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THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT ST CATHERINE'S HALL, NORWOOD, ON WEDNESDAY 29 OCTOBER 2025.

LAUNCESTON HOSPICE

The Committee met at 1.30 p.m.

CHAIR - (Ms Butler) - Welcome, everyone. Before we commence the hearing, I'd like to introduce members of the Committee that are here today. We have Tania Rattray, Helen Burnet and Dean Harriss. We also have Scott and Georgia as Secretaries, and on Hansard we have Karen and Harrison. Mr Shelton is an apology 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 the undermentioned proposed public work to the Parliamentary Standing Committee on Public Works to consider and report thereon.

Pursuant to section 16(3) of the Act, the estimated cost of such work being completed is \$20 million, Launceston Hospice.

CHAIR - The Committee is in receipt of two submissions from the Department of Health and from Mrs Lyn Lichon; could I ask a member to move that the submissions be received, taken into evidence and published?

Ms RATTRAY - So moved, Chair.

Motion agreed to.

The first 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 LIEUTIER, CHIEF EXECUTIVE HOSPITALS NORTH; **Mr JON HUGHSON**, DIRECTOR, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES; **Ms RACHAEL DOBSON**, SENIOR PROJECT MANAGER, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES; **Ms ANNETTE BARRETT**, ASSISTANT DIRECTOR OF NURSING, PRIMARY HEALTH NORTH; **Mr DANIEL MACE**, SENIOR PROJECT MANAGER, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; AND **Mr HANZ LEE**, PROJECT LEAD DESIGNER REPRESENTATIVE, DIRECTOR, JAWS ARCHITECTS; 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. Before you begin giving your evidence, I will inform you of some

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important aspects of committee proceedings. 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; do you understand?

WITNESSES - Yes.

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

Mr MACE - Since the closure of Philip Oakden House in 2007, Launceston has been without a dedicated, public palliative care hospice facility, leading to community concerns about limited access to contemporary palliative care and end-of-life care. In 2022, the Australian Government committed \$20 million towards opening a new hospice facility in Launceston. The Launceston Hospice will be a purpose-built facility, providing 12 beds, that will cater for community members with life-limiting conditions, and their families and carers.

The Launceston Hospice is to be located at 33 to 39 Howick Street within the existing Allambi Building, enabling the operation of the facility to leverage off existing clinical, hospitality and maintenance services of the Launceston General Hospital. The project aims to provide increased capacity to help meet future demand for palliative and hospice care as the Tasmanian population ages and more people develop chronic multiple comorbidities.

CHAIR - Thank you. Now, how we usually like to ask questions is we go through the statement that you've given to the Committee, or the submission. We go through page by page so just letting you know, we will try not to jump too much. We will try to keep it nice and organised. I'd like to open by asking a question about KP Health. If you could give us some background on KP Health; it seems to be a group that's provided a lot of input into this project and so, for the record, if we could have some background information on that organisation? Thank you. I'm not sure who's best to answer that question.

Mr MACE - I'll speak to that. KP Health was engaged by the Department's Health Planning Unit as part of the initial investigations into the model of care and service planning for the projects. It was engaged to prepare a service model and model of care for palliative care hospice services in northern Tasmania report, which then provided -

Ms BURNET - Excuse me, Chair. The other members of the audience just can't hear at all.

CHAIR - Okay. Would you be able to speak any louder, I am sorry, if that's okay? We will take a quick break and we will move the people attending around. As we resume, I will ask the same question, and maybe if you can just go through that answer that you've already started, if that's okay. I'm very interested in KP Health. Their name is mentioned in the

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introduction as being one of the large contributors as consultants to this project. I was wondering if you could give us some information on KP Health.

Mr MACE - KP Health was engaged by the Department's Health Planning Unit at the very initiation of the project. It was engaged for the development of a service model and model of care report. This informed a large majority of the design, some of the design principles that were taken on board, and provided a lot of the data that's gone into supporting the project through that initial planning and scoping phase.

CHAIR - Thank you. I will just quickly ask a question on the project: the proposed site for this project will be the Allambi Building in Launceston. It's a building which was built in 1921 as an infectious diseases hospital. Could you run through the heritage aspects of that site, or of that building, and just give us a brief overview, for the record, of the heritage aspects which will be addressed and maintained during this project?

Mr MACE - The Allambi Building is indeed heritage listed, built in 1921. The external facades are listed on that listing with the Tasmanian Heritage Council, together with a fair few of the heritage trees on the site. The gate - located on the very corner of Mulgrave and Howick Streets - but the internals have changed over time, and hence allows this project to continue in the refurbishment nature, and has been through a planning process with the City of Launceston and has engaged the Tasmanian Heritage Council through that process.

CHAIR - Thank you. I believe Ms Rattray has a question.

Ms RATTRAY - Thank you, Madam Chair. If I can, I might just double back to follow on from your first question in relation to KP Health. You indicated that it had been integral to the design of the proposed facility. I'm just interested in what consultation did KP Health undertake with the project reference group people, and in particular, the Friends of the Northern Hospice group, because obviously, there's that opportunity to have input at the front end and potentially not at the back end like today. Can I have some indication of what that looked like?

Mr MACE - Absolutely. KP Health facilitated a workshop with the project reference group. The Friends of the Northern Hospice group had two representatives on the reference group that attended that workshop. At that point, KP Health presented the literature review and data collection analysis that fed into its report, and then sought feedback from those representatives before delivering its report. Further to that, KP Health presented a draft report for feedback and review by reference group members, before delivering its final report.

Ms RATTRAY - At any stage of that consultation was there a large group that met with KP Health, or was it purely just representatives? I think you mentioned two from the Friends of the Northern Hospice group. Did they have a large gathering where they might have, you know, thrown around ideas and suggestions?

Mr MACE - The reference group was probably the largest sole gathering. All other engagements were more targeted towards particular audiences.

Ms RATTRAY - So, not really a large open forum where people could have direct input to share their views of community health?

Mr MACE - Yes.

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Ms RATTRAY - Thanks.

CHAIR - Okay. Any other questions on that page?

In the submission that's been provided, it states that the commitment to build the hospice was a \$20 million Australian Government funding grant. That was confirmed in the 2022-23 Federal Budget and that was to enable the construction of the Launceston Hospice.

Can I ask why this has taken about three years for it to come to the stage where it's at the moment when that's been a three-year wait? Can I ask what the hold-up has been with that process?

Mr HUGHSON - Essentially, there was quite a lot of time spent - there are some sites listed there - where we undertook some site assessments, but there was probably well in excess of six, possibly verging on 12, months in terms of assessing different sites going backwards and forwards. We did assess two sites to start and looked at a few test fits. Then we did an open-market approach to make sure that we got the very best site that we possibly could and, unfortunately, in this instance, that did have a fairly protracted process but we wanted to make sure with the money that we were getting, that we were getting the best outcome that we could.

CHAIR - Okay. Also, in line with that three-year wait for that, it's my understanding that the concept of having a hospice in Launceston to serve the north had been on the cards or had been discussed for about 10 years before that. Is that correct? Are you aware of the history of getting this project to this stage?

Mr HUGHSON - I personally am not aware. I've been in this role for four years.

Ms LIEUTIER - I think the Friends of the Hospice have certainly been advocating. I couldn't confirm that it's 10 years, but it's many years.

CHAIR - Okay. Does anyone else have any questions?

Ms BURNET - Just subsequent to that, I mean, it clearly says in the background that the Philip Oakden House was closed in 2007. So, presumably a permanent home and a home that's purpose built was the thinking for the Department, at that point.

Ms LIEUTIER - I couldn't go back to 2007. I can go back, for the Department, probably two-and-a-half years, but we have always been looking for a dedicated space to create the hospice and create the philosophy and environment for the hospice.

Ms RATTRAY - Just a question in regard to alternative accommodation - and thank you very much for the opportunity to look over the site this morning. You know, in a country girl's terms, it's in pretty good nick inside. So, to move the people that are working there out of that building and then effectively gut the building, was that taken into consideration through the site selection process and where do these people that are already using the Allambi site go to, when and if this project gains approval?

Mr HUGHSON - To answer the first part of the question, yes, factoring in the cost of essentially almost gutting the facility and rebuilding within, was one of the key points. Looking at a lot of other sites and having to actually acquire a building, or indeed build a building, was

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not really feasible within the funding that was allocated from the Australian Government. In terms of relocating the services - I just didn't quite catch the end of that question.

Ms RATTRAY - Where do those services go to if this gains approval?

Mr HUGHSON - The services have been relocated to Cimitiere House. I'm not that familiar with Launceston myself, sorry, so I'm not sure how far away from the existing service it is, but we've engaged a change management consultant to work with the impacted staff that will be relocating to Cimitiere House, and we're working with the landlord to do a fit-out to suit the services rather than what's happened in the past where the services have just tried to fit within the existing Allambi building.

Ms LIEUTIER - Cimitiere House is the space that we've been able to allocate for staff. There will be less costs ongoing, which we're working through in terms of the operational costing of running the hospice and relocating staff. It's going to be a dedicated fit-out. There's been formal consultation for three months, and certainly ever since minister Barnett made the announcement that Allambi was the preferred site, there has been ongoing communications and information-sharing with staff on potential sites where they may be located to, with Cimitiere House being the final selection.

Ms RATTRAY - Would there be any issue with that transition?

Ms LIEUTIER - I think there were 600 pieces of feedback in relation to the transition from staff, which extended the consultation period. We engaged with unions and staff. We have had confirmation from our clinical staff that they're now satisfied with the space that's been allocated to them and the fit-out. There's also going to be space allocated in the Launceston General Hospital for those staff who need to come up and have clinical responsibilities within the hospital. Alongside that, there is clinical space within Cimitiere House that's being designed and built.

Ms RATTRAY - You see no issues with the transition from one lot of people being accommodated in this current building to the next one while there's building?

Ms LIEUTIER - To be fair, the staff in Allambi have had the luxury of very, very good accommodation for a very long period of time, so there are challenges in terms of change management with transitioning staff who have had such beautiful surroundings into a city administration complex. So yes, there are challenges. We will work through them. The priority is to support our staff through that, but also to ensure that we're providing the best service for the community which the hospice provides.

CHAIR - We might move on to page six. I just wanted to ask a question about the existing clinical, hospitality and maintenance services of the LGH - it refers to that insofar as locality within the submission - and whether or not the LGH will be providing meals and maintenance for the new hospice?

Ms LIEUTIER - In terms of maintenance, that would be provided by Infrastructure Services, and we have Infrastructure Services based at the LGH. They also look after John L. Grove, which is very close to Allambi, so we already have services that will look after the site in terms of infrastructure.

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Ms BARRETT - We have had discussions with food services at the LGH, and we have factored into the model of care and into the budget their provision of food services to the hospice. We're not going with the traditional model of three meals a day necessarily. We're going with a more flexible room-service type of approach so that palliative patients can be provided with what they feel like eating when they feel like eating it. We've had quite a lot of discussion around how that will look and how that will work. Similarly, with cleaning services and support services for the facility.

Just going back, in regard to maintenance, we have factored into the model of care and the staffing FTE at this stage some specific FTE for a degree of maintenance of the facility incorporated with gardening support, because external environment is so important to palliative patients.

CHAIR - That would actually be quite a significant role, I imagine, looking after those beautiful gardens. How does the community garden section of the project fit in? Would that be maintained by the hospice, or would that be maintained by the community, as such? Have you got to that part of the detail yet?

Ms BARRETT - We haven't got to that part yet. I think we've had very limited discussion. I think we would see that there would need to be oversight and supervision by paid staff but, you know, supporting a plan around what community support was available and what components of the garden they were happy to contribute to and to maintain and support.

CHAIR - Whilst we're on that about the community garden - and I'm sorry if I am jumping, but it just seems an opportune time to ask about that concept with the community garden. How will the hospice ensure the security and safety - make sure there's no antisocial behaviour and so forth around community usage of that community garden, seeing as it is so close to the hospice?

Ms BARRETT - We have incorporated, again, into the model of care and the FTE, a security component built in, combined with an orderly function - an orderly role. The thinking behind that was to support patients being wheeled out into garden areas and back in, you know, moving equipment around, but also having a security function as well.

At this stage, that's not a 24-hour role, but it's got an on-call component. It is trying to strike that balance between inclusiveness - because we want the hospice to be part of the community; we want families and friends and people to be involved and to access those gardens - but obviously, there will be that need to ensure security and that the grounds are maintained the way we want and that patients can feel safe using it.

Ms BURNET - It would be interesting to explore that a little more. So, with your thinking, clearly Allambi is a beautiful setting, and it was used as an infectious diseases hospital, so we're told. The thinking around - and it would be good to hear from the architect, as well - the garden setting and that community basis, can you explore that a little more, about how important bringing that external space in has been, as this site has been chosen?

Ms BARRETT - I think certainly we had some consultations with managers of other hospice facilities - so, Cabrini, Eastern Health, the Whittle Ward, and HammondCare - and we asked them about the main feedback from their patients. You know, complaints, what the most valued aspects of hospice and the environment were, and they unanimously commented on the

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importance of the external environment and having that integration between the two. So, it was a really strong factor in the design, and communicating to the architects that it was really important. I think that's one of the great aspects of the design, that every room has immediate external access.

Again, we want to try to promote - I mean, the philosophy of palliative care is you want to be able to encourage children, families, pets, those sorts of features, into the care and support of palliative patients, so you need to have appropriate space to do that. And so, obviously, again, the external environment plays a very important role in that - family functions, barbecues, get-togethers, those sorts of events. It's really important. That's what we were thinking. We also know that there are a number of community members who we believe have already expressed interest in supporting the facility. Again, involvement in the garden and the external environment is one option to ensure that. So, that was the thought behind that, but, it's been very early stages around exactly what that would look like and how that would occur.

Mr LEE - Just to expand on that one: in addition to the community garden, the existing courtyard within the Allambi building will be maintained, and accessible not only to the patient residents but also open to the family visitors. We see that is an integral part of the hospice design and goes hand in hand with the model of care. We have professional landscape architects in our team that leverage the existing heritage trees, the value of it, and expand, and how that will integrate into the design.

Ms BURNET - It's been informed by other other hospices, from your perspective?

Mr LEE - Yes, as part of this project we, our team, went to do a study tour in Victoria of three hospice facilities. The lesson learned from both sides was what to do and also what not to do. One hospice facility attached to the hospital was mostly internalised; they had no access to a garden, and I think that sort of further reinforced the needs of access to outdoor space that's important to the people receiving hospice care. The other two facilities had beautiful, albeit small and in a different setting, one in a suburban - nothing as beautiful as the heritage setting of Allambi. This gives us the opportunity to use that to anchor the design.

Ms RATTRAY - Thank you. Obviously, hospice care is really important for families to be able to access and, I expect, friends. It says on the top of page six that 'the following criteria and requirements for the site were established', and it clearly indicates in 'Accessibility' that the site shall accommodate car parking for visitors, volunteers and staff. Currently there are 26 spaces - to be 19 staff, I think I read that somewhere - and there will only be 14 spaces for vehicles. Now I know we're in Tasmania and we like to park out the front of wherever we want to go, but in this particular case it would be really important, I feel, to also have car parking matters addressed. How does that meet the requirements when there's going to be a significant reduction in car parking availability on site? It doesn't even cater for the staff numbers.

Mr HUGHSON - There is, obviously, as you've noted, Tania, quite limited car parking on site. The LGH in early 2026 will commence the construction of the multi-storey car park, which will be across the road.

Ms RATTRAY - Down the road.

Mr HUGHSON - Yes, down the road from the hospice. I think that has approximately 470 car parking spaces. In the interim, while that's being built, we're about to deliver a

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temporary car park that will be across the road from the proposed hospice, and that delivers 174 car parking spaces. I'm looking at the Senior Project Manager at the other end of the table. So, I suppose in very close proximity, there will be quite a plethora of car parking.

Ms RATTRAY - So that's the rationale behind why you can't actually meet the requirements to have accessible car parking, is to be able to use the new LGH car parking in the future?

Mr HUGHSON - Yes.

Ms RATTRAY - Do you think that's adequate and not too far away for people to be able to leave their car parked, perhaps, for a week?

Mr HUGHSON - Well, I guess it is literally just down the road, and we have put as many car parks on the facilities as we can whilst still allowing the flexibility for those garden spaces and everything.

Ms RATTRAY - I completely understand, but I also acknowledge that these are stressful times for families, and trying to find a park for your vehicle and stay with your loved one is also going to be a challenge.

Mr HUGHSON - We'll be working with council, I believe, to look at some more on-street car parking as well.

Ms RATTRAY - You'll have to take out a loan then if you want to park in Launceston.

Mr LEE - The design incorporated a dedicated drop-off zone, so if you work with the service, they may be able to have short-term parking within the zone, offloading and then come back. It is a pretty constrained site. It's always about striking a balance between what's important to the project, I think throughout consultation with the stakeholders, unanimously everyone's agreed that the garden and outdoor space is paramount. It is an asset, it has a therapeutic function to it, so I think the car park drops down the list. We will have to just seek solutions outside the site and be creative about it.

Ms RATTRAY - This morning Daniel informed us that there may be an opportunity to have a pass that accesses the LGH car park, because people might need to leave their cars for a length of time.

Ms LIEUTIER - That's something that's reasonably easy to do, and we do do it from time to time at the LGH, so that wouldn't be an issue. I think all of us here are acutely aware of the car parking issues around the LGH, and there is no ideal solution to them, but we absolutely exhausted trying to find alternate sites that would meet every criteria and we just couldn't find one.

Ms BARRETT - We did even at one stage have a discussion and the architects did have a design for putting in additional car parks to see what that would look like, but it really did detract from the external environment. Patients were then looking over a car park, and it really impacted quite significantly on the accessible external space. That was another contributing factor.

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Ms RATTRAY - It's the compromise.

Ms BARRETT - Absolutely.

Mr LEE - For the record, a full traffic study was prepared and helped to inform the final design decision as well.

Ms RATTRAY - The communication with Launceston City around car parking - but the Launceston City Council don't own all of the car parks, so there'd have to be an agreement with private operators perhaps as well?

Mr MACE - Absolutely.

Ms RATTRAY - Is there?

Ms LIEUTIER - I operate the Launceston General Hospital car park.

Ms RATTRAY - So there's no issue there?

Ms LIEUTIER - No.

Ms RATTRAY - So you don't really need to engage with the Launceston City Council around parking?

Mr MACE - The only consideration for parking with the City of Launceston is that traffic study Hanz mentioned. That was assessed as part of the development application process which has been approved through the development permit.

CHAIR - A subsequent question to Ms Rattray's line of questioning, is there an opportunity within the new LGH car park to have even just four or five dedicated car spots that are allocated for the hospice people? Is there an opportunity, with us recommending that, potentially, as part of our report, and that way if you do have families that are needing to park there, and they're going round and round trying to find a car spot at a time of considerable pressure for them - or even potentially as a spillover for staff - that they are allocated as safe car spots? Would that be a sensible idea?

Ms LIEUTIER - Absolutely. We do it for the Holman Clinic for our cancer patients at the moment, we do it with our disability car spaces, and we do have dedicated disability car space parking. It would definitely be within the realms of possibility, and quite sensible to do so.

CHAIR - Thank you. I have a quick question around the capacity of beds. There's a minimum of 10 beds, this particular project is proposing 12 beds. Will that meet the current demand, and what is the projected demand at the moment for end-of-life care?

Ms BARRETT - KP Health research indicated that by 2027 we'd need 12.4 palliative beds, ideally.

CHAIR - When this is finished being built, will it be at that demand? Sorry for cutting you off.

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Ms BARRETT - That was across the north, too. We do have palliative-specific suites available at all of our district hospitals, so they provide additional palliative beds. By 2032, the prediction was 13.7 palliative beds.

CHAIR - Okay, so, that's not that far off.

Ms BARRETT - No.

CHAIR - Do you have any further projections, later than 2032?

Ms BARRETT - No. I'd have to go and review the KP Health data; they were the two that I was aware of.

CHAIR - Just to clarify, it's my understanding that end-of-life care and palliative care are different things? That this is not for palliative care as such as end-of-life care, is that correct?

Ms BARRETT - End-of-life care is a component of palliative care. We see the hospice not just being for end-of-life care. Currently our Melwood Palliative Care beds, if you analyse those, about half, a bit less than half of the patients are there for symptom control and management. It's not just end-of-life care. We would see the hospice providing that - supporting those patients as well.

CHAIR - Okay. What is the average time, I suppose, across Australia for duration of stay for people in end-of-life care facilities?

Ms BARRETT - I couldn't tell you that off the top of my head. The only thing I could say is that it's really variable. Predictability of death is very difficult even with the best expertise. Some patients, you believe, may die in a couple of days, and they survive weeks. Some you think may have a trajectory of months and die in a few days. So, it's a very difficult science.

CHAIR - I'm trying to get this clear in my understanding. You can be receiving palliative care for years sometimes, is that correct?

Ms BARRETT - Yes, our specialist palliative care service doesn't provide services to patients generally across years. It provides services to patients when they need more complex support and care, when they're entering -

CHAIR - That next stage.

Ms BARRETT - Not necessarily just end stage, but the stage of their illness where they're less independent and need more support and more clinical care.

CHAIR - Okay. For the record, the hospice is for palliative care as well as end-of-life care?

Ms BARRETT - For components of palliative care. So, we would not see for example, that you would put a patient with a palliative illness, that they would be admitted for a six-month period. The focus will be more on shorter-term care. Someone may be having a pain crisis - they may be admitted to have some diagnostic assessment and a review of their

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medications to try to manage that better and then be discharged. Of course, there will be a lot of patients who will be admitted for end-of-life care.

CHAIR - Okay. Also on this particular page, it talks about potential future expansion of the hospice. Is there space there for future expansion and do you think that this will need to be expanded into the future?

Ms BARRETT - There is a small amount of space at the rear of the landing.

CHAIR - Because you can't touch any of the trees or anything.

Ms BARRETT - No, there are no trees in that space.

That's one that I think is not too bad.

I think ideally, talking to some of the other hospice operators, having about 16 beds creates some efficiencies of scale and is an ideal number. I think from the projections, we know our rates of dementia, incidence of neurodegenerative diseases and cancers are increasing. So, there is an increasing demand for palliative care. I think 12 beds are the minimum, but that allowed us to have rooms that were an optimal size and provide a lot of the other features that we felt were really important.

CHAIR - All right, thank you.

Ms RATTRAY - I think I've jumped over to page nine, by the way, Jen. You mentioned the opportunity to have palliative care in our regional hospitals. Under the KP Health model or the 'Long-Term Plan for Healthcare in Tasmania 2040', do you see an opportunity to expand those services in some of our regional areas? For instance, the North Eastern Soldiers Memorial Hospital in Scottsdale, I believe, has two palliative care beds, but there is plenty of space for more that could relieve pressure and you could park outside the door at no cost. That's an aside. Do you see the opportunity to use our regional hospitals that are not being used to their full potential for general admission, but for those services?

Ms LIEUTIER - I think we would all be quite aligned that we all want the best efficiency and services provided from our district hospitals. The hospice is very much focused on the acute palliative patients. People are at the district hospitals to be close to their families and friends and their environment. If the need is there, then we would certainly advocate for increasing those facilities or increasing the bed numbers or swapping bed numbers - that is another thing that we would look at. There hasn't been any strong need indicated to us at the moment in relation to the district hospitals.

Ms RATTRAY - There will be in the future.

Ms LIEUTIER - The other thing that we do is have palliative patients in the Launceston General Hospital as well, and that would continue. We have a current contract with Calvary's Melwood Unit - that's where our current palliative care patients largely go, with overflow back into the LGH. The utilisation of the district facilities will change as the needs of the communities change.

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Ms BURNET - Just to be clear, how many beds are in the private arrangement at the moment?

Ms LIEUTIER - We lease on a needs basis, so we have a contract for around 1050 bed days a year. At any time we usually have between four and eight patients in Melwood. It just ebbs and flows depending on the needs at the times and if Melwood cannot take the patients, they come into the LGH.

Ms BURNET - Just for clarity, because I may have missed it, but when you were talking about the average length of stay in that kind of arrangement, is it too hard to pin down?

Ms BARRETT - I would have to go back and do quite a bit of data analysis to know exactly what that is, but I can certainly source that information. That's just public beds that we have. We also provide support for private patients on top of that. Private palliative patients, in addition.

Ms BURNET - A subsequent question: with the leasing arrangement from the private hospital, once it comes back into the public system again, is there likely to be savings in relation to that arrangement?

Ms LIEUTIER - The arrangement we have with the private hospital is complex because it is done on a bed-day basis. We are in constant contract negotiations and have been since I've been there. There will be certainly efficiencies from an administrative point of view. I think we will be providing far better facilities than the current Cavalry facilities once we have the dedicated hospice. Even our facilities in our district hospitals are also superior to the Calvary contract that we have. That's just because of the location and I think I've picked Deloraine for my space if I ever need it.

Ms BARRETT - Scottsdale is pretty good too, though. It has fabulous views.

CHAIR - Does anyone have any more questions? We will skip through to page nine. Any questions on page nine? Any questions on page 10? I wanted to ask some questions about the discreet entrances, service entry, and whether you could talk us through some of the unique designs that are part of this project, if that's okay? Probably best through you, Hanz.

Mr LEE - Sure. I will come to the question and answer shortly, but I'd just like to use the opportunity to provide a short design statement for the project. I think it will help inform that.

The design team acknowledged the importance or uniqueness of this project, and we have approached it with care, sensitivity, and a deep sense of responsibility. Every effort has been made, to the best of our professional knowledge, to achieve the best possible outcome within the project's spatial, the heritage building envelope, accessibility and budget constraints.

Our aim is to deliver a fit-for-purpose hospice facility that provides dignity, comfort and support for patients, family and staff within a family home-like environment. Throughout the process, we have worked closely with the project stakeholders to explore and refine solutions that balance functionality, accessibility, quality and value.

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As I touched on earlier in the hearing, to strengthen our understanding and inform the design approach, our team undertook a study tour of three hospice facilities in Victoria, gaining valuable insight into spatial planning, finishes, material selections, and also furniture, fitting and equipment selection. The lesson learned from this visit has been helpful in shaping a design that reflects both functional excellence and a compassionate, family-oriented environment that supports the emotional, physical and practical needs of its users. Throughout this collaborative approach, our team remains committed in delivering a facility that embodies care, inclusivity and respect.

To get back to your question earlier, Chair, one of the uniquenesses of this design is learning from one of the study tour - the facility we visited. It has a discreet entry separate to the main entrance to provide patients the options of exiting the building when they pass away - as touched on earlier, it's about the dignity for the family so they have options to choose.

CHAIR - Whilst we're talking about the design, could you run through the capacity within the separate bedrooms for patients to have family members stay there comfortably, especially overnight, and what that would look like? Also, the verandah access and privacy on those verandahs as well?

Mr LEE - Sure. The bedroom design has been carefully planned through consultation with the stakeholders. We landed on a design that has the ability to provide a fold-out bed if needed, should the family members choose to stay overnight.

As the design renders provide a part of the report, they approach it not just during the day, seeing, as we all can appreciate, people who receive palliative care or end-of-life care, the opportunity to visit the outdoor environment could be limited, so even during the night setting that the touch of a night sky design is to provide, again, an option for the patients should they wish to access it.

All the patient bedrooms have a private balcony, have a view or close proximity to the gardens, and each balcony will be separated with a fixed screen to provide the privacy quality that is needed.

CHAIR - From our tour today, and I thank you for your time this morning, for providing us that information, you mentioned the entrance doors and exit doors onto those verandah areas or balcony areas will be wide enough for a bed to potentially be moved out of that.

Mr LEE - Correct.

CHAIR - Could you give us a run through, for the record, of what that design would look like, and the remedial works that would have to happen because at the moment? It doesn't look like the current doors are wide enough to be able to have a bed go through them.

Mr LEE - Throughout the design process we have mapped out a patient journey and access pathway for the patient's need to get to and from - so every doorway will be wide enough to cater for that movement, including to and from the community garden to access to a lift or to their balconies and/or to the private courtyard.

CHAIR - OK, and for the record, the balconies, will they have any form of heating on them, outdoor heating on them?

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Mr LEE - Currently there's no heating allowance in the design. However, should there be a priority or need for it, we can certainly revisit it if the budgets allow.

CHAIR - It might be a nice touch for people if they're outside. It can get very cold in the winter. Thank you. Any other questions on the design?

Ms RATTRAY - The Committee has received a submission in regard to the lack of a spa or large bathtub for clients to be able to use. Can you provide the explanation to the Committee on why that has been decided to be left off and why you've chosen to have the design that was put before the meeting? It's a very compelling submission that has been provided that's just been handed out by our Secretary and this is from someone who's worked in this space. The questions were asked this morning, and the response has been received, and I'd like it on the public record. Thank you.

Mr MACE - Yes, the topic of an assisted bath or spa has been discussed at the project reference group meetings that we hold every second month. The issue at hand is a space constraint that we're dealing with.

Ms RATTRAY - Was it in the original plan?

Mr MACE - It was discussed at the concept design stage.

Ms RATTRAY - So it was never in any original plan?

Mr MACE - Not beyond our original concept plan taken past our gate one, which is essentially our scoping report. Essentially, it's a priority - what gets priority and what needs to be included in the hospice to make it operate. We are not dismissing a bathing function. We are continuing to explore options of a mobile bath system and we're workshopping that with our project reference group together with the clinicians and the design team. The option for the inclusion of a bath was discussed with the number of beds. As we've mentioned, our federal funding agreement requires a minimum of 10. We did look at the option of decreasing our bed numbers down to 11 with the inclusion of an assisted bath, but the project reference group agreed unanimously that that was not a favoured outcome. We want to guarantee that capacity of 12 beds is being provided.

We've also looked at other areas of the facility that we could include the bathroom, but in terms of priority we are at a bare minimum with the space allocated to staff and we do want to have those quiet break-out areas that support the use by families for quiet conversations that need that space away from the patient themselves.

Ms RATTRAY - So effectively the reference group and those people who have been part of putting this together decided that a priority of a break-out room and other uses like the allied health area for hot desking, I think was the word that was used, had a priority over a bath facility. Is that effectively what what took place?

Mr MACE - In terms of the staffing area, we've looked at the staff model and the service model required to support operations in the hospice. That set up our minimum floor area, and now the inpatient zone, beyond that staff area, is the area we've got to play with in terms of incorporating the patient rooms and facilities that support the guests.

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Ms RATTRAY - I'm not an architect or a builder - we do have a builder, in a former life, on the Committee - but I've had a look around and even a mobile bath, I'm not sure where you would put it when it was not being used. Is it effectively not an option? Because I just don't know where you fit it. There's an equipment room, but it doesn't look very wide to facilitate putting a mobile bath unit in there. You said you're exploring it, but where would you even put one if you had one available - or am I not reading this lovely drawing as well as I should be?

Mr MACE - The storage of the mobile equipment would need to be considered further, absolutely.

Ms LIEUTIER - The bath is something we genuinely grappled with, and the reference group also took it quite seriously. We've got to look after the staff as well because we need the staff to be able to look after the patients appropriately, all the hospice residents. The only option we were left with was reducing the number of rooms and that really was less palatable to everybody, including the Friends of the Northern Hospice.

Ms RATTRAY - Especially with the projected increase in call on that. So what about the chill-out room? Is that for families?

Ms BARRETT - For family members and friends, as much as -

Ms RATTRAY - So on one end you've got a chill-out room and at the other end you've got a day room. Is there any chance that you could - because they're both close to plumbing, I can see that - is there any chance that you could reorganise one of those two rooms to facilitate a bathing area? I don't need an answer right now, because you can always come back to the Committee, and because you might need to put a lens over that and come back with a couple of options. I've only looked at this over the last week, whereas you've probably lived and breathed it, but sometimes fresh eyes - a chill-out and a day room, I expect that they are something fairly similar, and they're at either end of the back of the building.

Mr LEE - I think there's a potential to refine those spaces should they need to become one, but I think at this stage the agreement is moving forward without a dedicated bathroom. However, I think as you pointed out, the chill-out room, with true consultation and workshopping, could be repurposed as a storage room for a bath. There is definitely potential there.

Ms BARRETT - I did have discussions with an infectious diseases consultant around the spa, because one of the biggest issues with spas is infection control. Their recommendation was, from an infection-control point-of-view, not a spa, but a bath would be preferable. That's just a consideration.

Also, in relation to allied health staff - allied health staff are really important in palliative care. We wouldn't be expecting the LGH allied health staff just to drop over. You need specifically trained palliative care allied health staff, and that's the advantage of this hospice - it's purpose-built specialist palliative care in a contemporary facility. We're not just talking about occupational therapy; physiotherapy; we've got diversional therapy, potentially massage therapy as well. We've got a whole range of components which are really important. If someone wants to have a last trip to the beach, or go home and visit their family one more time, or be at home one more time, the involvement of OT and those sorts of processes is really

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important. You know, we have a lot of patients with respiratory distress. Again, the involvement in physiotherapy is really important in those aspects. The model of care and the staffing FTE at this stage include those staff on site every day, not for full days but for some hours every day. We also haven't incorporated any space for students, really, or staff on placement being upskilled in palliative care. So, I think the loss of the allied health space would, you know, compromise other aspects of the service that we need to be mindful of.

Ms RATTRAY - Thank you. I understand that that's on the wrong side of the building, to be able to make any adjustment there. That's why I was looking at the back end of the building, where I found the day room and a chill-out room. That was really where I landed over lunch.

Ms LIEUTIER - I think it's really - with all due respect - it's easy to look at a plan and we can all say, 'oh, it would be really good to put a bath here,' but we've had extensive consultation on the plan. The reference group has been through a number of workshops on the plan and this was the priority that everybody came up with. There's been no force saying we have to have a day room or a calm room or a chill-out zone. This is the priority that the reference group, which had our specialists and our community members and the Friends of the Northern Hospice, has prioritised everything on here over the bath.

Ms RATTRAY - I completely understand that. But, it's also the Committee's role to take on board submissions and suggestions that come from our community, because at the end of the day, we all would benefit from something like this. I'm really grateful to have people who have invested their time to make contact, and just give us an understanding of what they see as an important aspect as well. Thank you. I do appreciate where you come from.

Ms LIEUTIER - Absolutely. I think one of the discussions we had is our preference would be to have a bath. We'd all love a bath there. It's just been very difficult to accommodate it without losing space that's actually very important.

CHAIR - In our consultation into this project, it came through very clearly, especially from Friends of the Northern Hospice group - who have been amazing in their consultation and absolute passion over many years to have this put in place and I know how excited that group is - and many people in our community. The subject of the spa was seen as really important from that group, and these are people who have worked in end-of-life care and who are professionals in that area. The information that I've been provided by a number of people is a spa in an end-of-life care setting provides much comfort to that person. A number of the people who are in end-of-life care areas may not have grown up with a shower and find a spa or a bath very comforting. It's a really important part of end-of-life care practices from the information that I've received.

That is why we would really appreciate this project having a look to see whether there is a capacity to have a spa. The infection control is really not a key issue for a person who's in the end-of-life part of this care. If infection control was so important, we wouldn't have spas and baths in most of the maternity hospitals across the country as well. They can be disinfected, they can be cleaned. I think it's really prudent for us, as a committee, when we have had that consultation and we know that a number of professionals have supported that wish to have that spa - if we're spending \$20 million on an amazing facility in a beautiful building, lugging around a portable spa bath, trying to fit it through corridors and getting it through different bedroom doors and which rooms will fit it and which rooms won't. It'd be messy, it would be

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probably quite heavy and uncomfortable as well, and it would probably be quite expensive to have to try to reorganise entrances to bedrooms or bathrooms to be able to fit in a portable spa bath. So, to me that just does not seem to make much sense.

Ms RATTRAY - You have convinced me, Chair.

CHAIR - As a committee we can't certainly instruct, but we can make recommendations and that has come through very clearly from many people who we have spoken to about the spa. Are there any more questions?

Ms BURNET - I have a few questions if I may, Chair. In relation to the storage space, it kind of brings up the big issue of having enough storage space with or without a bath: it seemed that there will be enough storage space - I guess you can never have enough - but what's a good use of space in relation to what we have on the plans? That's a clinical question really.

Ms BARRETT - I think, as you know, storage space is always at a premium. It is very tight in this facility. I don't think it has as much storage space as we would like. We have discussed options such as storing equipment nearby or off site and then having it transported to the facility as needed. We certainly are very mindful that the facility is not over-cluttered with equipment, and you have equipment in hallways or in unused rooms. That is an important consideration and something that we have to keep looking at options.

Ms BURNET - It would probably be an infection-control issue, which is clearly an issue with all facilities, no matter what sort of stage people are in, in their journey. Again, looking at the options of a bath either fitted or mobile, are there any particular work health and safety issues that would be associated with either of those options?

Ms BARRETT - Certainly with moving the bath, that was why we did include in the model of care that component of medical orderly so that there was some support for moving of equipment. I think even if it's a bath in a set facility, you know the cleaning of that, we haven't considered that or factored that in. That would be a process that we would have to consider. The manual handling, obviously, wherever the bath was located - in the rooms there'll be hoist systems, but in the bathroom that would need to be an added component. Getting palliative patients in and out of the bath needs considerable care. There would be manual handling issues associated with that, but there would be appropriate aids that could be used.

Ms BURNET - And presumably things that are automated on automated trolleys as much as possible as well to help with the movement, pushing things along.

Ms BARRETT - The beds that we were looking at were, yes.

Ms BURNET - In relation to bariatric beds, how many are you catering for?

Ms BARRETT - Two.

Ms BURNET - How does that, in the scheme of things - it's like how many all-access car parks do you have in a place - are two going to be enough?

Ms BARRETT - To be perfectly honest, I don't know. It's two more than we have currently. We believe that's reasonably appropriate. We haven't had a high number of clients

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of size that we've needed to care for in Millwood. I'm not sure how many remain at the LGH because they can't be transferred to Millwood or cared for there, but we felt it was a reasonable starting position.

Ms BURNET - There are hoists in every room. What are they rated to?

Mr MACE - Bariatric hoist system would be rated to a bariatric patient.

Ms BURNET - And the other hoists?

Mr MACE - Other hoists, I wouldn't know the figures off the top of my head, but for a standard patient.

Ms RATTRAY - I think they are 120 kilograms.

Mr LEE - I'll say a minimum of 100 kilograms.

Ms BURNET - And the other question I have and whether the reference group looked at this - with a diverse community, what sort of thoughts have gone into other culturally or a design that's looking at diversity of clients or patients?

Ms LIEUTIER - It doesn't have a prayer room, does it?

Mr MACE - No, it doesn't.

Ms LIEUTIER - The closest - we have prayer rooms over in the LGH, but not in the hospice. Again, that would probably be where we would utilise, if we needed to, one of the chill-out zones. If we had a religious - a situation that we had to provide a prayer space or something, that's where we need that flexibility of rooms so that we can convert for six weeks or however long we need.

Ms BURNET - Does the reference group look at those things as well? I would have thought that was something that was part and parcel of the Department of Health approach, to have a look at a range of culturally diverse or other needs.

Ms LIEUTIER - It should be. I just can't recall us having that conversation at all. Daniel, do you recall?

Mr MACE - Part of KP Health's commission for their model of care and service plan report, it does speak to having flexibility for multiple faiths, and not being specific to a certain demographic. That was workshopped with the reference group for discussion.

Ms BURNET - Thank you.

CHAIR - Just on that, will patients be allowed to bring their animals with them into the facility as well? How will that work?

Ms BARRETT - Certainly we encourage animals. We haven't discussed whether animals would stay overnight or be there on a more permanent basis, but certainly in terms of visiting and being there regularly - yes, that's something that we promote now. Also, our

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volunteers have a therapy dog that they take into the current Melwood facility, so we'd be looking to continue that activity as well.

CHAIR - Lovely. Does anyone else have any more questions before we move on to project cost? I might hand over to Mr Harriss.

Ms RATTRAY - - The member with the calculator.

CHAIR - He's better with the numbers than me.

Mr HARRISS - The phone never lets me down.

Just on the overall project cost estimates: it's got a note here that WT Partnership was engaged as quantity surveyors, and that it was based on the tender design suite of documents. Where are we at, I suppose, with that, as in cost-wise, and has anything changed in that base project cost that would change that?

Mr MACE - The tender period has finished and we have received tenders for that procurement phase. I can't speak to the costs that we received, but they landed favourably against our budget, and these figures are accurate.

Ms RATTRAY - Can you recount how many tenders have been put forward?

Mr MACE - We've received three submissions.

Ms RATTRAY - That's a good sign. You've competition.

Mr HARRISS - And where's it at with the council at the moment? Is it still in development, or have we got to building?

Mr MACE - We have a planning permit. We have submitted a minor amendment due to some minor changes to the facade that occurred through detailed design. That's currently being assessed by the City of Launceston, and following that approval, we'll submit for our building permit.

Ms BURNET - Does that have heritage considerations on the facade?

Mr MACE - Correct. There was a planning report prepared as part of the development application package. That was assessed by the City of Launceston and was deemed to be acceptable.

Mr HARRISS - In this layout, there are some contingencies broken down: ICT contingencies, FFE contingencies, and then a general contingency at the bottom. Are they sufficient?

Mr MACE - They've been recommended by our quantity surveyor to be in place. Our understanding at the moment is that they are sufficient.

CHAIR - Just under the general project contingency - because there's a contingency for design and construction of about 15 per cent, and then there's a 15 per cent contingency on the

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ICT, and then you also have furniture fittings and equipment contingency, again at 15 per cent. Then, you have a general project contingency, of again, another 15 per cent. I'm just trying to figure out what that is contingent against - when you've already got contingencies on the design and construction, on the IT, on the furniture fittings and equipment? I just wanted to see if you could talk me around what that general project contingency is for? Because there seems to be a lot of contingency costs within this remit. It's unusual for us to see this amount of contingency in a remit.

Mr MACE - Appreciate the question there. Essentially, we have allocated the contingency out specific to -

CHAIR - I'm sorry, can you speak up a little bit more? I'm sorry.

Mr MACE - Yes. We've broken down the contingency against components, just proportionately to those areas. The general project contingency is more of an unknown risk, I suppose you'd say. It covers things like project scope creep, elements of the design that are still being worked through, that may have an impact on our project cost. So, looking to just report that, under that one element there.

CHAIR - You've already got a contingency on the design, though. So, it just seems like a duplication in your costs on the contingency, that's all.

Ms DOBSON - We're seeing a number of projects that have been allocated a market escalation cost by our cost planners across the board. To provide the assurance, I guess, that we can deliver projects within budget and sustain any increase in the cost of steel or transport or anything like that, when we're delivering projects, it is part of the project framework that we operate under, we need to seek permission from the sponsor to access contingency funds. We can have a contract for all of these things, but the contingency component requires the sponsor's approval. That means that the Chief Executive of Hospitals North - it's at her discretion to approve access to those. I think, in this case, the intent is to allocate as much of the Australian Government funds to the delivery of this project, in the best way possible.

CHAIR - Okay. Could you also talk us through the art in public buildings? We talked about this this morning. It's important that we have this on the record. I might hand over to Ms Rattray because she had some further analysis on this.

Ms RATTRAY - You ask your question.

CHAIR - I was just seeing if you could talk us through the \$80,000 for art in public buildings funding, and what that might look like? I think Ms Rattray has some comments insofar as how that could be well utilised.

Ms RATTRAY - No, it'll be a question. I know we don't do comments; we do questions.

CHAIR - Yes. Suggestions.

Ms RATTRAY - Noting that it is not a requirement of the Federal Government to have that much allocated, give me your best answer.

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Mr MACE - Thank you. We have allocated the standard allowance that would be seen in a state-funded project. As you've noted, it's not required under this project due to the federal funding arrangement. The incorporation of artwork has been considered quite important by the project reference group, so we've left that allowance in place. How that is delivered with the project is still to be workshopped and sought input through the reference group.

We are looking at more of an incorporated piece at this stage, rather than a single element such as a statue or artwork piece that is placed in the facility.

Ms RATTRAY - What I call function. Agreed?

Mr MACE - We're looking at functional and incorporated within the design that is sympathetic to the hospice.

Ms RATTRAY - And will there be that broad consultation through that reference group, and particularly working with the Friends of the Northern Hospice group who have been integral to this project coming before us, that they would have significant input into what might sit in amongst that \$80,000? Given that it's a new build, there won't be any furniture that'll be able to be repurposed. It'll all be a new requirement, won't it? I know that there's effectively about \$1 million allocated for furniture, fittings and equipment, but I expect that that won't go that far when you're fitting out a significant building. That might help outside in the garden, for some functionality?

CHAIR - A fountain perhaps, or something therapeutic?

Ms RATTRAY - Somebody has to clean out those things. You've got to be careful where you go there.

CHAIR - True.

Ms RATTRAY - Anyway, I'm sure that you'll get some great initiatives put forward. It's really important that you have those people who have been on this journey really invested in it, to be part of how you spend that \$80,000.

Ms LIEUTIER - There's absolutely no intent to not continue the consultation and the reference group moving forward, right through to the implementation, so they would be part of that consultation absolutely.

Ms RATTRAY - There might be some who would argue that there could be a pretty good bathing room for that.

CHAIR - Okay. Do we have any more questions on the project cost?

Ms RATTRAY - I'm happy to ask about the timeframes.

CHAIR - Please do.

Ms RATTRAY - Given that they have blown out of the water - something to do with an election that came up that people weren't expecting. Can we have a revised timetable? You said

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that the tenders are closed, and then you have some relocation before you can even start on any works, pending approval from this Committee, so can we have a revised timetable?

Mr MACE - Yes, happy to take that on notice.

CHAIR - That would be great.

Ms RATTRAY - Taken on notice, is it?

CHAIR - If you can provide that to the Committee, that would be fantastic.

Okay, we might move on to page 21. A lot of the pages that we've just skipped, we've already asked those questions - they relate. Have I missed any questions, committee?

We will move on to the Australasian Health Facility Guidelines compliance, which is on page 21 of 31. There was a line within the first paragraph and that was: the Health Planning Unit, the AUSHFG, is not available for palliative care or hospice services, and that presents a risk that the design of the hospice will not represent contemporary best practice. Can you talk us through that risk to the project and how other institutions or other care facilities, such as the ones that Hanz spoke about visiting in Victoria, how they have got around this issue?

Mr MACE - I'm happy to start that one and then maybe hand it on.

CHAIR - Thank you, it's a big question, but it does look like it's a calculated risk, obviously, but if you can talk us through that for the rest, because it is a \$20 million investment.

Mr MACE - Absolutely. The Department of Health standard practice is relying on strict adherence to the Australasian Health Facility Guidelines. Wherever possible, it is always accepted and, I suppose, adopted in each project. There is no Health Planning Unit in AUSHFG for a hospice facility. There are components that we can rely on, in terms of details such as a medication room or a -

Mr LEE - A utility - I think the support facility can rely on a nonspecific health planning unit. We believe they are transferable in terms of their functionality. In consultation with other team members, we found it is sufficient to support the functionality of the hospice. One of the key aspects missing from the guideline is to inform the size of the room and the ones we design. That's part of the reason why our team took the study tour of three different hospice facilities to gain references. It's sort of a mixed model that we observe and some rooms are oversized and feedback when they were too big, some of them are too small. I guess we then took that information in consultation with the group, struck a balance and fit within the existing building. I think collectively you will find that what's designed on paper will be sufficient and will support the functionality of the hospice facility.

CHAIR - Okay. So, there's not a risk that this beautiful building is fitted out, we open up the new hospice and we find that it's not compliant and there has to be more work done on it later on down the track? That's not a risk?

Mr LEE - In terms of compliance, the design itself will meet the National Construction Code and other relevant statutory requirements - Heritage. The Health Facility Guideline served as a guideline, and it allowed for project specific alterations to it, and of course, through

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consultation with the clinicians. At this stage, I'm confident to say that we have received support from the clinician group.

CHAIR - Thank you. Does anyone else have a question on page 21? Page 22?

I was going to ask you some questions around the energy efficiency, for the record. If you can just give us a very quick talk through about energy efficient windows, the upgrade of the insulation, and the lighting and heating.

Mr LEE - At the beginning of the project, we had a Service Engineer in our team who undertook a full audit of the Allambi building, to assess it against the use of the hospice facility. I think what is listed in the document are three major dot points of improvements. Such as: upgrade insulation, provide thermal comfort, and energy efficient windows. Not only providing thermal comfort, but also improve acoustic quality and implement energy efficient lighting throughout and provide ambient and mood lighting where suitable, as part of the vendors providing the report.

CHAIR - How far can those windows be opened? So, you've got your sliding windows on your verandahs, the windows which would open out, I suppose.

Mr LEE - The window opens out to the verandah. They are a swing opening, because we are restricted by the heritage fabric. But we have enlarged it where necessary, to make sure the bed could be wheeled out to the balcony.

CHAIR - And your other windows - your normal windows - how far can they be opened?

Mr LEE - I think they are awning windows, so they have a restrictor on it to provide fresh air into a room. But they're not really fully openable windows.

Ms BURNET - In regard to the energy efficiency, I see that you're choosing to go up to the building code compliant glass, is it not a better investment to increase that insulation, in relation to the glass? I mean, there's a lot of natural light coming through into the building, which is fabulous and would be good for healing. But, has the project considered looking at a higher rating for insulation, for the glass in particular?

Mr LEE - We had investigated it, but one of the heritage restrictions applied to the project is to retain the existing window frame and that creates challenges to replace them with a contemporary window system. We also had a look at upgrading the under-floor insulation, et cetera, due to excess budget constraint. So, we have done our due diligence to maximise where it's possible for the project.

Ms BURNET - Fresh air coming through - like the ventilation - is important for health generally. Is that a standard consideration for workers and -

Ms LIEUTIER - It is. Heating and ventilation has been a challenge for -

Ms BURNET - The LGH.

Ms LIEUTIER - For the LGH, yes. It is an ongoing challenge and if you can get fresh air into the rooms that would be a priority. Again, you don't want the windows to be opening

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too far and you don't want the fresh air coming in upsetting the rest of the heating throughout the facility.

Ms BURNET - Is that a question around the filtration of air as well, is that built into to this build? By making sure that the the air is filtered?

Ms LIEUTIER - The heating and ventilation - sorry, I've come from a background of looking after hotels during COVID, which I never thought I would. So, I would have assumed that would be in the standard heating and ventilation, but it wouldn't be filtered obviously, through the fresh air.

Ms BURNET - Thank you.

Ms RATTRAY - Just a question in relation to the beds being able to access the balcony. When I have a look at the map, there's a different doorway, with obviously for some of them, a triangle, and then others are the standard arc doorway. So, does that mean that not every room will be able to have their bed outside? Or, do you mean just have it sitting in front of the doorway, not actually out on the balcony? I think you referred to it as a verandah.

Mr LEE - I could answer that question, I think. We have a more developed plan than what was presented as part of this report.

Ms RATTRAY - So, this is not actually the plan? So the bath might be in the new plan?

Mr LEE - I can confirm that all the doorways have access to the balcony and will allow bed movement to the balcony.

Ms RATTRAY - So, I am right, there isn't access to all the balconies in the one that's been presented?

Ms DOBSON - I think that's just the presentation.

Mr LEE - I think it's presentations of the drafting presentation.

Ms DOBSON - The architect's drawings do reflect it.

Ms RATTRAY - Are there any other differences that I'm not aware of?

Mr LEE - There are more details around it, but I think that the integrity and the functionality of the design still remains. There are more advanced detailed drawings that went out for tender.

Ms RATTRAY - Can the Committee be provided with an updated copy of the plan then, this floor plan? Is that possible?

Mr LEE - That's possible.

Ms RATTRAY - Because, I need to understand, Chair, what I might have been asked to approve.

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CHAIR - Just for future reference, we need to have the most up-to-date architectural information, or any planning information in this submission so we can make an informed decision. So, if that can be forwarded to the Committee before we enter into our deliberations, we'd be appreciative.

Mr HARRISS - On the noise, at 8.2 it's got the requirement to mitigate noise. Disruption to neighbouring services and nearby residents has been documented with the tender documents. Is that over and above what would be standard and required by council? Or is that just a standard piece?

Mr MACE - There's probably a couple of considerations for noise during construction. Number one, absolutely compliance with council requirements for neighbouring residents and businesses, but we do also have services continuing in neighbouring buildings within the same title, so John L Grove and Lindsay Miller. So, wherever possible, we will look to minimise that disruption to those services.

Ms RATTRAY - I noticed - and we touched on this as well this morning when we had our earlier briefing - that the concrete block work has a render finish on it, and obviously the front of the Allambi Building has got it, and other places in the courtyard. I suppose, that render is an old-type render. It's quite a rough render. You indicated that the Heritage Council requested that there be render on the new building as well. If we're keeping the outside of the facade, where's the render going to be?

Mr LEE - I can answer that. There's no new render proposed to the development. The key of the render's finish, solely where required, patch and repair and maintain the integrity of the original characteristic of the Allambi Building.

Ms RATTRAY - There won't be any attempt to try to match the previous 1921 render?

Mr LEE - No.

Ms RATTRAY - Thank you. But, what has been requested, from the Heritage Council is that it just be repaired and possibly repainted?

Mr LEE - Correct.

Ms RATTRAY - Thank you.

CHAIR - My final question is on page 27, 8.3, the heading is Heritage and in brackets, Aboriginal and Historic. I'm not sure who's best to answer this question. There isn't any reference to Aboriginal heritage within those paragraphs. I was wondering whether that's an oversight, or why Aboriginal and Historic was put in there when there's no reference to Aboriginal. So, are there any Aboriginal heritage issues within the site that haven't made the project submission?

Mr MACE - I'd have to refer to the Praxis Environment Report referenced in this paragraph, but to my understanding is there's no Aboriginal heritage to include within that statement.

PUBLIC

CHAIR - Okay. Can we seek clarification for that, if you can get that information to us? It's just because in the heading it looks like there should be something there.

Ms BURNET - Given the history of Allambi, is there going to be any sort of reference to that history of use over the years - interpretation - has that been considered?

Ms LIEUTIER - We actually have considered in terms of the naming, and I think it was the Friends of the Northern Hospice that suggested we actually keep the name of Allambi. So, that's going to continue part of that heritage. I think with that \$80,000 it will be for the arts. Maybe that's an interpretive history, but again, we'll take that back to consultation. I think that's a very good suggestion and one that we will definitely take on board.

CHAIR - Thank you. Any further questions? We might ask you to come back to the Committee. We have another submission now to go through. Thank you.

The Committee suspended from 3.12 p.m. to 3.14 p.m.

CHAIR - The next witness is Peter Miller. Mr Miller, could you please introduce yourself and then make the statutory declaration?

Mr MILLER - Yes, my name is Peter Miller, I'm a retired schoolteacher, sewing machine mechanic, whatever.

Ms RATTRAY - Supporter of the athletics community.

Mr MILLER - Supporter of the athletics community, correct. Tania knows.

Mr PETER MILLER WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED

CHAIR - Thank you, for appearing before the Committee today. The Committee is pleased to hear your evidence today. Just before you begin giving your evidence, I would like to inform you of some important aspects of the committee proceedings. 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 and without the fear of being sued or questioned in any court or place 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. Do you understand?

Mr MILLER - Yes, fair enough.

CHAIR - Wonderful. Mr Miller, would you like to make an opening statement? Thank you.

PUBLIC

Mr MILLER - Yes. I'm not opposed to a hospice in Launceston, but what I'm strongly opposed to is the planned relocation of the 12 health services out of the Allambi Building down to Cimitiere Street, which is a commercial area, not a health precinct, with hordes of compromises, which I can go into it.

CHAIR - Please do.

Mr MILLER - Thank you. Just a little bit background, I've been fighting this since June. The Health Department - despite my phone calls to them and my letter to them - haven't got back to me. I did write to the Premier, and he passed it on to the Health Minister, who did send me a lot of information last Sunday, which I appreciated. That's basically the first correspondence I've had on this subject.

CHAIR - Can I ask you to explain, in particular, what your main concern is with the site?

Mr MILLER - Yes, certainly. Basically, I think it's a waste of funds. The Allambi was refurbished three or four years ago, for its purpose now, with the current people who are in it. The cost of establishing them down there in Cimitiere Street is not going to be a cheap thing. The modifications and the fit out on the fourth floor, the cost of rent in the area, the cost of rent for car parking -

CHAIR - Is this for Cimitiere? Sorry to interrupt, keep going. I just want to clarify that you're talking about Cimitiere?

Mr MILLER - Yes, Cimitiere Street.

CHAIR - Okay.

Mr MILLER - I believe the building is not suited for purpose. There's access limitations. There's two lifts in there. One will take an ambulance gurney. I've been to the ambulance service and they've been down there and checked, but it is a tight fit. Hospital beds will not wheel into that lift, they're too wide, the entranceway is too narrow. So, it's very much a compromised building in that aspect, for its purpose.

There's no provision for staff parking. The Minister for Health suggested that they park down at Seaport, or the new one that's been built at the Gasworks. She did state there will be two or three sites there for clients, visitors, and one disabled site. All those sites that are there out of the end of the building, they're all rented out, and it's when they become available. So, that to me, is a compromise too far.

The cars that they need for their home visits cannot park on site. There is a negotiation going on with the Launceston City Council to park them down at the CH Smith Building. That's pretty well occupied at the moment, with council staff parked there. The clients will basically have to rely on - most of the time - getting street parking, paying for it out there. It's limited parking. Parking is almost near impossible to get there. It's on a very, very busy street: Cimitiere Street is a major through road for heavy transport. Most of the clientele are in the 70 to 90 age group. They can't walk blocks and a lot of them are on wheelie frames. So, to me it's another limitation.

PUBLIC

Ms BURNET - Can I just ask you, if you wouldn't mind, to describe who the clients are, which services people go to Allambi for?

Mr MILLER - Yes, there is community nursing in there - I've got a list of them here somewhere.

CHAIR - If you could read that list into the Hansard, that would be really helpful, if that's okay.

Mr MILLER - Yes, certainly. Just give me a moment, I'll find it.

CHAIR - Take your time.

Ms RATTRAY - You've got as much paperwork as what we've got.

Mr MILLER - I've been working on this for ages.

The people that are currently up at Allambi and working out of that site are: Hospital@home, Community Health Nursing Clinic, Community Dementia Service, Continence Service, Health Promotion, Home Care Services, Palliative Care Services, Community Rapid Response, Wound Care Services, Youth Health Services, Primary Health Management and Support Services, and Occupational Therapy.

CHAIR - It's a lot of people.

Mr MILLER - A lot of people, and they are listed on a board up there at Allambi - you may have noticed today when you were there. There's approximately 100 people working in those services.

CHAIR - Mr Miller, the points that you've raised are very valid -

Mr MILLER - I've got a few more, if I may?

CHAIR - but, I will just state that it is important to recognise that our remit as the Public Works Committee is on the Allambi Building project, not the Cimitiere - the moving from Allambi to Cimitiere - that's not part of our remit, under this.

But, I'm really curious to hear what you have to say about this, because even though it's not part of our remit, I am curious to understand how the people will move from Allambi to Cimitiere. It's my understanding that the move-out date is 29 December, and there is some reluctance by the people who are currently working in Allambi to move. So, you do raise a very valid point, but it is not technically within our remit.

Mr MILLER - Okay. The points that I will refer to is taken from the Masterplan, that the Health Department have put out. On page three, that -

All developments achieve maximum public value in terms of economic, social and environmental outcomes.

PUBLIC

Well, having it as a hospice, I think you're going to be very limited. Obviously, it's compromised, and what I was picking up in the conversation today is there's no room for expansion, there's no room internally or externally to expand.

The refurbishment cost - and I say refurbishment, because I don't see that as a construction job, you may argue that - but the \$20 million that was allocated from the Federal Government was for construction. I can't see how refurbishing is going to use \$20 million anyhow, but I could be wrong.

I don't know how much payment of that has already been received by the Government, but it was over a four year period, from the 2022-23 financial year. It's expected to be completed by 26 June next year.

CHAIR - We have asked earlier in this hearing for an updated timeline to be provided to us.

Mr MILLER - I've got a copy of the contract here, that the Premier's signed, that was all. I'm basing my information on and the money that was allocated and the completion date on there.

This plan aims to optimise existing land and buildings to deliver safe and high-quality healthcare now and into the future. I wonder in the future, whether the hospice is good for 10 years, 20 years, it's soon going to outgrow its life on that site. So, it's a shame to upset everyone and move everyone down to Cimitiere Street on that basis. I look upon Cimitiere Street as not lasting - that's a band-aid placement, as far as I'm concerned. I think it's going to be eventually a waste of money, waste of time - and rent won't be cheap down there. That's a commercial building. Pitt&Sherry is still in place up there on the fourth floor. I went up there yesterday for a look, to check the lifts out and everything.

The move down there doesn't fit in with the Masterplan of the Health Department. It does not match up on some of the points they put in there on safe environment, better staff and patient amenities, improved way in findings, greater connection to green space, and integrated parking. There is no integrated parking down there at Cimitiere Street.

I just wonder whether the impact of that move down to there has been assessed at all.

CHAIR - We can ask those questions for you.

Mr MILLER - I don't know, I wonder. To me, the solution - and I've been looking at it long and hard, and looking at Health Department sites and availability around the place - is that cleared site on 36 to 40 Howick Street that they're going to use as a temporary car park.

Now, we haven't had a hospice since 2007 in this town. What's another 12 months until they build a three storey - or whatever it is - car park and that site becomes available and can build a purpose built, beautiful building that's going to serve its purpose, and something that everyone would be proud of? I just look upon it as a total lost opportunity.

CHAIR - That's for a whole new building to be built on that Howick land, is that what you think would be -

PUBLIC

Mr MILLER - Yes, that's what I think. Because Allambi is an old building, it's over 100 years old. A lot of cracks in it, okay, that could be fixed, but to me, it's not the solution, at all.

Surely, this move of 12 community services to downtown Cimitiere Street is not a considered move, not applied common sense. Everyone I've spoken to has agreed with me and told me it's a crazy move. The staff at the workplace at Allambi, like the nurses - they're the only people that I've spoken to - and one nurse casually said to me one day, 'How are you going to get on when we've moved down to Cimitiere Street?' I said 'What? Where on Cimitiere Street?' Then, every other nurse I spoke to after that - I've seen probably about 15 of them during my wife's journey up there - are all adamant that they don't want to go there. I know of three who said they were going to resign before they go.

CHAIR - It's a pity.

Mr MILLER - It is a pity. It is an absolute shame. I can't see the point of the move and it's going to end up being a total waste of money, as far as the move of the 12 services out of there.

That's about all I've got to say. I would like to finish by saying thank you, Scott and the committee, for allowing me to have my little issue. I've been in *The Examiner*, I've been on three news's, I've written lots of letters and so far, I'm getting nowhere.

CHAIR - Well, thank you, for coming today. I really appreciate the evidence that you've provided our Committee today. I will just see if there's any questions from any of the other Committee members.

Ms BURNET - Thank you, for that. I know it's the consequences of this proposed site for the hospice, and I hear those concerns and know very well what inconveniences that can cause.

Mr MILLER - If I can make a suggestion - I've just thought of this - maybe the Committee might like to go down and check out Cimitiere Street House.

Ms BURNET - Thank you.

CHAIR - Before you leave the table, I'd like to reiterate the statement I made earlier about committee proceedings.

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 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?

Mr MILLER - I understand, I've given up on the media.

CHAIR - Well, thank you very much, Mr Miller, for coming in today. Appreciate it.

Mr MILLER - Thank you.

The witness withdrew.

PUBLIC

CHAIR - We've just heard from Mr Miller in relation to the moving of the services provided currently in the Allambi site to Cimitiere Street. I did explain to Mr Miller that we have very strict areas in which our remit extends to, that the works at Cimitiere Street are not part of the remit, and at the moment we're looking at Allambi.

What I would like to ask is, what is that funding looking like to be able to redo Cimitiere Street to be able to accommodate the current staff and the areas which are being serviced at that current site? Could you give me a broad overview of that, for our own information?

Mr HUGHSON - I'd probably have to take it as a question on notice, because it's the Infrastructure Services accommodation team that's been dealing with the fitout costs and the lease of that new facility. But, we can certainly provide that.

CHAIR - Another question Mr Miller asked was, has the impact of Cimitiere Street been assessed by the Department? Would you be able to talk us through that?

Ms LIEUTIER - Cimitiere Street is not the ideal location, but what we have done is a thorough assessment, the project team and Infrastructure Services have been working over a long period of time. The Cimitiere House is already leased by the Department of Health. We already have services in there, including clinical space on the ground floor. So, it is not a new facility in terms of introducing a clinical area to a greenfield-type site.

Mr Miller is correct, the lifts have been examined by Ambulance Tasmania. We would never be taking hospital beds into a facility such as that and we wouldn't have a need to. But, Ambulance are very comfortable that the lifts are of a sufficient size to accommodate any patients who they may need to bring through that facility. We've had mobility scooters trialled within the lift area, and it has met all accessibility requirements.

In terms of the administrative - there's two floors that are being considered - all administrative spaces over both floors will comply with the Treasurer's guidelines on accommodation within government buildings, including the desk space. And, there are clinical spaces being designed and dedicated for those clinical areas and services that need to be undertaken. So yes, there has been fairly thorough assessments of the plans.

There is additional parking within the building for staff. There are plans for night shift, staff will utilise the car parking under the building and car parking at CH Smith. The Department of Health and a number of other government agencies already lease significant car parking space down at CH Smith. Some of the car parking space is currently utilised by the Department of Health. My understanding is that it will be repurposed for the services out of Cimitiere House.

CHAIR - Mr Miller referred to a number of staff who are currently at the Allambi Building being very unhappy about the move and potentially resigning. Is that pretty realistic about the current state of affairs? Just noting that we have heard that there has been a really big delay in moving the staff from the Allambi Building to Cimitiere. Do you think there will be some resignations?

Ms LIEUTIER - I'd probably ask Annette, but my understanding is there are a couple of staff who are very unhappy about the move, who live very close by, within walking distance

PUBLIC

of Allambi. Indications have been that they may choose to resign. All staff at Allambi, if they don't want to work at Cimitiere House, we could probably find them employment within the LGH. So, it wouldn't be necessary for them to resign if they choose not to move.

CHAIR - Okay.

Ms LIEUTIER - I might refer to Annette.

Ms RATTRAY - What if they all want to resign? Where do you house them all?

Ms LIEUTIER - Well, there's actually quite a proportion of staff who are very happy to move to a new facility. So, I don't think that's a risk.

Ms BARRETT - We have had three staff who have resigned already, who cite the relocation as contributing to that decision. The majority of those staff were at, or nearing, retirement age, and there are a number of other staff who said they will not move.

CHAIR - Will Cimitiere Street be fit for purpose? Has that been one of the main reasons why staff are saying that they're resigning? Is it compatible, will it be able to service the functions that they've been able to provide in the Allambi Building?

Ms BARRETT - The main feedback that I'm hearing, the two critical aspects are around staff safety and security. The proximity to a number of hotels and the fact that some staff there work seven days a week, you know, until 10.00 p.m./10.30 in the evening, so, feeling unsafe. They're not all nine to five services; that's a key factor. The car parking and the need to have to pay for car parking, when they've never had to do that before, that's a financial impost for a lot of staff which they believe would be prohibitive for them.

Ms BURNET - Just in relation to the fit for purpose arrangements, and I suppose there are two questions, just following on from the Chair. The current building, so is Allambi fit for purpose, but also having lived through a move by the Health Department into a building where older people were coming to services, the tiles were very slippery. The lifts were quite confusing. I'm not quite sure how many outpatients you're likely to see in the Cimitiere building, but I'm curious to know, to follow up on on that, knowing full well that this is out of our remit, but those considerations as well as obviously staff safety would be of concern to me. So how are they addressed?

Ms BARRETT - There'll certainly be some advantages. We'll have completely new clinic spaces. So where we've got four clinic room spaces at the moment, we will have capacity for, I think it's at least five, if not six, so we'll be able to see more patients.

That will be an advantage, for example, our Hospital@home service, which has very limited access to clinical space at the moment. So they'll have increased access to that. Five current community nursing clients did visit the Cimitiere House site and provide advice and feedback and some potential suggestions around optimising its suitability; so things like self-opening doors, having more seating so that there are opportunities to rest on the way to get to the clinical areas, looking at where intercom and signage is located, those sorts of things. That was very useful information.

PUBLIC

There will be some advantages to having all our services co-located in one area, so our clinical services, Hospital in the Home, our Rapid Response Service, Community Nursing Clinics, that they will be able to integrate and support each other probably a little bit more than they do now. We will be splitting some, like our Community Nursing Service and our Palliative Care Service. That's not necessarily ideal. So some pros and some cons.

Ms RATTRAY - I don't think in our previous part of today did we spend a lot of time on site selection. Peter's contribution made me go back and have a look at what was presented. It says you did talk about two sites potentially, and the Allambi building was the one that was chosen. The old nurses' home in Franklin Street being deemed unsuitable for repurposing. But what about the five other sites. I mean, was that because they were effectively greenfield sites?

Although I just looked up 35 to 37 Watchorn Street, South Launceston, and it says it's no longer available. It looked like an old house, so was there a potential purchase of land for that and then to pull down the old house?

Can I have an understanding of where you landed outside of the last two you were down to? Do you understand that question? It was a bit of a roundabout way.

Ms BARRETT - I could probably comment just in relation to, I know from a clinical perspective, our Medical Director and the medical staff were very strongly advocating for a building within the LGH Precinct.

Ms RATTRAY - So that's why Technopark, Mowbray Country Club and -

Ms BARRETT - And our advice from managers of other hospices in other areas was that that was a key aspect, the need to be near the LGH, not just to leverage off their existing services, but also for access to diagnostic and potentially other support services. So my understanding is there were very few alternative sites that were within the LGH Precinct and from a clinical perspective that was one of their highest priorities.

Ms RATTRAY - What about the old nurses' home? What was the issue with that? Because then it wouldn't have unplaced the people working currently at the Allambi.

Mr MACE - Yes, happy to speak to that one. So, just to expand on what Jon explained earlier. Site selection was sort of a two-stage process. The first two sites that were assessed were the old nurses' home and the other, Allambi. We had Xsquared engaged to provide recommendation and advice whether the two sites were suitable. The old Nurses' Home is indeed empty, but the advice we received from Xsquared Architects was that it was not suitable as a hospice without significant alterations to the site which were deemed beyond what the project could deliver for the budget.

Outside of those two sites, we expanded the search to include greenfield sites. The five listed there, were five identified through an analysis of the market and potential Crown Land or land owned by the City of Launceston. If I go onto the next page, they were assessed against the criteria listed there: locality, size and accessibility. Again, as Annette mentioned, the location being within the LGH Precinct was seen as a significant benefit.

Ms RATTRAY - What about the Howick Street property that is going to be used as a temporary car park? When was that considered or was it ever considered?

PUBLIC

Ms LIEUTIER - So, that site is obviously the temporary car park whilst the multi storey car park is being built. Then, in the LGH Masterplan, it is going to be a subacute tower. Originally it was going to be the co-located public/private hospital with Calvary. So, when we were doing the site selections the plan was the private hospital. That's now off the board, but, the next plan is, in the Masterplan, for that to be subacute space for the Launceston General Hospital. If you've been through that hospital recently, it is in very, very strong need of extra space and subacute is one of those areas that is in significant need.

Mr HUGHSON - If I can just add for the Committee's information, the revision of the LGH Precinct Masterplan, that identifies that as a subacute facility has yet to be made public, I believe. Has it not?

Ms RATTRAY - It's too late now.

Ms LIEUTIER - No it's public. It's out for public consultation.

Mr HUGHSON - Is it? I do apologise to the Committee.

Ms BARRETT - And that does include all the services in Allambi currently. So, they would be relocated back to that Precinct.

Ms RATTRAY - Thank you, for that further explanation.

Ms BARRETT - I was just going back to your first question that you asked about the development of the hospice - why it was delayed. I was a little bit involved in that process and that did relate to the proposal to establish the new co-located private hospital in Launceston, and we were involved a little bit in the planning and development of the palliative beds as part of that hospital. We didn't feel that what was being proposed would enable contemporary palliative care practice. So, we then did have interest-initiated discussions with infrastructure to say that we've got some concerns about the new private facility, that it's not going to cater for the needs of our palliative patients, can we consider other options, which probably then started that process of looking at a departmental managed facility.

CHAIR - That makes sense. Thank you, we appreciate that.

Okay, in light of there being no more questions, I have some questions to ask of you and if you can answer yes or no. You know how this works.

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 - I've just got to make sure everyone answers yes or no to these things.

PUBLIC

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 privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you said have said to us. Do you understand that?

WITNESSES - Yes.

CHAIR - Thank you. Thanks for coming in today. That is the conclusion of the hearing.

The Committee adjourned at 3.48 p.m.