - Has there been an increase, like an uptick, in that kind of scanning post COVID, or any sort of pattern there?

Ms LIEUTIER - I'm just trying to think: we've had a 53 per cent uptick in tier 2 presentations in our ED. Our tier 1, which is the highest category, has remained fairly stable, about a 3 per cent increase, I think. Every increase in ED reflects in the CT usage. Yes, there has been increase and we're doing a lot of work with radiology and imaging separate of the Heart Centre project in relation to trying to get our staffing and our models more effective and efficient.

CHAIR - Thank you. We might move to page 14.

Ms RATTRAY - We've already touched on the fact that a partial part of Franklin Street will need to be closed. I note in the project costs that there is an allocation of $912,000. I'm not sure whether that goes to the City of Launceston. It just says COL.

Mr MARTIN - That's a likely reimbursement of loss of off-street parking revenue. Generally speaking, there's a precedent for this, so if I could just lean on a recent precedent that that the University of Tasmania -

Ms RATTRAY - I think my blood pressure's just gone up.

Mr MARTIN - Well you're with the right people. The recent precedent is the recent Inveresk transformation for UTAS. Where that infrastructure was requiring road closures - Boland Street, where there was bridge infrastructure coming into place, council -

Ms RATTRAY - Corporate citizen council? Do they have the interests of the citizens?

Mr MARTIN - Yes. Just for the record, we haven't definitively been approached or invoiced. Now is not the right time for that to occur anyway. We have to allow for worst-case scenario here because it is such a high volume of on-street car parking that will be reduced for a very long duration of construction. Plus, there is also a square-metreage allowance that when you look in the corporate charges that council will apply for this, this is what our liability would be if they implement. Now, we don't know if that's going to happen yet or not. Council may look favourably on the public service and say, 'Well, we shouldn't.' But I'm not so comfortable with that.

Ms RATTRAY - This possible payment, is that not something that's been discussed through the DA? You said the DA has passed.

Mr MARTIN - No. Look, we won't be mentioning it either.

Ms RATTRAY - It's too late now, it's on the public record.

Mr MARTIN - If we want to get into the nuts and bolts, if we want a risk perspective, I can't not allow for it, whether it's a retrospective. It doesn't necessarily mean it's committed - these are only estimates. As opposed to then trying to find the better part of a million dollars post-contract award, that's going to be very difficult. It's better to build those allowances in now.

Ms RATTRAY - I've never seen this before in my time, and that's a long, long time now.

Mr MARTIN - Certainly, that has not been built into any statutory -

Ms RATTRAY - But it's part of 118 square -

Mr MARTIN - Agreed, but what I'm saying is it hasn't been built into any statutory costs that we know to date. In terms of, say, a DA application, it hasn't been an embedded cost. It hasn't yet been embedded costs because we haven't lodged for building approval, but it may in fact come at that point. That's not to say that we can't lobby, push back. I'm just putting on the public record here that there is precedent of this occurring recently.

Mr MCPHEE - It's perhaps worth noting as well that that allowance is based on the time. Once we get a contractor on board and a program that will then allow us to narrow what that may be, the road closure or part road closure may only require 12 months. Could be six months; could be for the full duration. We're unsure of that at the moment. We won't necessarily know that until the contractor is on board and they put their offer forward, depending on how many contractors go for the project as well. Each may have different programs. Each may have - all been in alliance as well, leading to earlier - we don't have that crystal ball at the moment. You could perhaps lean on a little bit of the procurement process as well, the difficulties in being able to obtain that information.

Mr MARTIN - I think it's either going to be - if this cost is a real cost, and let's hope it's not, it's either going to be cost applied to the principal or to the agency, or it will be a cost that the contractor inherits and then will effectively pass through their tender price.

Ms RATTRAY - Regardless, somebody is going to have to pay it. The next one I have is around the disruption allowance in the budget. Now, I can see, for one, there's a $4.032 million. Given that there is significant disruption, are you comfortable with that figure? I mean, you've got a million in contingency-enabling disruption work, so potentially $5 million.

Mr MARTIN - There are a couple different ways of answering that. For the public record here, these projected cost estimates are based on an 80 per cent contract documentation, so we're getting pretty close to 100 per cent documented, ready to go to market. We're pretty close. That 20 per cent difference in terms of the documents that the QS [quantity surveyor] has seen versus what's yet to be completed is probably minimal. It's schedules, it's the total final detail.

Working through the various cost plans, and we've had cost plans at all gateway approvals, a lot of those contingencies have now worked back, so those disruption contingencies or allowances are now captured in physical drawings. So they are actual construction elements the QS has been able to embed within the construction cost. A lot of the risk around what those enabling works will be and won't be are now minimised. To answer your question, 'Is it enough?' -

Ms RATTRAY - It was really, 'Are you comfortable with what's there?'

Mr MARTIN - I am comfortable, yes. I'm comfortable in the sense that, from where those disruption allowances started as just general contingencies, because we didn't have the detail in the drawings, to now understanding what those schedule works will be, the QS has been able to capture it, embed it, but until we've got the final set of documents on the table, we're still allowing some risk items there to be captured as a small contingency.

Mr HARRISS - This estimate, is that a P50 or P90 at the moment?

Mr MARTIN - They're neither.

Mr HARRISS - We normally, or predominantly, have P90 estimates.

Mr MARTIN - I say it's neither because the QS has been engaged but they haven't been engaged to provide that framework. However, the statusing of how the QS would view this would be around a P70 or P80. But in terms of the formality of differences -

CHAIR - Subsequent to Mr Harriss' question, there is a significant amount of contingency within the budget. I didn't work out the percentage, but it is quite significant. I'm gathering it's because - we will talk about the crystal ball again - a contractor needs to be appointed, because it is such a complex build, which is going to require quite a bit of change management. I understand that that contractor is also probably working with you as the project manager. Maybe we will have some different ideas about how to roll things out and what the cost might be. Is that why there is such a large contingency aspect to this budget? Could you run us through it? It is a lot larger than what we normally see. Is it the unknown facts?

Mr MARTIN - Again, we are still at 88 per cent, so we understand that some of those contingencies might likely work their way right back. Those contingencies exist - not all these contingencies, but some of these contingencies exist for the QS or for us as the PMs (project managers) to narrow up where numbers may go up or down depending on the QS getting from 80 to 100.

CHAIR - It's also the long duration of the project too, isn't it? A lot can change in that four years.

Mr MARTIN - Correct. If we talk about design contingencies, for example, they are effectively QS-directed. Design and construction contingencies are QS-directed. Now, that design contingency that we're saying there, at about 1.9, we're expecting that to close right up. At 100 per cent documentation completion there will be no need to be showing any design contingency, really, unless we are expecting some potentially - what's a good example of that? - a during tender addenda to go out. For example, if there are additional drawings to go out which might not yet be consolidated, we would be leaving some site contingency.

Construction contingencies, or contract contingencies again, they, to me, feel about right for the size of the project. Again, they are QS-dictated and we are allowed to question them, but we typically don't massage those numbers too much, primarily around the risk there. It may move a little bit between now and 100 per cent, but unlikely. Again, how we report that is up to Rachael and Simon. To me, that sort of 5 per cent construction factor there, seems about right.

The other allowances in here which sit into that construction or project contingency are things that we know are embedded into the market at the moment. So, cost escalation from start and cost escalation to finish, is the point we mentioned this morning about just how quick the market is growing. We know that the market is growing 3 per cent - 3 point something per cent - per quarter. That's likely to increase.

Once we see the stadium come on, the private sector up here is - the liquidity of the market, this marketplace, the supply and demand thing is tight. It's driving the market factor per quarter higher and higher and higher. The QS has been able to capture what the market will do between tender to start, and from tender to finish. They are costs that we have to build in. They are costs that will effectively be passed on by the contractor, too, because they are subjected to the same escalation rates as well.

It may be a little misleading in terms of allowances versus contingencies in this estimate here. We're certainly happy to take that on notice and revise the wording of that, but -

CHAIR - I don't think we need to do - I just wanted to have it on the record around that, as I think we're quite - Ms Rattray has a question.

Ms RATTRAY - Oh, no, I've asked, I think, far too many. I will let the member who has a heart -

CHAIR - Are you going to ask that one? It's up to you two who wants to ask this one.

Mr SHELTON - I'm hoping my lifestyle has got the right thing and I don't follow in my predecessors' footsteps -

Ms RATTRAY - And all that walking and all that cycling -

Mr SHELTON - As you went to specifics here, and I just had a look at some of the detail, under the financial use forecast milestones in the 2024-25 financial year $22 million; and then in this year 2025-26, $48 million. As I understand, the project won't see a contractor until the end of this year. Does that need revising as far as documentation goes?

Mr MARTIN - Yes, we spoke this morning around the potential to re-baseline this project. We currently have the FFA financial construct around this project. We understand what those milestones look like. We understand when they're occurring. They are solely dependent on the moment of having a successful tendered outcome in the ability to reach a contract. Should one of those two things fall over, a departure will be required. Now, the departure, in terms of what the re-baselining of the program will look like, I can't tell you at the moment what category because it's a 'choose your own adventure story', to some extent.

Mr SHELTON - But hasn't it already been departed from? I wouldn't imagine you've spent $22 million so far.

Mr MARTIN - The financial forecast milestone is primarily based on the FFA milestone. In terms of the actuals versus forecasts, it's running at a different model. This is FFA, this is what the Commonwealth is, not hedging milestones on it.

Ms RATTRAY - So, why is there a gap at 2028-29, if nothing –

Mr SHELTON - It will all be moved.

Ms RATTRAY - What happened there?

Mr MARTIN - I don't know. We can take that on notice and maybe Fiona can tell you. In terms of how the milestones are structured, they are based on the substantiation of design construction documentations. They are substantiated on core construction milestones being completed and a completion milestone. So, it's quite likely that there is a gap between 2028 and 2029; 2029 will be operational readiness or completion.

In other words, the building is practically completed, but now we're operationally in and running it. That makes sense. That's probably why that gap exists, but all the forward allocation of funding would be around construction, design, and documentation milestones.

Ms RATTRAY - My second question, maybe following on from the member for Huon. It talks about P50 out in the little side there, so there are P50 and P90.

Mr MARTIN - There definitely are P50 and P90.

Ms RATTRAY - But you said this isn't -

Mr MARTIN - No, it's our estimates that have built the project aren't P50, P80, P90.

Ms RATTRAY - If it is a requirement, won't you have to meet something to do with a P50?

Mr MARTIN - I can't talk to that, I'm sorry. I am happy to defer that.

Ms RATTRAY - Who is likely to be able to talk to that?

Mr MARTIN - What I can tell you is that our engagement with our sub-consultants or our quantity surveyors, they are not engaged on a P50, 80, 90 framework. Now, there are a few reasons maybe for that. On a positive note, though, the QSs are really wanting the state government to start to lean into that. It's seen as industry standard, and it's probably a good segue into mentioning the Infrastructure Tasmania audits; the gate 3 audits this project has gone through in the last fortnight. They are Infrastructure Tas-hosted gateway reviews. It's a gate 3 review, so it is a pre-tender review. Those questions were asked then, as well, of the quantity surveyor.

It's simply around how Health wants to engage its sub-consultants at the moment. It's not to say that what the quantity surveyors are producing at the moment is incorrect, but the P50,

80, 90 takes risk reporting to a different - it has a different approach, it has a different strategy, plus there is a programs-control component to it. In other words, doing a deeper dive into contractor programs, once a project has sought a tender outcome, but at the moment we can't retrospectively make this into a 50, 80 or 90 because it's -

Ms RATTRAY - I apologise for asking now.

Mr MARTIN - Yes, it's complicated, but I am happy to defer to Simon or Rachael but at the moment that's –

Ms RATTRAY - Is there an answer? If there's not, that's fine.

CHAIR - Rachael looked like she had an answer, but we can take it on notice. Rachael, would you like to have a crack?

Ms DOBSON - I can have a crack. There were a couple of comments in relation to the milestone payment. The next payment will be upon evidence of detailed design completion, which is imminent, in the next few weeks. We've mentioned this is fully funded by the federal government. At that point of receiving that milestone payment, I think will be in excess of $30 million having been paid and we haven't come close to spending that through the design phase. From a state government cashflow perspective, we are in the position where, should the tender be delayed or we not get the response, there are adequate funds there to sustain going back to the market or whatever the procurement activity or strategy might look like. That risk profile is fairly low. We're also in conversation with the federal funding agency to provide them with updates, so they're comfortable with that level of risk as well.

Ms RATTRAY - There's a little matter of the Public Works Committee approval process too, thrown in there.

Ms DOBSON - Yes, there is, noted and proposed project. There was another question. I can't remember.

Mr MARTIN - The status of the QS, the P50, P80.

Ms DOBSON - I just wanted to speak about the consistency.

Ms RATTRAY - I was a little confused when you said there was no P50, P90 to the question from the Member for Huon, yet it's here in the side in the federal paragraph, that's all.

Mr MARTIN - That is somewhat confusing. But, in terms of the response of, 'is it or isn't it 80 or 90?', it's definitely neither.

Ms RATTRAY - I am going to get some help later.

Mr MARTIN - I'm not sure if this is a template carryover from whether it's compared to State Growth or Department of Roads or something.

CHAIR - On that last page, Ms Rattray, did you want to ask the public artwork question?

Ms RATTRAY - No, that's okay.

CHAIR - Mr Shelton, do you want to ask the public artwork question?

Mr SHELTON - There's a typical question always when you're spending $80,000 of taxpayers' money on public art. Presumably you're seeking artists and going through that process. What can we expect as far as a public artwork worth $80,000, and where will it be likely located?

Ms LIEUTIER - One of the strategies that we're applying with all the infrastructure works that we've got happening at the LGH, because of the volume of it, is we're trying to get a consistent approach to the art. It might be that we pool it all to make a better front entrance, with an artistic design, to the hospital. We're working through a more strategic approach to how we spend that art funding.

Mr SHELTON - Good.

CHAIR - Perfect. Is the Committee okay for me to move to page 19?

I had a question around the regulatory compliance with AusHFG. Can you just give us a quick understanding - that relates to whoever wins the contract after the tendering process, and that's part of the building - the builders need to be compliant. Is that correct?

Mr McPHEE - No.

CHAIR - I got that muddled up in the evidence this morning.

Mr McPHEE - Through the design process, there's a whole suite of information around standards of care and health planning unit data that forms a national document called the Australiasian Health Facility Guidelines. As architects and health planners - clinical health planners - it's one of the standards that we refer to when it comes to designing health facilities. Included in all that, there's a whole gamut of information from services and infrastructure requirements, proximity of entries and exits, car parking, all that kind of stuff, but there's also another suite where it's just standard room layouts. The idea is to standardise the health system throughout Australia.

We refer to that document the whole way through our consultation across each phase with our project working groups, including Dr Paul MacIntyre and Dr Lee-Archer. We present the room layouts and it's everything from the location of medical gas panels, for example, to desks, to nurse calls, pendants in the ceilings, all those kind of things.

If we ever depart from that, we have a register noting the departure, and we seek sign-off and endorsement from the project working group and ultimately the project sponsor. So, we monitor that the whole way through. It's ultimately just to keep consistency in health design and care for the community. That then forms our documentation, which the builder ultimately needs to comply with. It's also under the local provision in the National Construction Code that in Tasmania we have to comply with the Australasian Health Facility Guidelines.

CHAIR - Is the accessibility DDA compliant with inclusive design?

Mr MCPHEE - Yes, absolutely. We have a DDA consultant on board who has been advising us the whole way through on everything from tactile indicators, to hand rails, to ramps, clearance around doors, circulation space, lifts, the whole thing. They've been fantastic, actually - very proactive in their reporting, and we've managed to capture all that. When it comes down to equitable access to care we're all good.

Mr SHELTON - Along the lines of design of services and what fits in a ward and that sort of thing: AI. It will be interesting to see where it all ends up, but what sort of planning and processes have been put in place for possibilities of what you need in the future? It's changing that rapidly. We have a new build coming up in a couple of years time to be finished. What contingencies are in there - conduits in the wall that are open, or whatever? Has there been planning along those lines?

Mr MARTIN - I will answer that from the infrastructure perspective, if that's okay, then I might defer on what that looks like in a clinical sense.

Dr MacINTYRE - We don't know. Can I say that? That's the truth.

Mr MARTIN - There's been no dedicated infrastructure as such, that's sitting there ready to retrofit or futureproof the centre around AI. We've had conversations around, for example, our procurement models and when we're ordering that key equipment like cath lab equipment, for example, knowing that this centre is not really going to be up and running until late 2028. What does technology look like then?

CHAIR - Is it going to be compliant in four years' time with what we're doing now?

Mr MARTIN - We had this conversation directly as a PWG. Do we wait? Does AI do something different? We know, for example, that the systems and how they're utilising AI around dosage levels and radiation levels is changing all the time. We have a commitment from the vendors that we're likely to seek pricing from on some of that equipment to make - even though we might be purchasing that equipment now - that by the time it's implemented they will be giving us current, modern software, for example, that maybe has those AI tweaks to it.

As far as the actual envelope of the space and all the things that go through it, no, there's nothing dedicated that suggests that AI is going to represent something different. We have, obviously, a Health ICT component of this project and they are embedded. We have our design zone, but the Health ICT aspects are being looked at by DOH. I think it's probably okay to say that AI isn't necessarily - it hasn't been a conversation point around this build. Now, whether that's right or wrong, I don't know. I'm going to defer to Dr MacIntyre to talk about what AI looks like in the clinical space.

Ms RATTRAY - We know what Dr Paul thinks.

Dr LEE-ARCHER - He's redundant. The only comment I wanted to make, not so much about AI, is that it's been a great project to think about the future for us in Tasmania with our hospitals using an electronic medical record, which we don't currently have. It's going to be a real game changer. This is a part of what we call our 'Bluegum Project' in the Tasmanian Department of Health. That's coming, that will be ready and in place for when this new build is done. We have been thinking about that - how that will integrate. People will be using

computers much more than we have ever before. To that level we've talked about AI - it would be good to make Paul redundant, wouldn't it?

Dr MacINTYRE - The answer is that we don't know, but that's a very important point about the electronic patient record. We need to be ready for that. We need to engage the Bluegum Oroject from the Northern Heart Centre perspective, sooner rather than later. My perspective on AI is it's predominantly a software development, not necessarily hardware. We have AI on the radar in terms of the strategy. A good example of that would be the use of robots to generate images of the heart, for echocardiograms, that are then potentially reported by AI and verified by humans. There's lots of projects going on around the world in AI and I think they're beginning to crystallise into clinical practice. However, I think we are probably five to 10 years away from a real change.

I do think it will impact on workforce. I think it will change the way we do things over time. I don't think it's going to be instant, but in a 10-year period we will be in a completely different environment, particularly around things like reporting and imaging. It lends itself to that; there are packages out there. We will embrace that as it comes online.

There are barriers, major barriers, to getting AI integrated around things like patient confidentiality or risks of information going on to the internet. The UK and the NHS have embraced it more than the Australian Government because there are various concerns about what you can and cannot do in ChatGPT and who gets hold of information that is potentially confidential. There are lots of barriers to it, but it will come. What it will look like in 10 years time, I don't know.

Ms RATTRAY - I think that's the question of the day.

Ms BURNET - I think that answers one of my questions around the digital record.

I'm just going back to something that you were talking about before, about filling those positions - you think that it's likely that there will be an interest in working there. What are the barriers though, in relation to filling those positions because you're looking at nurse practitioner positions as well, and presumably some allied health, not that I think it's touched on in this report. Can you just tell us about any of the headwinds you might have?

Dr MacINTYRE - First up is buyers funding: we have funding attached to the strategy and this is confidential. We're waiting for that to be signed off, so we can't actually say that it's there yet, but we've put forward proposals as to what we need. That's the first tranche and that's related to implementation of the strategy, so all has to align with what's in the strategy document.

The next obvious target is to try to fill in the gaps, I think, in medical consultant level as to what we need in terms of additional medical staff to provide the services that we don't provide at the moment. That's really what I did in Hobart as head of the Department: to try to identify the gaps and then address those through business cases, get them funding and develop services. I think I've probably got it to the point where I'm happy with it in Hobart. Although I'm no longer head of the Department, we have robust level 6 services. We send very little to Melbourne; we can do most of the things here.

What I want to do is replicate that in the north, at level 5. That would be my focus: get the level 5 services sorted, and we need personnel to do that. We need to embrace modern ways of working, which would be nurse practitioners involved in delivery of care and allied healthcare staff. There are major gaps in terms of echosonographers that we need to address. We need to find solutions to bringing those allied healthcare professionals into that environment, in advance of the Northern Heart Centre.

Training your own is the philosophy. Having gone out to market, particularly for nurse practitioners and allied healthcare professionals, we struggle to appoint people from the mainland because of the differentials in salary, or the perceived differentials in salary. That's always been a barrier. There are various workforce category barriers to bringing people to Tasmania from mainland Australia, so really training and growing our own. We've had some very successful examples of that in Hobart where we've appointed good graduates, with biomedical degrees from UTAS, who have flourished in the environment.

There's a period of training required, and part of our strategy is to deliver that training program statewide, so that we support that growth in the north of the state and we try to get these allied healthcare professionals and the whole service out into the north west. Whether virtual healthcare has a role to play, which I suspect it will have, but also bodies on the ground, because at the moment we have very patchy services in terms of cardiology in the north west of the state that we need to support.

Ms BURNET - Is there likely going to be any clinical trials associated with the new service?

Dr MacINTYRE - Yes. I think we have to, first of all, prove that it's working. We have to implement what we would consider as best practice and we have to first do a clinical audit. We have a few projects, one of which Mark mentioned this morning. We have electronic dashboards to bring on board. We have to show that the Northern Heart Centre actually delivers what we think it will deliver. We probably do need to measure baseline in order to measure improvement and we're doing some projects around that at the moment, particularly in transfer from the north west of the state into the Launceston General. We need to be able to demonstrate that this has worked; we know it's going to work, but we have to actually prove that in terms of unlocking the flow of patients from the north west and delivering on equity of access.

In terms of clinical trials: I think the Northern Heart Centre becomes an environment in which you can conduct clinical trials as they come on board for new medications. That's lacking a bit in LGH at the moment; it's more robust in Hobart. But I think it's something we need to develop with an academic focus, which is not really there in cardiology at LGH, but we need to develop that as part of our strategy - it's the fourth pillar of the strategy. So, yes, I think that's on the horizon and it will link with UTAS and will hopefully attract academic output.

CHAIR - And it will save lives.

Dr MacINTYRE - It will save lives, no doubt about that.

CHAIR - Do you have any more questions?

Members - No.

CHAIR - Before you leave the table, I'd like to reiterate the statement I made earlier about committee proceedings. I believe I have the right script in front of me: 'statement after evidence'.

Ms RATTRAY - The really important questions.

CHAIR - I have a series of questions to ask you. You can answer yes or no to these. You can all do it at the same time if you want.

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

Witnesses - Yes.

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

Witnesses - Yes.

CHAIR - Are the proposed works fit for purpose?

Witnesses - Yes.

CHAIR - Do the proposed works provide value for money?

Witnesses - Yes.

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

Witnesses -Yes.

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

Witnesses - Yes.

CHAIR - Thanks for coming. Thank you for today.

The witnesses withdrew.

The Committee adjourned at 3.39 p.m.