PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON TUESDAY, 18 MARCH 2025.

ROYAL HOBART HOSPITAL DIAGNOSTIC BREAST IMAGING

The Committee met at 11.30 a.m.

CHAIR (Ms Rattray) - Welcome, everyone. Before we commence the hearing, I'd like to introduce the members to you, even though we met this morning. Just for the broadcast's sake, I have Helen Burnet, Tania Rattray, Simon Wood and Dean Harriss. We have an apology from Ms Jen Butler. That's the committee today.

We have a message from Her Excellency the Governor in Council. Secretary would you please read out the message from Her Excellency the Governor in Council, referring the project to the committee for inquiry.

> 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 $15 million. Royal Hobart Hospital Diagnostic Breast Imaging.

CHAIR - Thank you very much. The committee is in receipt of one submission and it is from the Department of Health. Could I ask a member to move a motion that the submission be received, taken into evidence and published. Thank you, Mr Wood.

Motion agreed to.

The witnesses appearing before the committee today are representing the proponent, the Department of Health. Could I ask you each to state your name, your position and the organisation and then make the statutory declaration that's in front of you?

Mr MATTHEW ARNOLD, ACTING GROUP DIRECTOR, POPULATION SCREENING AND CANCER PREVENTION, DELIVERY, DEPARTMENT OF HEALTH; **Ms LYN GIBSON**, STATE MANAGER, BREASTSCREEN CLINICAL SERVICES, DEPARTMENT OF HEALTH; **Mr HANZ LEE**, DIRECTOR, JAWS ARCHITECTS; **Mr REMY BOYER**, PROJECT MANAGER, INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; AND **Mr JON HUGHSON**, ACTING DIRECTOR, PROGRAM AND DELIVERY, INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. I have a statement that I need to present to you. Thank you all for appearing before the committee. The committee is pleased to be hearing your evidence today. Before you begin giving your evidence, I'd like to inform you of some of the important aspects of committee proceedings. I know that for some of you, it's the first time, so welcome.

Our committee hearing is a proceeding in parliament. This means it receives the protection of parliamentary privilege, and 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 and it implies to ensure that parliament receives the very best information when conducting its inquiries. It's also 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 of the confines of the parliamentary proceedings. Again, it's a public hearing and members of the public, maybe even journalists, might be listening in and/or they may well be present. This means your evidence may be reported. Do you all understand?

Witnesses - Yes.

CHAIR - I would like to invite Jon to make an opening statement. Thank you.

Mr HUGHSON - Thank you, Chair. In the 2024-25 Budget, the government committed $15 million in funding to deliver a new public diagnostic breast care centre in Hobart. The new centre will include the co-location of BreastScreen Tasmania and will facilitate an increase in capacity for services to align with the growing demand for the service. Thank you.

CHAIR - Thank you. As I indicated prior to commencing our hearing today, it's the usual practice of the committee to start at the beginning, so that is the introduction of this particular project, which is on page 5 of our paperwork and a project of the summary. I'll certainly open it up to questions from members. Just in regard to 1.2 - well, I don't think we need to discuss the name - and 1.3 which is the project location.

Ms BURNET - Just for the record, can you describe why this move is going to occur to Liverpool Street, to the Liverpool Street Clinic, and the opening of the Diagnostic Breast Imaging Clinic (DBI) alongside BreastScreen.

Mr HUGHSON - The clinics are physically relocating to a larger footprint so that we can co-locate services that are currently splintered. With the larger footprint, we also provide for an increase in capacity of services. It also aligns with the Hobart CBD accommodation plan currently sitting with the Department of Health.

Ms BURNET - I suppose subsequent to that, how long is it likely that the service will be in the - whatever you call it - the Vodafone building, the Liverpool Street clinics.

Mr HUGHSON - I can't actually answer that question. As far as I'm aware, as much as it's a leased facility, I don't have the actual knowledge of the period that the lease is for. I would need to report back.

CHAIR - That would be very much appreciated and the secretary will provide some documentation at the end of this process to ask for that. I think that would be useful to have some indication.

Ms BURNET - If I can ask another question because it kind of goes to that relocation of services. Clearly, you're going to have the DBI there, as well as BreastScreen, as well as the other screening clinics. Will you have all of the facilities that you require in that space?

Ms GIBSON - I believe so, as far as we know. That was the project that was put to the architects to provide for all our services. The population screening cancer prevention, the cervical screening program, the bowel screening program, breast screening and the diagnostic breast imaging.

Ms BURNET - That includes all the diagnostic equipment that you might need for breast screening and treatment into the long term?

Ms GIBSON - Yes.

CHAIR - A supplementary if I might, just following on from that - we had a really good look at the floor plan at the new proposed building after we'd been and visited the current site this morning. Thank you very much. That was really useful for me and I'm sure other members appreciated that. There is some additional space that won't be utilised under this proposal. Is there any discussion about what might potentially go into that future services area?

Mr HUGHSON - We have had some discussion about other outpatient clinics and we're reviewing what sort of patient cohorts might be appropriate to co-locate with the BreastScreen clinic. We haven't quite landed what that might be. Also, obviously, based on the space, there needs to be enough space for those clinics to relocate to. We have had discussions but we have not determined the appropriate clinic to go there yet.

CHAIR - But the department will be paying for that space underutilised for whatever the length of the lease arrangement, which we will find out later -

Mr HUGHSON - Correct.

CHAIR - Is that something that you anticipate those discussions will happen fairly readily or is it something that might be two or three budgets away? I'm just interested.

Mr HUGHSON - I couldn't provide advice on the number of budgets away that it may be, but it would certainly be subject to additional funding for more fit-out of that space.

Ms GIBSON - If I could just add a little bit of intel, I suppose. I know that there are a couple of services that are keen to join that space, and that is the genetics counselling service, which is an allied service to what we provide. We have a lot of interaction with that service and also the surgical outpatients clinic from the Royal.

So, people who are consulting with their surgeons pre and post-surgery are also looking at what they can do because, ultimately, there is this vision, I suppose, in terms of a centre for excellence for a breast care centre - thinking about all of the other sort of allied services that would be like a one stop shop. So, I think that is being hoped for, but it is probably outside the scope of this project. But just to answer the question, those are certainly some discussions that are happening outside and I am not sure how far that has gone with infrastructure, but that would be something.

CHAIR - So, Lyn, do you see, in particular, those two allied health services fitting quite well, adjacent to what is being proposed here?

Ms GIBSON - I do, but to be fair, I have not really - it is just a bit of - that discussion, it is not as if it is sort of like it is a blank bit of space that has been left in the corner and forgotten about. There are actually some discussions going on with other service providers who we have a relationship with, to see if they can piggyback and try to put up a case to join the services that we provide.

Ms BURNET - I want to get back to this idea of a one-stop shop. You are saying that any tests that might need to be done, any desirable tests can be done there rather than having to go to the Royal campus, for argument's sake?

Ms GIBSON - Correct.

Ms BURNET - What about MRI? Is that something that is required?

Ms GIBSON - Sometimes and the Royal does provide MRI, but does not provide any other breast imaging. So, mammography or breast ultrasound are not at the Royal. There has been talk about the possibility of MRI, but then that is provided by the hospital. The bigger question is the mammography, so the breast diagnostic imaging, mammography and ultrasound, are not provided in the public system, so either the hospital has to pay to outsource that or the cost is borne by the patient.

Ms BURNET - So, where do people go now for those services?

Ms GIBSON - Either nowhere and stay at home -

CHAIR - Did you say 'nowhere'?

Ms GIBSON - What I mean by that is - that is why this project is so important - some people, because of the cost, will choose to stay home if they have a breast symptom and eventually end up in the emergency department with - it sounds like, it is an awful term - a fungating breast, and that is what these lesions end up becoming. They progress. So, this is a really urgent need because, I think, with only the exception of one other state, to the best of my knowledge, Tasmania has not had a public diagnostic breast imaging service. So, if you have a breast cancer and your surveillance - if you have your surgery in the public hospital, your recommended surveillance is annual mammography and ultrasound for five years - they have to either pay that themselves and even if you are on a pension, you still have to pay a gap. There is no -

CHAIR - Nothing that fully covers the cost.

Ms GIBSON - No bulk billing and in some cases the hospital has paid for that imaging, but not for the full five years. So, there are lot of deficiencies, deficits, and that is why it is really important and we have that within this service that we are proposing.

Ms BURNET - Where do people go currently for that service?

Ms GIBSON - Okay, so, for the last couple of years we have been providing that surveillance service to the public patients, only the public patients who have had their surgery through the hospital and that is through those three clinics a week, or they go privately, or they

don't go anywhere at all. They stay home and don't have surveillance to see if they've got a recurrence, or they don't have their symptom investigated, because of the cost.

Ms BURNET - So, that would be Icon, is it? Privately? Where do they go?

Ms GIBSON - For imaging? Women's Imaging, mostly, or I-MED at Calvary.

Ms BURNET - I see.

Ms GIBSON - And similarly, around the state - it's no different anywhere else in the state.

Ms BURNET - Thank you.

Mr HARRISS - Jon touched on this just briefly in the introduction. In the project summary, it mentions that the project will facilitate an increase in the capacity for identified services. Do we have numbers or something that that will look like, as from current to the increased demand? Do we know what that demand will be?

Ms GIBSON - This is for extra capacity for breast screening, so the importance of screening is that early detection before they get to a symptom. Our current participation rate is 59 per cent of the eligible population, and we're looking to be able to increase that participation. That's a voluntary cohort.

I'm just trying to think of what the extra capacity will be. I was just having a look here, because I did have some figures here prepared for me. At the moment, with our five clinics a fortnight, that capacity is about 10 per cent of the population, and we're looking at increasing that to about 50 per cent. That's on MBF data.

In terms of the forecasted clinics - because we have to differentiate again - we're talking about something that's entirely new that hasn't been done before for the state, which is a diagnostic public clinic, in addition to extra capacity for screening the world population, and diagnosis of the people who've come through the screening program who don't have a symptom, but we've found something minute in there and it's going to improve their chances of survival. So, that's the three sort of groups of people who we're looking at.

Does that answer your question?

Mr HARRISS - Yes, thank you.

CHAIR - We heard - and I wrote this down this morning - that currently there are 37,000 per annum bookings. Did I record that correctly?

Ms GIBSON - You did. That's for screening, and it's important to note that we have a biennial screening cycle, so we have double that on our books. Yes, 37,000 people screen, but that's still only a small number. It's still only 59 per cent of the eligible population of people aged between 50 and 74.

CHAIR - And that includes the mobile service, as well? That 37,000?

Ms GIBSON - Yes. That's how many we screen each year, but in terms of the client group, if you like, it's double that - because one year, 37,000 screen, and the following year, a different 37,000 screen.

CHAIR - Right. You said 59 per cent of the population that is eligible, if you like?

Ms GIBSON - Fifty-nine participation rates.

CHAIR - Fifty-nine per cent participation rate?

Ms GIBSON - Yes. Of the people who are eligible to screen - you're eligible to screen from age 40, but there is a particular focus on people aged 50 to 74, because they are higher-risk postmenopausal women, because of the higher risk. There's 100 per cent of people 50 to 74, but only 59 per cent of that group actually screen. So, there's another 41 per cent of people out there who are growing a possible breast cancer.

Ms BURNET - That's huge, isn't it?

Ms GIBSON - It is, so it's really important -

CHAIR - (cont) Is there a target like an initial target to increase from 59 per cent to, I mean a hundred's aspirational, but -

Ms GIBSON - Absolutely, 70 per cent is the aspirational target and that's a national target set by the Breast Screen program, that's a national organisation. It's funded by the Commonwealth and the state. So yes, there's an aspirational target of 70 per cent. Tasmania, I proudly say, has the highest participation rate in the country so we do have really good participation, but it's still, we say not good enough.

Mr WOOD - I just had a question around the location there. Obviously there's lots of spaces available around Hobart. What was the main drive to choose to move to that particular site in Liverpool Street, bearing in mind, that the CBD is hectic.

Mr HUGHSON - We have an accommodation services team that would be better off to answer that, however the Department of Health has a drive to those Wellington St clinics to eventually populate more and more of that building as a secondary centre to the Wellington Centre that's currently opposite the RHH. That's the main drive.

CHAIR - Nothing to do with a good price for the lease.

Mr HUGHSON - I couldn't comment. Sorry, Chair.

CHAIR - I note in the paperwork that the tender was issued on 8 February, so can you give us some indication, that might be your area Remy, how many sets of documents have been let and where are we in the process and when's it likely to close, given that this committee's just undertaken the site visit and deliberations haven't even occurred yet?

Mr BOYER - The tender has been issued on 8 February and will close on 9 April. In terms of documents issued, a first preliminary set has been issued on the 8th and the full tender set of documents, 100 per cent design documents, was issued on 24 February. Because we are

under this committee's scrutiny, it has been made clear to the tenderers that the tender was conducted pending approval of the committee.

CHAIR - Can you give us some indication of how many sets of documents have been requested? How many companies?

Mr BOYER - How many tenderers? We had six building companies attending the compulsory site visits.

CHAIR - That's quite a good number. Six? Often we've had one in the past for other projects. The 9th of April?

Mr BOYER - Correct.

CHAIR - We've already touched a little bit on the over the page on the project scope, it talks about problem and opportunity statement and I think opportunity's been well canvassed here and then it talks about despite this expansion, the service is currently oversubscribed in its existing space and clearly saw that today, with an identified increase in demand over the coming 5 to 10 years, the centre is required to house these services.

Is that, between 5 and 10 years, somewhat to the question that was asked by Mr Harris about how long is this - or it might have been you Miss Burnett - how long it's going to be fit-for-purpose if you like, given that we've got this information here as well on page 6. Does that make sense, that question?

Ms GIBSON - Yeah, from a infrastructure services perspective, we are certainly not aware of the clinical planning and demand forecasting that would be a clinical service response. I'm not sure if Lyn has the answer to that or not.

CHAIR - It talks about increasing demand over the coming 5 to 10 years.

Mr ARNOLD - Chair, if I may, we're expecting an increase in demand once the diagnostic breast imaging service becomes available for referrals from GPs. As Lyn said earlier, currently clients are coming only from the hospital after they've received surgery, so once GPS start referring into the diagnostic breast immune service, we will receive an increase in demand, plus the team will undertake more promotion to encourage GPs and women to seek a referral for diagnostic breast imaging. There will be an increased demand, because this is new in Tasmania we don't have the data to make a projection on that beyond what we know of demand for breast screen services.

CHAIR - Right. Is the actual physical screening device something that we already have?

Ms GIBSON - Yes.

CHAIR - So we don't have to order a new one?

Ms GIBSON - We don't. All the equipment is -

CHAIR - It's transferrable.

Ms GIBSON - and as I said earlier today, that was part of the rationale for acquiring the BreastScreen services, to extend to provide the diagnostic breast imaging, because we have the staffing, we have the technology. It's very specific.

CHAIR - How's the message going to be delivered to GPs, should this service gain support? How's that facilitated out into - because we have a churn of GPs in Tasmania like nothing else? I expect other states may well have the same situation, but you often cannot see a GP - like, the same GP.

Mr ARNOLD - The department works closely with Primary Health Tasmania. That's effectively the link into the primary care sector. With this program, and many other programs, we work with Primary Health Tasmania to share information. Primary Health Tasmania has a process and approach for communicating directly with GP practices. So, like this and in many other programs, we prepare resource materials and work with PHT to share that information with general practitioners. There's also a general practitioner liaison program in the Department of Health, so that that team has contacts through the primary care sector as well. Quite often, we will have multiple methods of communicating with the primary care sector, including running forums and sessions, particularly when there's a new service or program being established, and we'll keep that communication focus up throughout the program to make sure that GPs are aware of the program and how to refer clients into it.

CHAIR - That's good, because it's going to be an important part of being able to deliver the service.

Ms GIBSON - That's right. We have a steering committee for the governance of this diagnostic service, and on that steering committee is a GP liaison officer who works with the department, and, as Matthew said, with the GP network.

CHAIR - Sure. Any other questions on page 6? I think we've covered the options evaluation.

I note on page 7, which is the relocation of the centre to level 6, and there's some category scope on quality and time, and I highlighted around the relocation to level 8, and then it's relocation to level 6. Well, we went to level 8. It talks about the slab penetrations, underslung plumbing and noisy works outside - of the completed works outside of working hours. Do you want to just walk me through what that actually means?

Mr BOYER - The table in page 7 compares the options of a relocation to level 8 and a relocation to level 6 against scope, quality and time criteria. We visited level 6. Basically, initially the location of the project was on level 8. We assessed the relocation, and specifically that part, because level 7 is currently an operating outpatient clinic. To fit out the new space, we need to drill - to core - through the concrete slab from one floor to the one underneath it to install plumbing equipment, which would have had pretty -

CHAIR - Significant costs.

Mr BOYER - and significant consequences on both floors, which is not the case in level 6, where we are completing the fit-out above a carpark space, which will be much, much easier to work on.

CHAIR - That was really the comparison table, and the relocation to level 6 came out cost effective and didn't need as much work.

Mr BOYER - Correct. Time effective, and quality as well.

CHAIR - Makes sense.

Mr HARRISS - On page 7, in the comparisons, in demolition, you've got demolition works completed by a previous tenant before handover to department on level 6. There's still some demolition there to be done, though, isn't there?

Mr BOYER - Yes. Since the table was used, there's been a bit of a change due to the understanding of the lease agreement.

Initially, the understanding of commercial services was that the previous tenant had to retrofit the floor basically back to bare base building, which appeared not to be the case. The landlord confirmed that the tenant had to leave the floor as you've seen it this morning, so there's a little bit of extra demolition to be completed to go to base building services.

CHAIR - Is that an additional cost? Is that included in -

Mr BOYER - It is included in the current project budget.

CHAIR - Right. Is it part of the design and construction contingency, or where is it?

Mr BOYER - No, it's part of the base project. It's been included in the base project cost estimate.

CHAIR - Right. That's been reassessed, the budget, but not this table.

Mr BOYER - Correct.

Ms BURNET - Could you describe the amount of floor space available in the current location versus what it is coming in?

Mr LEE - I can answer that.

Ms BURNET - Done your homework over lunch. Thank you, Hanz.

Mr LEE - The current 25 Argyle Street that you went to this morning, the approximate floor area is 860m^2 and the temporary BreastScreen clinic on Collins Street is 110m^2. The available floor space on level 6 is approximately 1800m^2.

The functional design brief for the projects was set up for - let me have a look.

CHAIR - Does that include the future services space?

Mr LEE - Yes, that's the whole floor plate. The functional design brief for the project was developed by the clinician team user group, which states that the desired requirements to carry out the service came in around about 1300m^2. That's the functional design brief. The

finalised floor plan that you have in front of you, the floor areas that will be occupied by public screenings Tasmania is 1350m^2.

CHAIR - That doesn't include my expansion on that future services area.

Mr LEE - It doesn't, no.

Ms BURNET - Thank you. In total, then, it's just under 1000m^2 at Argyle Street and Collins Street.

Mr LEE - In total, yes.

Ms BURNET - Following on from that in regard to the current headcount, i.e., people on the floor, how many staff will be working in the new facility?

Ms GIBSON - My figures here tell me that there are 55, but we require an additional nine full-time equivalent (FTE) for the expansion.

Ms BURNET - Is that 55 full-time equivalent as opposed to headcount?

Ms GIBSON - Yes. I couldn't tell you the headcount. For example, we have - I forget what the full-time equivalent is of radiologist specialist clinicians but they may only work a few hours per week, coming in and reporting those breast X-rays for $36,000 a year. We have a large headcount coming in briefly for maybe five hours a week to people job sharing, like the two client services managers currently job sharing, who you met on site. I couldn't tell you the actual number at the moment.

Ms BURNET - You have nine FTEs to go to the new site. Does that cover vacancies? Of that 55 FTE, is that with vacancies or without?

Ms GIBSON - That's without vacancies, but the nine is to cover the staffing of clinicians and, basically, clinical staff and extra administrative staff. At the moment, we are sort of stretching ourselves with staffing from BreastScreen. We are mining that pool.

Ms BURNET - Right, okay. Thank you.

CHAIR - I think it will be useful to be able to ask some questions around the actual proposed floor plan at this, because then we move on to the project costs and the like and we don't actually come back to that. Again, thank you very much for the opportunity to clarify some aspects of the new proposal this morning. It's important that we confirm that the size of the rooms meet the Australian standards. I think we were looking to see that they were going to be a little bigger than the spaces that are currently being used by people, particularly in shared spaces. There was a particular standard that you spoke of, Hanz?

Mr LEE - It is called Australasian Health Facility Guidelines, not Australian standards, just for the record. The design they presented to you was informed by an approved functional design brief, which is where the clinicians went through extensive internal consultation with the team to see, based on the staffing models, the numbers. A very detailed room requirement was presented to us before we started the design process, overlaid by the health facility guidelines. For instance, the minimum size of mammography rooms are around 20m^2, so that

will be the minimum size. It has to be designed accordingly to put in a new floor space, to answer your questions.

CHAIR - Thank you. I think that is important. Just for my own satisfaction here, there was a particular office in the DBI area next to the stairs that is going to have - from what we heard this morning - three, if not four, workstations in it, and it has an opening door. Yet farther on down, we have offices with actual sliding cavity doors. I suggested that be looked at, to take away that opening door and have a sliding door, because you would facilitate another workstation. I just wanted to put that on the record. You agreed that you could have a look at that. Is that still the case?

Mr LEE - Yes, we will have a further look, a more detailed review of that request.

CHAIR - Kevin has it written down, so I am sure it will get done.

Mr LEE - We just need to make sure there are no other regulatory requirements.

CHAIR - You talked about the fire, the smoke -

Mr LEE - The smoke compartmentation, yes.

CHAIR - You could see that it would make a difference, because it appeared to a lot of us this morning, it certainly appeared to me, that there is a varied amount of activity going on in the one space. People need a little space, at the very least, to be able to have phone calls and meetings alike.

That brings me to the meeting room, and we heard this morning that the current meeting room at the facility is only fit for about 18 people, maximum. The new proposed floor plan will have two meeting rooms and there will be one that will hold 25 to 30 people comfortably. The smaller meeting room - that doesn't have a bifold door, and you can tell us why it doesn't - is for approximately 10 to 15 people. Having that on the public record would be useful as well, because I thought, you know, you get a bigger meeting room if you have a bifold door.

Mr LEE - The reason for not having a bifold door was discussed during the design meeting with the clinicians. There was an option tabled or suggested by the team. I think we went through a few design workshops with them to evaluate the pros and cons of a bifold door of being hard to operate, heavy, and if we want to achieve a very optimal sound separation result, it will be very costly. The team was informed and agreed that they'd rather have two different-sized meeting rooms to cater for different needs, and supplemented by the video conferencing capability, so there's no need for a bigger meeting room.

CHAIR - Thank you. My other question, before I open it up to other members, is about the wonderful bin collection that was scattered across the current facility. There's a bin in every area. We even used it as a bit of a leaning tool, one of them, this morning. Can we have some understanding that the current facility in the proposed floorplan will accommodate all of those wayward bins that are sitting around - even in the staffroom.

Mr LEE - Just for the public record, the current facility wasn't designed -

Ms BURNET - By you?

CHAIR - For bins.

Mr LEE - It wasn't designed by me and wasn't designed to run the clinic at that size.

I can say that after design consultation with the team, that everyone feels comfortable that the amount of clean storage, waste storage, cleaner rooms and utilities will be sufficient to meet the demands of waste storage and handling.

Another layer in terms of checks and balances is that the infection control prevention unit also had a look at the design and didn't express any serious concern. In fact, they commented that because we separated - you have a dry waste room and what they call a dirty waste room - separating those is good practice for this kind of facility.

CHAIR - There's store, dirty utility, store, store, all virtually in a row. So, those four spaces will effectively hold those bins.

Mr LEE - Everyone feels comfortable, yes.

Mr WOOD - I have a question about the existing staff rooms. Obviously, they're pretty tight on space. How much larger will the proposed new staff room be to provide a better amenity for the good people who work there?

Mr LEE - I don't know the size of the current staff room at 25 Argyle Street -

CHAIR - Small, with bins.

Mr LEE - But, the new facility has a staff room of a size of around 48 m^2, plus there's a courtyard on the ground floor if you walk in. Yes, there's a cafe. I think that's a good value-add to this facility that we have a cafe on the ground floor that you can, you know, go and get some fresh air, if you like.

CHAIR - Get a chai latte.

Mr LEE - And that too, yes.

Mr WOOD - Great, so it's significantly -

Mr LEE - I would say it's larger, yes.

Mr WOOD - That's great. Thank you.

Ms BURNET - Clearly this is a clinical space, and I'm just curious to know what type of clinicians work in this space, for the record?

Ms GIBSON - We have medical specialists in surgeons, breast surgeons specifically, and radiologists who specialise in breast radiology. We also have radiographers who are the allied health clinicians who perform the mammograms, and sonographers who perform breast ultrasound. These are all specialised fields of their particular disciplines.

We also have qualified counsellors, so psychologists and social workers, who also work in the clinic, and we have nurses - breast care nurses in particular.

Ms BURNET - And then, of course, the -

Ms GIBSON - The administrative staff as well, yes.

Ms BURNET - Yes, admin staff. That's quite a range of health professionals and admin staff. Were each of those professions part of the -

Ms GIBSON - Representatives of. We have lead clinicians in each of those disciplines. We have what we call a designated radiologist, or a lead clinician - Professor John Waugh - W-A-U-G-H - or as he says, 'Waugh,' because he's from Edinburgh - and Dr Gausihi Sivarajah, who is our designated surgeon and clinical director, and a number of the chief radiographer and the team leader for the counselling team as well and the nurses obviously, very outspoken, the nurses.

Ms BURNET - Given it's a large area, were there any sort of difficulties getting services or functions co-located or located closely. I am sure Hanz would have done a fantastic job, but how did it go, were there any problems with that?

Ms GIBSON - I said on our site visit to the Vodafone that we started with not quite a blank canvas but a proposal and, to Hanz and Remy's credit, they were very open and at times I felt that the rigour that we were applying was probably holding the project up, but they were very open to make sure we got it right, including the consultation with the consumer reference group and a specific consumer who is on the hospital consumer group as well, so I do feel that a significant amount of consultative rigour was applied to this final design.

Ms BURNET - It's a clinical space that integrates clinical care as well as patient-influenced design as well?

Ms GIBSON - Yes, definitely we did that. We have a number of community champions, I guess you could say, the Claremont Cricket and Racing Club for example, who are very invested in our service and we've consulted them. They've been consumers themselves and we've talked to them about their experience. I think I said to you, Helen, we are very strongly and tightly governed by the national accreditation standards, which has a very large focus on client focus for the acceptability and accessibility of the service and their experience. We have a number of ways of consulting with their actual experience at the time as well as this future state as well. We have been very engaging and we recognise too that people who work for us are also part of our client group, so we use every resource available to us.

Mr LEE - If I may add to that, we also had a consumer reference group workshop, talked to the consumers and showed them concept design plans and the look and feel and the feedback received was very positive. One feedback that we did receive and make an amendment to is to the removal of some of the fixed seating and substitute it with a lot more comfortable chairs and cater for different needs and length of stay in the diagnostic waiting area.

Mr HARRISS - Thank you and I hope I'm not jumping around too much, Chair, but if I go to page 8, in the budget where we're still talking about the relocation to level 8 and then consequentially to level 6, we've got a construction budget there of $8.3 million and then the

relocation to level 6 talks about cost savings expected due to fewer limitations on construction hours et cetera. Then when we jump over to the project costs, the base project cost is $9.1 million. Can I have some understanding of the differences there?

CHAIR - I think it's probably from page 8 to page 9.

Mr BOYER - Yes, that's right. Yes. The construction budget mentioned in the table on page 8 is construction only, without contingency and escalation. That budget that was a pre-tender estimate by the quantity surveyor. The figures in the updated budget on page 9 are coming. The base cost project estimate includes construction costs plus consultant, project management internal (inaudible 2:49:43) cost and design costs, updated with the most recent quantity surveyor's estimate.

Mr HARRISS - Right, so the 8.3 - do we know how long ago that was done? Just trying to get time frames of some $800,000 addition.

Mr HUGHSON - I think, if I may add, the $8.3 million in the table on page 8 is literally the construction budget only from the quantity surveyor's estimate. The figure reported, as Remy stated, on the table on page 9 actually includes consultant and design costs as well, not necessarily the escalation. Escalation costs would be covered in some of the contingencies.

Mr BOYER - To answer your question about time frame, the initial estimate would have been dated around September 2024.

CHAIR - Just a couple of other areas, you talked already about the removal of some of those bench seats due to some feedback from consumers. That's really good to see because that's the first thing I thought: they do not look very comfortable and then facing the window as well, not very good at heights. There will be some updated, more comfortable furniture moving forward?

Mr LEE - Yes, the loose furniture selection is not part of the tenders out there currently, but it's something that we will work with Lyn and her team, to show this and look at the furniture selection.

CHAIR - That's in the budget?

Mr LEE - I believe so, yes.

CHAIR - But it's not actually - because we often see furniture and that's separated. It's not separated here.

Mr BOYER - It's not separated here.

CHAIR - Do we have any idea?

Mr BOYER - From memory, we've made an estimated allocation of 600Ks for mobile furniture or loose furniture.

CHAIR - Some furniture from the existing facility, certainly all the medical equipment will be transferred over.

Mr BOYER - All the medical equipment that will be transferred is excluded from that budget. The purchasing of the medical equipment is obviously excluded. The transfer is included and the reinstallation in the new site is included and then in that base project cost estimate, there's an allocation of approximately $600,000 for loose furniture.

CHAIR - The other area that I think would be worth putting on the record is around the sound control. The really important acoustic separation aspect, because, as I've already said, people are working fairly closely even though there are some walls up because currently you can hear what's happening in another room side by side and if you're on a teleconference or even making some of those important phone calls to clients, there needs to be some sort of sound separation. Can you talk us through that?

Mr LEE - Sure, concern around acoustic separation was definitely raised by the user group and my first comment to them is, do not use your current facility as a given because it's not a purpose-built facility. The new facility will follow the Australasian Health Facility Guidelines acoustic recommendation. It has three tiers - high, medium and low - using that as a starting point, overlayed by some of the concerns received by the user group and then we went away and did a design development based on that feedback.

We also have acoustic engineers helping us to develop that appropriate system to mitigate that risk. At the completion of the project, the acoustic engineer will undertake a site inspection to verify the installation was carried out accurately and appropriately.

CHAIR - They are currently in the building itself, now it looks like it has got quite a bit of ceiling acoustic infrastructure - if that is what you would call it - or will that all have to be pulled out?

Mr LEE - They will all have to be pulled out because the current - are you referring to level 6 in what you saw in that?

CHAIR - Yes.

Mr LEE - Yes, it serves a different purpose. When we talk about acoustic performance, it often comes down to two things; one is separation, one is reverberation. For a room like this, you need to do two things: sound separations, so people who stay in the corridor cannot clearly hear what you are saying; but also need to minimise the echo where you have a group of people talking at the same time. Those acoustic panels hanging on the ceiling would not be fit for purpose for this facility and the new design will have a tailored system to fulfil their needs.

CHAIR - Will any of that be able to be reused in some other government facilities, whether it be schools or anywhere?

Mr LEE - I think part of the project aspiration, you might say, is to put a call out to the community, not-for-profit groups, charity, churches, schools and see who will be interested to take that for repurposing.

CHAIR - Carpet, floor tiles or the ceiling?

Mr LEE - Yes.

Mr BOYER - Any of the equipment that is currently on the floor, the plan is to duplicate the approach we had for level 7, which is basically when the demolition will be completed. The demolition will be completed by the landlord under a separate works package, but the expected outcome is the same. They will issue an expression of interest or make a call to whoever wants to pick up anything; it is free, is welcome and everything will be given away.

CHAIR - Is that a standard thing for the Health Department to do?

Mr BOYER - That is something we have done for level 7 with the landlord.

CHAIR - That is good. Put out a press release about that, a good news one would be good. My last question is can you elaborate on what comms is?

Mr LEE - Comms just stand for communication room, just a server room.

CHAIR - But you have data and IT across here as well, on the other side.

Mr LEE - That is the workspace for the data/IT staff and the comms room is the server room.

CHAIR - Okay, thank you. Members, any other questions? We have done the floor plan because it's pretty much part of the scope of the project. We will move now onto project costs and Mr Harris has already asked a couple of questions, so one that I am always keen to know is: is this firm? Are these numbers firm? Is there any rubber in them?

Mr BOYER - The numbers will be firmed up once we get the market's answer to the tender. That is the main component. The construction cost remains an estimate until we have a firm commitment from the market.

CHAIR - The quantity surveyor says that this project can be delivered for $15 million?

Mr BOYER - Correct.

CHAIR - If you're not interested in providing it or delivering it for $15 million, your tender will not necessarily be entertained or is there some - I know this is a bit difficult because the tenders are out and people are probably watching, but if they know it is firm and there is no flexibility, then I expect that they will need to sharpen their pencils.

Mr BOYER - It is always good for tenderers to sharpen their pencils, but there is a design and construction contingency which is here to act as a bit of a buffer. Design, construction, contingency and market escalation are the lines which give us a bit of contingency to try and anticipate or manage, mitigate any variations due to changes in market conditions.

Mr HARRISS - Is that high, that design construction contingency?

CHAIR - I thought it was.

Mr HARRISS - That's nearly 23 per cent, isn't it, of the base project cost? That seems pretty high. Is that to get to the 15?

Mr HUGHSON - In this instance, it is a healthy contingency, but the market in Tasmania over the last couple of years has been quite hot in the construction industry, and we've experienced some tenders coming back well over the quantity surveyor estimate. We've also experienced some tenders coming back in within or slightly under the quantity surveyor's estimates. It is a healthy contingency, but nevertheless we still think that the quantity surveyor's estimate, being only less than six months old, is a fairly good estimate of what it should cost.

Mr HARRISS - If those estimates or quotations from contractors come in well above quantity surveying, do we ever go, 'Let's not do this project,' or do we just accept what it is and get the numbers from somewhere?

Mr HUGHSON - We would not necessarily not do the project. We would look at opportunity to potentially descope the project to bring it within what the market has responded to or we would seek additional funding to go out with the project as it sits.

CHAIR - A supplementary, then. This is for you, Lyn: where are we going to descope here? What can you cut? I'd suggest nothing.

Mr HUGHSON - I do not believe we would need to descope this project or would descope this project, Chair.

CHAIR - Do you agree, Lyn? There's nothing to -

Ms GIBSON - No, there isn't.

CHAIR - There is nothing.

Ms GIBSON - We've always run pretty lean - in fact, very lean. Yes, this is all conservative.

CHAIR - When we know that there're four workstations needed in the area that we looked at today, because there's an RN been added, we're going to get rid of that doorway, so we can put a workstation behind that door - former door. You've already got four people working in a fairly small space, I can't see that there's much opportunity. It's what it is as presented.

Mr WOOD - My question is just about the line item: medical equipment: $2,065,000. Is that additional equipment to be purchased, because obviously you've got more facility, more space, more scope?

Mr BOYER - When going through the design process and the consultation process with the business unit, we identified an opportunity to include some additional imaging equipment. I don't remember exactly which piece of equipment, but it's a piece of medical imaging.

CHAIR - It's one piece.

Mr BOYER - It's one major piece plus some minor ancillaries.

Ms GIBSON - It's to the best of my ability, this one, because I wasn't part of that discussion with the clinicians. I know in terms of future state when you talked earlier about

MRI, there is advanced technology in breast imaging, and that is - you might have heard it - Contrast Enhanced Mammography, which is sort of like a halfway step to MRI, and it's being used in lot of breast clinics in the rest of Australia.

Certainly, that's been talked about if we were going to progress to the next level, if you like, of state-of-the-art technology, less expensive. A doctor in Sydney did talk to me about it, and she said it's not quite the poor man's MRI, but it is, it's sort of like what you can afford to get that extra level of detail in imaging. Yes, that's the next step, really - Contrast Enhanced Mammography. I suspect that this may be what that discussion was about in terms of future state.

CHAIR - It's what I call the Commodore model compared to the Rolls Royce, even though they're a thing of the past.

Ms GIBSON - It's an interesting one. We could have lots of discussion about the pros and cons of MRI to Contrast Enhanced Mammography. It's cheaper. It's more advanced in some ways, because of its sensitivity and specificity; the MRI does result in a lot of false positives. It picks up a lot of things, which then can cause increase in patient morbidity due to the fact that if they find something that might look concerning on MRI, they go in to perform a surgical procedure and it turns out benign, so that false positive. There are pros and cons, and this Contrast Enhanced Mammography is something worth looking at, and I know the clinicians have been talking about that.

Ms BURNET - Is there any increased clinical risk with that?

Ms GIBSON - That's a question on notice. I don't think so, in terms of radiation. What they're inserting is a contrast product. I'm not sure. I'm speaking well outside my scope, sorry.

CHAIR - One question, Remy or Jon, how come the Australian Government have not made any contribution to this? It appears to be a nonsense to me. You probably can't answer that. Minister for Health?

Mr HUGHSON - Sorry, I can't.

CHAIR - I can't believe they're not putting in a cent. Looking after their Australian people. Goodness me. I'll take that up with the federal member.

Project benefit - I think we've pretty much done that, unless anyone else has any more questions about the benefit of this project?

We've talked about the patient flow, talked about the regulatory compliance with the Australasian Health Facility Guidelines.

Architectural statement. Do you want to tell us what that is, that's just your vision for the project. Is that right, Hanz?

Mr LEE - Yes, it's our design statement for the project and where it started and how we come to the final design look and feel. It actually started with talking with the staff and asking how they would like to see the centre. We did a breast screening project, we just started Rosny last year.

CHAIR - Yes. I saw that in the notes.

Mr LEE - Everyone was so pleased about the look and feel of their clinic, and we sort of extend that concept into here, hence the flower and petals.

CHAIR - The petal metaphor.

Mr LEE - The petal metaphor came into this.

CHAIR - Is this the same as what's been used at Rosny?

Mr LEE - Yes.

CHAIR - We haven't had to reinvent the wheel, pay another graphic designer?

Mr LEE - No, we didn't. In fact, we're using the same graphic designer who's part of our team to do - which we haven't seen in the renders - the wayfinding and enhanced graphics that go on the windows and some feature areas.

CHAIR - Is there anything about the materials that are being used that the committee should be aware of? Is there any questions, members, about the materials? Because we haven't got an outside necessarily to worry about the weather conditions on how the timber will wear, if you like, we can pass on that one.

Mr WOOD - About signage, it is up a bit of an alleyway. I think there is a carpark - I'm not that familiar with Hobart. There is a multi-storey car park there. For a punter - sorry, that's the expression.

CHAIR - A client?

Mr WOOD - A client coming down from the north, what's being done to make it easy for people to find their way in the big smoke?

CHAIR - In one-way traffic as well.

Ms GIBSON - You can talk about the design, if you like, in terms of the wayfinding and then I can talk about how we assist people who are having to travel to Hobart.

Mr LEE - Yes. In terms of the design, there will be signage on the main entrance, which is at Liverpool Street. Subject to landlord approval, additional signage could be provided.

CHAIR - What about council approval? Do you need council approval? You usually do.

Mr LEE - Within the building, probably not. Above the footpath or the awning sign, yes, they will need council approval. My understanding is the business unit will put out a very simple instruction to find a way and then relying on, and then some queue and additional signage to find a way to the clinic.

Ms GIBSON - Yes, and we're about to go through an accreditation in June, where we have national surveyors attend, and part of the acceptability, if you like, of the service and

accessibility is all about signage so that when you're driving by you can see, 'Oh, there it is'. They have that pop-up clinic at the moment, where we put a sign coming out of the - is it called the awning, soffit, or the verandah? Yes, signage is huge for us. My hope is that we can have some partnerships with the various businesses that are part of that walkway as well, just like where we are currently, we engage the support of the gynaecological service on one side and the Hobart Heart Centre on the other, where they agreed to have signage on their windows that face the street. I am hoping to have some partnerships there, and welcoming, if you like.

The other way that we support people attending those investigation clinics is that they have that phone call with the counsellor to book them in, we send them a lot of information, including a map, which is a modified map, a simplified map, with signage. We talk to them about where food's available, parking, et cetera, as well as our phone number, so they can call us even while they are driving around thinking 'Where am I?' in the one-way streets.

Ms BURNET - You'd have some volunteers, too?

Ms GIBSON - Yes, we do.

CHAIR - Finance and procurement - is there any questions in regard to that? Package of works, demolition works, essential services, and then the fit-out of the Public Diagnostic Breast Care Centre.

Mr HARRISS - Chair, why was it decided to split the works package?

Mr BOYER - It came from a requirement from the landlord and guarantee and liability issues. The landlord notified us that they wouldn't accept to hold any guarantees on liability on services. They haven't modified themselves on the base building. Nominally, mechanical services, dry fire, wet fire and coring of the concrete slab - for them to accept a guarantee, they wanted to do the works themselves. Hence the split of the packages.

In other terms, if the Department of Health was to complete the works under the fit-out package, the Department will have to wear the guarantee of, for example, mechanical services that are connected to the base building mechanical services. That creates major guarantees issues because where is the limit and what service completed for level 6 impacts the overall base building service?

Mr HARRISS - Is the landlord tendering out that works package 1, the demolition?

Mr BOYER - Currently, commercial services and Crown law are working on an agreement between the landlord and the Crown so the landlord can complete those services and claim a reimbursement and invoice that back to the Crown.

Mr HARRISS - Right, so the landlord can do their own demolition and coring work and then charge it back to the department?

Mr BOYER - Correct.

Mr LEE - If I may add to that process, the quantity surveyor will get involved and validate the costs are fair and reasonable.

Mr BOYER - The details of the agreement will include a cost review and acceptance by both parties using an independent quantity surveyor, mostly.

CHAIR - What if there's a dispute?

Mr HARRISS - We've also just heard that sometimes construction costs go over because the market's hot, or whatever it be, and we have a landlord that has -

CHAIR - Got the upper hand.

Mr HARRISS - Yes. Essentially saying, 'We'll do this work at this cost'.

Mr BOYER - That is the whole point of the agreement being currently drafted; to secure that specific issue.

Mr LEE - If I may add to that, why the landlord is in a better place to do the work, is just the nature of this project. It has a higher demand in terms of mechanical services, so each mammography room is required to maintain a very specific temperature. The current mechanical system on the floor wasn't designed to cater for that, so any additional load created will need to go back to the central energy plan, which is not part of our liability. I think it's just the base building being able to look after their central energy plan and ensure the ongoing maintenance of the units. It has a value-for-money aspect to it as well.

CHAIR - The tender that's been let is only for the fit-out of the space?

Mr BOYER - That's correct, yes.

CHAIR - Do you see that as a risk? There's no risk attached to this? It's almost that we're at the mercy of the landlord.

Mr BOYER - Again, the mercy of the landlord, that's a risk that is currently managed, the Crown lawyers are currently working on to mitigate that risk and make sure the agreement is fair for both parties. The fit-out tender itself carries, if anything, probably a lower level of risk because the fit-out contractor will not interfere with the base building. There will be potentially some complexities in the management of the interface between the two works packages, which has been flagged in the tender and which we consider carefully between the landlord, the contractor and ourselves.

CHAIR - That takes me to the project timeline. You don't see any issue with meeting the projected timelines, given that the development agreement is still in draft?

Mr BOYER - At this point in time, we're on track.

CHAIR - I'm pondering this; you can probably see that.

Mr HARRISS - Do we know, in project timelines, when will the first works package need to be finalised to stick to completion end of 2025?

Mr BOYER - The objective is to have the first works package to be completed in early June, so that the fit-out contractor can get in and start their part of the work. There is a bit of

program contingency, for one, the time it will take. The start of works is the start of works under contract, which includes ordering of materials and site possession, which gives us a bit of leeway before the fit-out contractor will actually put the tools on the floor or start drilling on the floor.

The other level of contingency in that program is that we have a possibility to come to stage the handover from the first works package to the second works package, which allows us a delayed start and gives a bit more contingency, in terms of planning.

Mr HARRISS - I'm going backwards a bit here, Chair, sorry. Where's the money going to come for that first works package? We're discussing the $15 million estimate for this project, but this project's going to be more than that, isn't it?

Mr BOYER - It's included in the construction in the 9.1. It's been estimated by the QS. The split is a procurement thing, not a cost or technical.

CHAIR - I feel like we've touched on the risk. Are there any other questions about the risks and sustainability?

Ms BURNET - I think I asked a question before about the length of time that the clinic is likely to be there, and also that Lyn talked about the value-add or access to other diagnostic services.

CHAIR - I think those were covered with questions. To move the current medical equipment from one facility to another, will that be over a January period, or, what is the - I don't mind who answers - as the transition? Given the 37,000 clients per year, large numbers of people coming through the door needing those services.

Mr ARNOLD - We have a separate project that will focus on the transition, the decanting from one site to the next. That's being worked out in a lot of detail to minimise client disruption. It all depends on when Remy gives us the building, and then we can kick off that transition process.

CHAIR - But do you see it something like a January? Given that perhaps - Tasmanians love to holiday. They don't do very much in January, only holiday - has been my experience.

Mr ARNOLD - We don't have that detail at the moment.

CHAIR - Because you're going to have no service while you transition.

Ms GIBSON - What's wonderful is that we have -

CHAIR - The bus.

Ms GIBSON - We have the bus, we have the Rosny site, we have the screening site in Collins Street here. We have a number of services that we can continue with.

CHAIR - Right, okay. It won't be a complete shutdown?

Ms GIBSON - No. It will be a staged approach. The biggest thing will be offices and people. The machinery. There's not that much to move, actually.

CHAIR - Really, the whole thing relies on Remy? Is that what you're telling us? No pressure.

Mr BOYER - That's fine.

CHAIR - Jon's fine, because he's only acting, so he'd be fine.

Mr HARRISS - The medical equipment from Collins Street will come across as well eventually, though?

Ms GIBSON - Yes.

CHAIR - When you've got that one fully operational, then that one will possibly shut down. But Rosny's not going anywhere?

Ms GIBSON - Rosny's not going anywhere, no. But we've got capacity there, you see, so we can continue screening, and we can manage the way people attend for the diagnostic side of things. We will have contingencies, yes.

Mr LEE - We'll maintain communication with the team once we have a contractor on board and work through the decanting and relocation strategies in detail.

CHAIR - We've already talked about stakeholder engagement. We've talked about the stakeholder consultation. That's been very helpful, Lyn, to have that information, and to meet with some of the staff this morning who have been closely involved. That's really key to my decision, and I feel sure other members in their decision as well.

Mr HARRISS - Page 22, plumbing permit's got to be issued? Have we been issued a plumbing permit there, or not?

Mr BOYER - It is in progress. The permit has been lodged.

CHAIR - What about that Hobart City Council? You just never know what they're going to throw up.

Mr LEE - It's planning exempt, given these [inaudible] projects. At the moment, the only pending permit is plumbing.

CHAIR - Will there be a need for any traffic management or are you going to use the carpark for -

Mr LEE - Traffic management for the construction?

CHAIR - It's a pretty busy area where you're making your - where it'll be an entrance. You have to bring some bits and bobs in, I expect.

Mr BOYER - So far, the options we have, first, there is a bike cage that is DoH property in the carpark, which is inside the carpark, and that we will make available to the construction contractor for temporary storage so they can get in, in a safe place, to load and unload their materials.

CHAIR - You won't have to use Liverpool Street itself?

Mr BOYER - We will probably not use Liverpool Street. What we did, for level 7, was we used Argyle Street. There was a crane in position in Argyle Street and a gantry where, in the first aid room, where we removed a few windows. This will be up to the construction contractor and traffic management would be the construction contractor's responsibility. The difference with this project compared to level 7 is that there is no bike lane between the footpath and the road, which may complicate the installation of a crane.

CHAIR - I think we have pretty much exhausted our questions then, so thank you very much. We appreciate that. Is there anything else that you would like to add before we wind up? Thank you. Before you leave the table, I would just like to reiterate the statement that I made earlier about the committee proceedings and, as you were advised that the commencement of the evidence, what you said to us here today is protected by parliamentary privilege, but again, once you leave the table, be aware that the privilege does not attach to your comments that you may make to anyone, including the media, even if you are just repeating what you said to us. Do you understand?

WITNESSES - Yes.

CHAIR - Thank you. We have some really fantastic questions that we always like to put at the end of a project and it is just very much about does the proposed works meet an identified need or needs or solve a recognised problem? I think Lyn is going to answer this.

Ms GIBSON - Yes.

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

Mr BOYER - Yes.

CHAIR - Are the proposed works fit for purpose?

Mr HUGHSON - Yes, they are.

CHAIR - Do the proposed works provide value for money?

Mr LEE - Yes, they do.

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

Mr HUGHSON - Yes.

CHAIR - You can all answer yes to that one.

WITNESSES - Yes.

CHAIR - Again, thank you very much for coming along today. Certainly, the site visit was very helpful in giving evidence and we shall conclude our hearing from today and you will be advised once the committee have deliberated. We have one question on notice, that I believe, secretary, you have that organised, and that will come in a written form and the committee will welcome the response to that.

The broadcast will conclude, thank you.

THE WITNESSES WITHDREW.

The Committee adjourned at 3.28 p.m.