PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT PARLIAMENT HOUSE, HOBART, ON TUESDAY 28 NOVEMBER 2032, AT 1.30 P.M.

ROYAL HOBART HOSPITAL EMERGENCY DEPARTMENT EXPANSION PHASE 2

CHAIR (Mr Valentine) - Welcome, everyone, to this Public Works Committee hearing on the Royal Hobart Hospital Emergency Department Expansion Phase 2. For the record, the members on this side of the table, Jen Butler MP; myself, Rob Valentine MLC; Tania Rattray MLC; and Simon Wood MP. We have the secretary to the committee, Scott Hennessy, and Henry on the all-important Hansard.

Welcome to the hearing and thank you for the guided tour through what was a very busy time. Probably not as busy as you might have experienced in the past, but for us you could see the activity was quite high. I can't imagine what it would be like at peak operational level. You spending the time showing us the ropes down there was really important for us, but we do know that it was interruptive, so thank you for that.

We have an apology from Mr John Tucker MP, who is unable to be with us here today.

I will ask the secretary to read the message from Her Excellency, the Governor, with regard to the Royal Hobart Hospital Emergency Department Expansion Phase 2.

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 when completed is $105 million. Royal Hobart Hospital Emergency Department Expansion Phase 2.

CHAIR - Thank you, Secretary. We are in receipt of one submission: The Emergency Department Expansion Royal Hobart Hospital Submission to the Parliamentary Standing Committee on Public Works, Department of Health, 28 November, 2023. Can I have a member move that the submission be received, taken into evidence and published?

Ms RATTRAY - I move.

CHAIR - Thank you, Tania. Someone seconding?

Ms BUTLER - I second it.

CHAIR - Thank you, Jen. All those in favour?

Motion carried.

Mr BRENDAN DOCHERTY, DEPUTY SECRETARY HOSPITALS AND PRIMARY CARE, DEPARTMENT OF HEALTH; **Mr ANDREW HARGRAVE**, DEPUTY SECRETARY INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; **Dr PAUL SCOTT**, DIRECTOR EMERGENCY DEPARTMENT, ROYAL HOBART HOSPITAL; **Mr MARK LEIS**, PROJECT MANAGER, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; and **Mr HANZ LEE**, DIRECTOR, JAWS ARCHITECTS - MADE THE STATUTORY DECLARATION

CHAIR - Thank you. Before you give evidence today, there are some important aspects of committee proceedings that you need to be aware of. This committee is a proceeding in parliament. That means that it receives the protection of parliamentary privilege. It 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 in conducting its enquiries. 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.

It is a public hearing. Members of the public and journalists may be present or online and this means your evidence may be reported.

Do you understand? I need an acknowledgement from each witness.

WITNESSES - Yes.

CHAIR - Thank you. We normally ask whether you wish to make an opening statement?

Mr HARGRAVE - I will make an opening statement.

CHAIR - Thank you, Andrew. Over to you for that. Then we have a suggested format for the presentation from your side and we're more than happy to follow that. I ask the secretary to give me a copy because that is something I didn't print. We're happy to follow that but we may also have questions after that or on the way through. Over to you for your opening statement.

Mr HARGRAVE - Thanks for having us today to talk about the ED (Emergency Department) Redevelopment Phase 2. In 2019, the Tasmanian Government committed funding for stage 2 of the Royal Hobart Hospital (RHH) Redevelopment. At the time it was estimated to cost $91 million. In the 2021-22 Budget, an additional $110 million was announced for the RHH Stage 2 which included the redevelopment of A Block to provide a new roof and facade, and ward upgrades.

The RHH Redevelopment Stage 2 is well progressed and has already delivered 28 additional treatment points by the ED Phase 1 Expansion Project, which you would have probably seen today.

CHAIR - Yes.

Mr HARGRAVE - We've also delivered major upgrades and expansions to the ICU and major upgrades to Cardiology, Sleep Studies, Endoscopy Unit, Trauma and Acute Surgical Unit and the Rapid Assessment Unit.

Obviously, today we're here to talk to the parliamentary standing committee about Phase 2 of the ED redevelopment. Phase 2 will deliver a modern, contemporary Australian Health Facilities Guidelines (AusHFG)-compliant ED across two levels, providing, ultimately, 121 treatment points.

CHAIR - Over to you, Dr Scott, for the clinical need, current issues, resolution of the new model of care and clinical response to the new build.

Dr SCOTT - To clarify for the record, my title is Acting Director of the Emergency Department. I've been part of this project for the last 15 months. Preceding was the work done by Emma Huckerby and Trish Allen. I'll do my best to answer your questions. However, given I've been with the project for 15 months, there may be some things that I would have to take on notice and get back to you.

CHAIR - Not a problem. We have the opportunity to send you questions on notice and they will be in writing so that it is clearly stated what we might need, if we get to that point.

Dr SCOTT - The Royal Hobart Hospital is the only public hospital in the southern part of Tasmania. As such, it sees all public presentations. The existing Emergency Department was built in 2007 for a planned occupancy of 45 000 patients a year. In 2010, we already exceeded 45 000 a year and, over the last three years, we've been seeing around 75 000 patients a year.

The predicted growth in Emergency Department presentations is quite alarming in that the population of Tasmania is predicted to age, with a dramatic increase in people moving to Tasmania in the age group of over 65 - 50 000 out to 2050; and with an 85 per cent increase in people over the age of 85 between now and 2035. That means that the demand on the Emergency Department is predicted to increase significantly. We've worked with Kelly Shaw and the government Treasury and Finance figures to anticipate how many points of care we will need to provide to future-proof emergency department care out to 2035.

That's where the basis of the footprint size of the Emergency Department has come from, requiring 118 points of care. We think we can deliver 121 out of the existing footprint. That is bearing in mind the ageing population with increased need for lay-down bed spaces and to have an older person-friendly emergency footprint.

It's also bearing in mind particular groups who will use the Emergency Department, such as the paediatric population needing to be seen and treated in separate areas from adults, as well as other groups such as mental health and other patients who have specific needs. We have tried to address all those needs with the footprint that is proposed. To gain the size of the department we needed a two-storey build, requiring a significant footprint which runs from Campbell Street across to Argyle Street. That is thought to be able to deliver care out to 2035 with what we expect to be the predicted increase in population growth from the current data modelling.

Ms RATTRAY - Thank you, Dr Scott, I appreciated the opportunity to look around this morning and would like to congratulate the staff on the work they do in what would probably be considered a not-fit-for-purpose space, in my view. In regard to the proposed 28 points-of-care that are going to be extended, is that enough to future-proof, or is there no other opportunity to provide any more space at this point in time?

Dr SCOTT - I will clarify, we have already completed phase one of the development, and that has delivered an additional 28 points-of-care. We have that already and that has been a fabulous improvement in the care standard that we have been able to provide to the Tasmanian public.

Ms RATTRAY - What are the extra ones now?

Dr SCOTT - The actual end product of the proposed rebuild essentially doubles our existing points-of-care. Prior to this project we had 61 points-of-care. We have gained some through the additional 28, as Andrew has mentioned. By the end of the rebuild we will have 121, essentially doubling the existing footprint.

Ms RATTRAY - Given that somebody mentioned that the existing model was opened in 2007 and had already reached capacity in 2010, and we are in 2023, how much future-proofing would this capacity deliver?

Dr SCOTT - The rebuild that was done separate to this project back in 2007 planned on 45 000 per year. That was reached in 2010. Back in 2017, planning occurred for this rebuild with a proposal coming away in 2021, and that was an entire new build. Currently, we are essentially in the old footprint, the old build, and this proposal is aimed at addressing need out to 2035, provided we have other improvements in patient processing in terms of access to sub-acute beds, district hospitals, NDIS funding, hospital avoidance programs and other things that address access-block.

Ms RATTRAY - There are still quite a few other arms to go into the whole structure to possibly meet future demand?

Dr SCOTT - A bigger emergency department alone will not fix the health needs of the Tasmanian public. They need ways of avoiding coming to the hospital in the first place. We have multiple initiatives currently under way to address those. Among those include telehealth, urgent care centres, increased primary care support, increased hospital in the home beds, geriatric in the home and mental health in the home. All these initiatives are looking at keeping people away from hospital or supporting people who would otherwise need to come to hospital out in the community. That addresses some of the flow coming into the hospital.

There is the emergency department that is the front door to the hospital, if you like, but we also need efficient means of having people leave the hospital and that traditionally in Tasmania has been very difficult, with the older population needing access to sub-acute beds, nursing home care, rehab beds and district hospital beds. Without fixing that exit or draining from the hospital, the larger ED will fill up.

Ms RATTRAY - I appreciate that further explanation.

CHAIR - I imagine staffing is an issue as well. What are we talking about and what increase in staffing would be needed to be able to cater for the new structure that you are building now to make it fully functional?

Dr SCOTT - Thank you for the question. Yes. I have recently returned from our national conference in Canberra last week and staffing is a problem across medical, allied health and nursing workforce in the health sphere nationally. I'm proud to say that we've achieved significant improvements in staffing. We had assistance from the Department of Health a year ago realising that the extra points-of-care were coming on board. We've doubled our registrar, which is the main workforce cohort, to 54 FTE next year up from 26 this year. We're full in the intern space and in the SRMO space. I'm actively recruiting specialists to act at the supervisor level. In nursing staffing, we've been benchmarked against increased presentations and we're fully recruited from a nursing perspective.

CHAIR - Who do you benchmark with?

Dr SCOTT - It's a national process. I'd probably take that on notice, but they look at how many presentations occur through the department per year and then allocate staffing based on the presentations, so we've gone through one of those cycles a few months ago and been able to recruit to those spaces based on 75 000 presentations per year. We are undergoing active training and you would have seen on our tour this morning a dedicated training space to bring those nurses and medical staff up to speed in terms of operating in more remote areas across the dual-storey ED staffing procedure rooms, resuscitation rooms -

CHAIR - So, you're fairly confident that once the build is complete that you will be able to make it fully functional with staff?

Dr SCOTT - Staffing remains challenging in the health sector. It is a difficult place to work and it's challenging for staff who work here. We are better off compared to many places on the mainland with our staffing next year and we propose to open 103 beds initially and then open further beds from the rebuild as the demand becomes apparent. That will allow us, with further releases of funds from the department, to actively recruit extra members as the need becomes apparent.

Ms BUTLER - A subsequent question to that, when you're talking about opening beds are you talking about opening beds within the hospital itself or within the ED?

Dr SCOTT - I'm sorry for the confusion. A simpler term would be a point-of-care, which is a treatment space. It may be a bed. It may be a reclining chair and that is where we can deliver care. There are certain requirements of that point-of-care. It needs to have oxygen nearby, power, medical suction. So when I'm talking about opening beds, I'm talking from an ED perspective and I'm talking about a point-of-care. We do need extra beds in the hospital, but we also need efficient drainage from the hospital's subacute sector.

CHAIR - Support services to support the bed, in effect.

Dr SCOTT - Correct. Yes.

Ms BUTLER - That goes to my next question. Once this project is complete, you will have double the capacity when it comes to those point-of-care sections. How do you envisage

tackling what you do with people from that ED as they are transitioned into the hospital? Otherwise you could end up with just an ED overflowing with people.

Dr SCOTT - Yes. Absolutely. That is a problem that is faced Australia-wide, where we have trouble accessing inpatient beds. We work collaboratively and closely with the integrated operation centre, so the patient flow people. We're aware of the pressures. We have meetings of the senior decision-makers across the hospital every morning, who are fully aware of the pressures on ED and working as hard as they can to improve flow out of the ED.

As mentioned previously, the main problem, the one thing to fix, would be the subacute beds, the nursing home beds, the rehab beds, and that would then create extra bed capacity within the hospital which would then allow those access-blocked patients who you saw this morning who were stuck in ED and they couldn't move to the hospital, have the care delivered over a six-day admission, whatever it might be, and then move on out. So, it's collaboration. We're well aware of the problem. We're trying to work ahead of it and we're trying to not only invest in initiatives that avoid people needing to come to hospital in the first place, but also improve the back end of processing to give people a safe place to go once their acute care episode is over.

CHAIR - Back in 2018, we had an acute health services inquiry. Some might remember it. We had an inquiry and we were introduced to a number of mechanisms that were applied in Queensland and other places. We were made aware of the Lean model and shown how successful that was. Has anything like that been attempted or considered for that alleviation of bed block, I suppose you might call it?

Mr DOCHERTY - If I may just start for you, there is another program called [inaudible] group. The [inaudible] group does embrace the [inaudible] methodologies, so that's how we've been rolling that out across some of our facilities and services. We're talking here about emergent demand, there are other elective plan demands. We do have a state-wide plan around elective surgery, digestive health and endoscopy, and of their outpatient improvement program as well. The emergency side of the build is also being -

CHAIR - Is one aspect-

Mr DOCHERTY - is being coupled with planned care improvements, as well. We've set up operational centres across our facilities. That's where the bed management and demand management happens. We have a state-wide plan around improving them, in terms of the systems and processes, to support and free up clinicians to look after patients.

CHAIR - Thanks for that.

Any other questions on this section? We could move on to the architectural response to the clinical need, highlights and design, et cetera. Are we happy to move on?

Mr LEE - As you all witnessed this morning, working on a [inaudible] and operating hospital site is challenging. Our team is made up of a team of local designers and engineers who are familiar with the site. They pair with one of our important JV partners from Melbourne who has experience in designing emergency departments.

We recognise that this emergency department is just not a healthcare facility, but also a place where lives are impacted and healing begins. Our approach works closely with the key stakeholders and our health planning experts, to plan a layout for an efficient flow of patients, staff, and emergency vehicles. Our design aligns with all AusHFG guidelines, the model of care, and adhering to the fundamental principles outlined by the health planning unit, also as outlined by AusHFG. We endeavour to implement the best practice in health planning and emergency department design.

Patient comfort lies at the centre of our consideration when it comes to designing the new emergency department. We believe that a hospital environment should be a place of comfort. To enhance the patient experience we are cautiously choosing materials that not only meet the highest standard in durability, infection control requirements, but also create warm and welcoming feelings. Soft colours, wood finishes, and comfortable furniture are centre in our consideration.

Clear signage and way-finding systems are important in emergency department design. We have thoughtfully integrated it to guide visitors through the space, prioritise the functionality and efficiency, reducing stress during critical moments for both patients and their loved ones.

As you witnessed this morning, in the subterranean space where access to natural light is limited and challenging, we placed strong emphasis on selections to maximise the use of available light. Our strategies include integration of artificial lighting and care for design of interior spaces, ensuring a well-lit, inviting environment, even in areas where access to natural daylight is so limited.

Recognising the wellbeing of the staff is vital to the success of running the facility. We work closely with the stakeholders, incorporating spaces and amenities dedicated to staff for relaxation, respite, and collaboration. Well-supported and comfortable staff contribute not only to a positive work environment, but also overall quality of care provided.

The new emergency department entrance is designed to prioritise the functionality and efficiency. The layout ensures the smooth flow of patients, staff, and emergency vehicles. The design for the emergency department entrance considers the surrounding urban fabric, aiming for seamless integration of the surrounding environment. The architectural expressions and materials chosen for the entrance harmonise with the surrounding context instead of competing with it, ensuring a cohesive appearance. Consideration is given to the scale, mass and proportion of the entrance, enhancing overall visual appeal of the urban landscape.

We also respect the indigenous culture of nipaluna/Hobart. Our design incorporates elements inspired by culture, stories, inclusivity and the natural environment such as artwork. In collaboration with the representatives of the Tasmanian Aboriginal Centre, these cultural elements are considered and will be built into the functional aspects of the entrance, the interior design and the material selection.

In conclusion, I think the design for the Royal Hobart Hospital Emergency Department combines functionality, cultural sensitivity and adherence to the highest standard of health planning principles.

CHAIR - Thank you. A question on the artificial lighting. Most things that happen these days seem to be in the LED space, but LED can be very cool and not very comforting. How are you managing to consider the tones for the different areas of operation of the emergency department? Warm lighting in maybe the paediatrics? Have you looked at that side of it? Can you talk us through any of the changes that you are making to make this a very pleasant place to not only work in but also for patients?

Mr LEE - As an overarching principle in lighting selection, warm tone lighting is more comforting from a patient perspective whereas in a work environment it needs to be well lit to a certain temperature. In most of the clinical space, the lighting is dimmable and they can change and enhance the intensity of the lighting. They are subject to the activities undertaken. For example, you might have a patient lying in the bed. Lights are dimmable when they need some rest and when they are doing an examination they can be intensified.

CHAIR - You can set each of the lights up to something from 6k down to 3?

Mr LEE - Yes, that is overarching and they all have the drivers to do that. In certain spaces like paediatric there is a paediatric lighting design principle. I will probably need to get back to you in the exact standard, but you need to keep children engaged and the lighting selection needs to be in sequencing. Things like that will be implemented in the final design.

CHAIR - And the mental health space in particular?

Mr LEE - Yes.

CHAIR - What are you doing there? Obviously, there are issues with the type of lighting that you might have there, strobing and those sorts of things. I have presumed that you have paid attention to that.

Mr LEE - It is definitely in the centre of our consideration. I wouldn't say we have the answer. We are working with a health planning expert and Dr Scott's team to look at the available selections and precedents and look at what's best for the projects. It is definitely an issue we will not overlook.

CHAIR - It is variable enough to cater for whatever the particular sensitivity the patient has, is that correct?

Dr SCOTT - The acute laydown spaces are zoned for whatever need may be required of that space. We do have an area that is sensitive to mental health patient design, however, that is also potentially used for acute laydown space for older persons, for example. Those considerations are taken into account to cater for both groups and work closely together.

CHAIR - You can adjust them accordingly.

Mr SCOTT - Yes. We have inspected other facilities such as the Vodafone Centre with very good lighting solutions for health spaces as well. That's been part of the journey.

CHAIR - Vodafone?

Mr LEE - No, it is called the Liverpool Street Clinics.

Dr SCOTT - I am sorry, Liverpool Street Clinics.

WITNESS - A lot of people call it Vodafone colloquially. The Liverpool Street Clinics. Level 7 is what Dr Scott would be referring to in particular.

CHAIR - Sorry, I am just trying to imagine the Vodafone call centre. I imagine that is not really what you are talking about.

Ms BUTLER - A question about the design. I picked up this morning that the current hospital layout or building is prone to leaks and sometimes flooding. Can you talk through how this design would ensure that doesn't happen?

Mr LEE - This design has acknowledged this ongoing leaking issue within a subterranean ED. Part of the contributing leaking problem is the ground floor space subject to weather. We are in-filling the ground-floor space, becoming internal spaces, as part of the build, and the slab design will have a better waterproofing technique and mitigation strategies to prevent that happening.

Another thing is, consciously, we are in-filling quite close to the retaining wall on Liverpool Street on the lower ground floor. These are responses to create a service corridor again, rather than build very close to it. The construction of that wall is a double-wall system. We also consulted the leading waterproofing contractor nationally to select the appropriate waterproofing system for that new wall. In front of that new wall there is a 2-metre-wide corridor that is not a patient care area, so in the event of any catastrophic failure there is a bit of a buffer to protect the Emergency Department.

CHAIR - A question I have, and it goes back to what I learnt when I was on the council, is that the sewerage line that comes from Cascades direction which also included the tannery and all sorts of things, so it had all sorts of nasties in it. Although I don't think it's quite that bad today, it goes right under the hospital. Are you aware of that? And what measures have been taken to make sure that if there was a catastrophic failure with the sewerage system, that you could handle that? Given that you have got generation equipment down there, you have got all sorts of things in that basement?

Mr LEE - The answer to your question, Chair, is we acknowledge that a critical sewer infrastructure running underneath the ED -

CHAIR - It goes to Macquarie Point, which is also a big issue for some other little projects that are going on around town.

Mr LEE - I think the process to that is we work with Hobart City Council to get a record of the existing sewer line. In addition to that, we also undertook a detailed CCTV survey. We understand where the line goes and where the line came from or linked to it. We are in the process of developing diversion strategies. But during the build there is a plan or strategy in place to protect this critical infrastructure and we will have multiple access points to maintain access and inspection of this sewer line.

Ms RATTRAY - I have got a question around the continuation of the function of the ED while these works - but are we not quite there yet?

CHAIR -We could do it now. We have got project budgets, stakeholder consultation and program, and a summary statement, so it may have been the earlier one but ask it now.

Ms RATTRAY - I'd like Mr Wood to go first because I've had a question.

Mr WOOD - My question was along those lines. Obviously, there is going to be a major upheaval to what is an incredibly busy and essential department in the hospital. What will be done to ensure patient comfort during that period? There is going to be a lot of noise, a lot of people moving around. What things are being organised to mitigate and ensure patient and, of course, staff care during the two-year project?

Dr SCOTT - Thank you for your question. I might start and perhaps we can have some architectural input after that. Firstly, a very good question. We acknowledge that this is going to be a very complex process to move through. We have been well aware of its complexity now for several years. Since I have taken on the role in the last 15 months, we are having multiple stakeholder meetings to future-plan for the best way to deliver emergency care to the Tasmanian public between now and the end of the rebuild. Involved in that are significant communication strategies.

There is also careful selection of where we place patients. We are doing our best to place the older, more vulnerable patients away from noisy building work such as jackhammering concrete and other things. People who have a shorter stay in the emergency department, such as a minor limb injury, will be closer to the building works at times. That seemed to be a reasonable stratification of the disruption and the impact of the noise, in particular.

For staff, it's going to be very challenging. We will require our staff to work across four different levels in the hospital. With our staffing model that has been supported by the Department of Health, we've planned ahead to get more orderlies, security guards and other staff members that will facilitate patient movements across those different areas.

Overall, moving forward from here, meeting with manager groups but also key stakeholder groups, looking at what the actual model of care delivery looks like in those different phases through the rebuild. Also,0 planning to deliver responses to events like mass casualty or major incident during those things, maintain fire evacuation pathways and processes for patients in different areas. These are all things that occupy a great deal of my thought process and will continue to for quite a while. But we are actively doing our best to get ahead of that and make a workable plan that will allow us to deliver high-quality care during the rebuild.

Ms RATTRAY - Supplementary question: is it fair to say that patient safety is the greatest risk that this project will have to face?

Dr SCOTT - It's a compromise. Patient safety already is significantly compromised by the ED we're working out of. It's not fit for purpose. Staff safety is compromised.

CHAIR - I think everyone would agree with that.

Dr SCOTT - Whilst we have challenges over the next few years while we move towards a much better solution, I think we'll manage. The challenges won't be any worse than they are currently, working out of the existing footprint.

Mr DOCHERTY - If I might just add, one part of the equation, of course, is safety. The other half is quality. The whole new build is focused on the quality, which is the outcome of clinical care for our patients. We can manage and mitigate the risk, absolutely, as we've described. But now the part is the benefit and return on investment would be around the quality of care being optimised and improved.

Ms RATTRAY - From where I come from, it's short-term pain for long-term gain.

CHAIR - That's fair enough.

Dr SCOTT - I'll just add in. I think there are some building design considerations that we'll do to protect patients from noise, dust ingress and infection control principles that we need to adhere to. That may involve building double walls, putting towers around dust-generating procedures, maintaining highest infection control measures that are needed in a hospital environment. That is all part of our planning as well.

Mr LEE - If I may, we will have the highest acoustic performance of the temporary construction hoarding. Dr Scott covered a lot about the coordination from the hospital side. I think one of the key aspects is also to maintain transparent and open communication with the contractors working on site, educating them that this is a live and operating hospital, making them aware of this as well.

CHAIR - Is it fair to say that this particular project, this upgrade, would be as complex as it comes for a hospital or not? Would moving the ICU be -

Ms BUTLER - It's normal, other states do this.

Mr HARGRAVE - It would be up there. Redevelopment of working hospitals is always complicated. It's not something that's unique to Tasmania. I was actually going to mention just when Mr Lee and Dr Scott finished speaking, that part of the reason, in my opening statement, I indicated when funding was first made available for the project. It has been staged and there are other parts of stage 2. But the reason it has taken us so long to get to where we are is the consideration of the staging and identification of the risk, and mitigating that risk through the build. How we plan that out and execute it is really important to the safe operation and maintenance of patient safety during the build.

There's a lot in the planning, I think is what I'm trying to say. That's why it has taken us so long to get where we are. Dr Scott has indicated the sorts of conversations and consultation that we've been having, not just in the hospital but with council and other consumers and those sorts of things. There's a lot of thinking and a lot of planning that goes into this project before you even start a procurement to build.

CHAIR - Looking at this, I totally appreciate it. I've had a bit to deal with project management over time and training in it and all the rest. But what you've got happening on that hospital site at the moment - isn't ICU in the process of moving? Or has that already

moved? And pharmacy is in the process of having upgrades. Are they all going to happen at the same time as this or are they staged so that they are not going to impact?

Mr HARGRAVE - Correct. A bit of both. The ICU is complete. We have had to move patients out of there recently because we had a roof leak, but we are resolving that.

CHAIR - As if you needed that.

Mr HARGRAVE - I know, it was rather unfortunate; but fortunately, we had capacity in the ICU to make that happen. When the ICU project - as part of stage - was completed, that added 12 beds to the ICU. It took us up to a total of 32 or thereabouts. When we had that storm event a number of weeks ago and we had a leak, we were quickly able to move patients in to another part of the ICU.

In relation to the pharmacy project, it ran on a different part of the hospital site, with establishment of the works and the housing of the workers in a completely different area of the hospital. But yes, that was very much a consideration and will continue to be a consideration given the time that will take to build the ED because, hopefully, we will bring online the A Block redevelopment as well. So, a lot of consideration given to concurrent projects and how that may affect the delivery of services in the hospital and also how you accommodate everybody and how people get to the site and move around the site. There is a lot of planning going in to that. A consultant is currently working with one of the other project managers in relation to planning out and strategising how all that will happen.

CHAIR - So, you've had higher-level concurrent timeline things happening to demonstrate what impacts are likely to happen where-

Mr HARGRAVE - Exactly. Basically, through our linear programming and scheduling. As part of our project governance we have those conversations with people like Brendan and others, like the chief executives of the hospital and clinical staff, to get their feedback on what might happen if we stage too many projects at once and what that means; and does it mean that we have to slow something down? Because if we bring on too many projects, that puts the provision of services and quality of services at risk - and that is a massive consideration.

CHAIR - You can be satisfied that on this side of the table we understand how complex it is. All power to you in achieving, it if these projects get up.

Ms RATTRAY - Do you see any issues with workforce availability? Not for the hospital itself but for undertaking the works, given that you have got so many balls in the air?

Mr HARGRAVE - It is a good question. There is an ongoing shortage of capacity. If I go back a step, the Tasmanian building and construction industry is small. There is a small number of players that would take on this sort of work or have the capability to take on this kind of work. That's the first thing. Secondly, nationwide there is a shortage of specialist trades -whether they be carpenters and joiners, electricians, plumbers, plasterers. We are seeing all of that in Tasmania but more broadly across the country, we are seeing those sorts of shortages as well. Yes, it is a consideration. When we approach the market, it is often something, particularly in relation to pricing, that lead contractors are very keen to secure a contract because their subcontractors are only prepared to provide pricing for 30 days - our

tender validity periods are normally 90 days - because of that shortage. There are often concerns that their subtrades will -

Ms RATTRAY - Go off and do something else.

Mr HARGRAVE - Exactly.

Ms RATTRAY - Good luck with that.

Mr HARGRAVE - We try not to hit the market all at once, for that reason as well.

CHAIR - It is certainly a thing for any major project in Tasmania, let alone something as complex as this.

Ms BUTLER - I don't want to ruin any of the potential tendering process and I understand this is a public meeting. There would be a level of expertise within some of those building firms, I assume, with some of the work that has already been undertaken around the state with different hospitals and medical facilities. So, is that expertise here in the state already to be able to tender for some of these jobs?

Mr HARGRAVE - I'll get Mark the project manager to chip in a bit here but-

Ms BUTLER - Because we love a 'spend local'.

Mr HARGRAVE - I will let Mark elaborate, but absolutely. And we have seen that with the stages of the RHH - stage 2 of that we have already delivered. Not just the RHH, also work that we have done in Launceston General Hospital, work we are doing at the Mersey Community Hospital.

Ms BUTLER - St. Helens?

Mr HARGRAVE - Yes. Lots of things, the Peacock Centre that we opened earlier this year. There are a number of key players that are focused in particular provision of health building construction services, and I can say without reservation, the quality of their work is excellent. Local companies too.

Mr LEIS - Certainly, through this first phase, Hansen Yuncken have done that to an excellent standard, and the hospital does have very high standards with infection control. Likewise, all the services internally, like fire management - it is an extensive process to make sure that the hospital is maintained as a safe space. Hansen Yuncken is owned in Adelaide, but they have a local contingent here of around 40 staff, as well as all the subcontractors are predominantly local people. Likewise, there is Fairbrother group, Voss group, and Hutchinson Builders. They are national as well but are building their local presence, so we are certainly hopeful and we are considering the fact that it will be a large package of work we hope to bring to market next year.

CHAIR - Also desirable in the sense that some of those firms will be able to gain experience in that area, so you should get some reasonable quotes.

Mr HARGRAVE - To add there, chair, they see a lot of benefit in it as well, particularly from a training and development of their staff and apprenticeships. There are lots of benefits. They are all very busy, as we have indicated, but they are also very much targeting health projects.

Ms BUTLER - I imagine it would make it so much easier being project manager with a building firm that already understands the culture, already understands that specialist nature of trying to rebuild in a project in a hospital site -

Mr HARGRAVE - In a brownfield site.

Ms BUTLER - Yes, in that setting where it has to be quietly and methodically done and the project has to be very streamlined to fit in with such a busy ED area. That won't be an easy fit.

Mr HARGRAVE - No, and the hospital build is esoteric in its nature and it's very different to building a set of apartment blocks or a commercial development. So, the contractors that deliver this work for us do have a specialist skill and they particularly understand the infection prevention control side of working in a hospital.

CHAIR - But the services side must be huge.

Mr HARGRAVE - Building services or?

CHAIR - The services in the building.

Mr HARGRAVE - It's huge. Hanz could speak more to that.

CHAIR - All the fire management and electrical works.

Mr HARGRAVE - HVAC, medical gases, water, sewer-

CHAIR - You name it.

Mr LEE - Certainly quite a few new consultants.

Ms RATTRAY - It's amazing where water just manages to get through isn’t it.

Ms BUTLER - A question around the air filtration services. It was an interesting part of the first aspect of our tour this morning, talking about the negative and the positive filtration systems. If you could run us through what you envision for this project?

Mr LEE - I'll start. With phase one - the 28 short stay units - they have what we call a negative flow. In the simplistic view, if you stay in a closed space, the germs and the viruses will stay within the room and won't get through the corridor and all the HVAC systems have vertical HEPA filter which is a finer filtering system, so they won't get into the main HVAC system and connect to the other hospital departments.

CHAIR - Low pressure and then vented externally?

Mr LEE - Yes, the 20 SSU have 100 per cent outdoor air; but in the subterranean - in the new ED - we are currently exploring a hybrid system just because it is subterranean and it is challenging to bring in 100 per cent outdoor air into that presence but we are working with the ED team to see how we can navigate through that and also to ensure the safety of the patients and try to follow that principle.

Dr SCOTT - The previous build - the current footprint we are in - back in 2007 was also built to AusHFG standards, which at that time didn't pay attention to how we move air through the department. What we found was air was leaving the patient cubicle and being recirculated through the roof space and then coming down onto the staff areas. That obviously runs the risk of staff illness and absenteeism as well as increased transmission risks for patients. In the overall design of the proposed rebuild, the cubicles will have a negative flow so air comes in the cubicle and leaves the cubicle and leaves the space and may or may not go through a viral filtration system. In addition to that we've got some high-end negative pressure rooms for highly transmissible infections such as measles or other diseases like that which need a higher level of protection from staff and having air mixing in a common space.

CHAIR - So how does that exit? Does that exit through the filter system as well which ensures that it's not going to fall out on people in the public domain?

Dr SCOTT - There's possibly a better place but on top of the helipad there's a number of chimneys that push air, for want of a better word, stacks -

CHAIR - So they're sufficiently elevated as to not be a problem.

Dr SCOTT - Yes, that air is treated as special air that should not mix again in a common space.

Mr HARGRAVE - Some of them at least have HEPA (high-efficiency particulate absorbing) filtration.

Dr SCOTT - Yes, they do.

CHAIR - That's okay, I just imagine a chopper coming in a disturbing it and pushing it around to everybody. That would be great.

Dr SCOTT - I will just add that the single rooms with doors - on the rooms that we're able to put doors on - also significantly decrease, from what we can tell, patient-to-patient transmission and outbreaks of COVID-19. In the older footprint of the hospital - A Block - we've had a lot of ward-based transmission of infectious disease. In the newer build - K Block - we've built to current standards and we've found that COVID-19 isn't getting transmitted from patient to patient or patient to staff in anywhere near as high numbers so the new standard will protect patients and staff.

CHAIR - Did you say something about having positive pressure rooms as well?

Dr SCOTT - No, probably negative pressure. You don't want to push air out.

CHAIR - I was going to say, unless you are seen as someone who's totally sensitive to anything, you're not wanting air to come from outside into the room space.

Dr SCOTT - The standard would be negative flow for most rooms which we have and then negative pressure for a small number of rooms, including the resuscitation bay, which we have as well.

CHAIR - So, the resuscitation bays, you were saying at the moment are very small compared to what they're supposed to be, and so in the new builds we're talking an extra metre or two?

Dr SCOTT - Near on an extra metre in x and y axes for both rooms, so that would add another eight square metres or so, or 10 square metres, roughly. We also have a larger trauma resuscitation bay that allows us to accommodate large pieces of equipment such as portable special X-ray machines, rapid blood transfusion, that's a 36 square metre bay which will allow attendance of large trauma teams for critically injured people and would be in line with other resuscitation bays on the mainland.

CHAIR - Another aspect from an architectural perspective, I suppose, is bariatric patients. How's that being improved, for the record?

Dr SCOTT - We have dedicated areas for bariatric ambulance vehicles to park, we have measured doors, turning circles, corridor width and entry points to the cubicles to accommodate the larger stretchers from both ambulance perspective and the hospital perspective. The original project bid and model of care has in-floor scales for weighing patients and we've also got a bariatric heavy lift in one of the resus bays proposed, as well as other bariatric features downstairs in acute areas -

CHAIR - So, the ambulance itself has lifting capacity?

Dr SCOTT - The ambulance has quite a good system for moving heavier people from the pre-hospital environment that usually involves hover mats and slides and sometimes we need the fire brigade as well. I'm talking from my experience in pre-hospital environment as well as a doctor who worked with the ambulance service for five years. From our perspective we have our own equipment but we can also use and do use at times ambulance and, if need be, fire brigade to help with things but the build would have our own capability to match these patients in a respectful and dignified way.

CHAIR - Excellent. Anyone else have any questions in relation to the building spaces?

Ms RATTRAY - I have a question. We already talked about the consultation or the working with outside entities like the Hobart City Council and the Department of State Growth. It would be interesting to put on the record around the changes in the traffic management for the entrance. I don't know who would like to do that but I think it's important that there's that communication and conversation happening because there will be significant change in traffic management.

Mr LEIS - Yes, there certainly will.

Ms RATTRAY - There's a GHD report?

Mr LEIS - Yes. We've had GHD on board as specific consultants addressing the traffic flow around the site as well as how it will impact the site. So, I think we would have gone through at least half a dozen designs with the team and with Ambulance Tasmania to determine the best way to exit the site. GHD's experience with the Geelong site that has been recently done whereby ambulances can essentially trigger a change in the lights, that's the current proposed solution. We have yet to fully consult with DSG on that, Department State Growth. We obviously need to move through the Hobart City Council for a start. They're considering that as we speak. There are other aspects of it in the transition as well that we've worked on with our design as well as internal surveys of understanding how people use the site. Our design has accommodated that within it.

Ms RATTRAY - So, if there's an issue being able to receive the appropriate compliance, I guess, with the Department of State Growth and the Hobart City Council, does that impede the project in any way if there is a 'no' or a pushback or - I'm just interested in what happens, particularly when it's talking about the entry to the emergency department.

CHAIR - Is it a show stopper in other words?

Ms RATTRAY - That could be a way to put it.

Mr HARGRAVE - No. We would work with the planning authority to understand their concerns. There might need to be some modifications to the design or how it operates but that's consistent with projects that we work on with our partners both in council and other state government agencies. I wouldn't envisage that it would be a 'show stopper'. It might just be that we need to work through some concerns with whoever it is, whether it's State Growth or with council or both, to resolve them and incorporate those changes into the design. I wouldn't foresee that it would be a show stopper.

Ms RATTRAY - But the issue is, once that the design goes out to tender, and then if you are still trying to negotiate with Hobart City Council, would you do that before you put this out?

Mr HARGRAVE - A development application would need to be submitted and approved well before. Ideally, we would have done that well before we went to tender. It doesn’t always happen that way but that's what we'd seek to do.

Ms RATTRAY - We might have a look at the time lines.

Mr LEIS - Certainly, within this one and what we've allowed for within the time lines allows for that consultation and DA period with council as well as DSG and we wouldn't go to tender without those key stakeholders on board - in this case because it is a critical aspect of how it works.

Ms RATTRAY - So, it is a show stopper?

Mr LEIS - We have six other designs that are less favourable, I suppose.

Mr HARGRAVE - Our partners are very good. We work with them and take on -

Ms RATTRAY - But sometimes there is a delay in receiving the appropriate levels of go-ahead and that can affect the price.

Mr HARGRAVE - Possibly, it more likely affects the time line for you to start delivery.

Ms RATTRAY - Which then affects the price or can do?

Mr HARGRAVE - Possibly, it can do. The variable of price relies on lots of things; market conditions, does someone have an opening in their workbook. So it may do, depending on the scale of the modification to the design. If it pushes something out by a couple of weeks, you'd probably say it's not really going to affect us that much; but if it's going to push things out for six months, that's a big concern to us. Price is very important and we have an obligation to make sure that we drive value for money for the taxpayer. Also, as you kick delivery down the road, it is potentially six months further until you can commission the site.

We are trying to deliver it as effectively and safely as we possibly can to make sure the timeline for the operationalisation or commissioning of the site is as short as we can make it.

Ms BUTLER - Further to that, for the record, could you run through what that traffic management plan will be for Liverpool Street and Campbell Street? There are traffic lights there and on Liverpool Street and Argyle Street. The traffic flow around those areas. There's also the pedestrian access points, ambulance access and exit points and also the passenger drop-off section as well. There's a lot in that.

Mr LEIS - Each of those aspects has been done within the plan. Starting from the Campbell Street side, Campbell and Liverpool Street. If we look at delivery of the ambulances in from there, as we experienced today, the lights go on if they need to urgently cross into the current subterranean space. In the future, they will be at street level and have access to their area there.

Public can drive along there as well but we will look at a number of different aspects of signage and wayfinding to assist people with navigating that area, because there is drop-off in that area for the Holman Clinic and less-able people.

Ms BUTLER - Or someone's wife is having a baby and they need to drop them off at the front - that kind of emergency situation.

Mr LEIS - Yes, out the front for the emergency is then farther down Liverpool Street at the Argyle Street end. Again, signage will be a critical aspect of that.

Ms BUTLER - So, there are two?

Mr LEIS - There is one main entry on the design as it is at the moment. Both the ambulance as well as public drop-off will be going along the front parallel with Liverpool Street.

CHAIR - They are separate entrances for ambulance and for public?

Mr LEIS - They are not separate entrances in this design.

CHAIR - The way it happens at the moment, where you have the ambulance going into a corridor to the left of the emergency, if you are looking at it from the outside, the main public entry there-

Dr SCOTT - May I clarify. There is one vehicular access point which is used by both ambulance and members of the public. There are separate entrances for ambulance patients and walk-in general public entrance into the building.

Mr HARGRAVE - Page 15 of the report gives a schematic render of what it would look like.

Mr LEIS - Vehicular access will not be dissimilar to what it is currently, in that public go down underground as well. That will be the same up at ground level and it will be easier to see. We are working on better signage for it to make it very clear where you have to go.

CHAIR - When ambulances are backing in to their space, because that is what they are going to do - do they go anywhere near the footpath that is out the front or is that quite a distance?

Mr LEIS - Quite a distance for the footpath. The footpath as you currently see on the side here is up against the buildings. It will be effectively out on the street where the current row of trees is.

CHAIR - So, that is the edge - the edge will be where the trees are and then come in from that.

Mr LEIS - There's actually a hump in Liverpool Street - it is about 400 millimetres high to what the flat level will be across on the ED at the moment. It's caused us a few challenges in engineering but that clearly creates a delineation between what will be vehicular space and what is pedestrian; and then the new bike lane that will go in and the remaining two lanes of traffic for Liverpool Street.

CHAIR - They are quite separate, which is good to know.

Ms BUTLER - So, pedestrian access and pedestrian crossing - what will that look like?

Mr LEIS - I will take you from the other angle where most of the pedestrian traffic comes from, which is obviously closer in to the city and the mall area and where the carparks are on Argyle Street. That will will come along Liverpool Street, and then there is a pedestrian crossing of the traffic to get back into the hospital. But we will be working through a communication plan for anybody who is a visitor using the Campbell Street access, which is the front access to the hospital.

CHAIR - That's good. Another aspect from the architectural perspective is the EMU - the emergency medical unit: Is anything further being done to that, or is that as it is at the moment? We went in there today. What's going to change in its physical nature, for the record?

Mr LEIS - As part of phase one, we have set that up so it can accommodate when the ED in J Block pivots across to H Block. It's been set up ready for that. There are a few minor

changes that need to be tweaked - provide drug room storage and a few other aspects to accommodate the transition plan - and then after the transition has occurred, there are a few minor tweaks to have that back to an EMU.

CHAIR - The separated airflow and the no-touch doors, they're already there?

Mr LEIS - Correct, and that's the way we designed that to get the uplift in capacity for a start, and then be able to maintain and pivot through this transition period. I think the best way to describe the transition period, further to what my colleagues have said, is it's a combination of Tetris and Jenga, which we've been enjoying across the last period.

CHAIR - That's probably not a bad analogy. The period of transition is just a matter of couple of days, you were saying, to go from one site to the other?

Mr LEIS - Yes, that's the actual transfer of care, which Dr Scott's team will handle. The planning that goes into the back end of that, we've got numerous spreadsheets that have mapped out a period of months to execute that couple-of-day transition-

CHAIR - No doubt. It's got a lot involved.

Mr LEIS - We had a good practice at that with phase one as an easier run-in; this one will be quite a bit more complex. What you don't see in there is actually how much data and ICT goes into the back of that, which I've been quite surprised at, so we've got another meeting tomorrow-

CHAIR - I know about that.

Mr LEIS - We're working through the next level of detail on our spreadsheets of how both the ICT, the build ability as well as then the operational aspect, is going. That will continue to be the case and we'll literally get down to minutes at the end of the day when we do that transition so that we're comfortable with any security-

CHAIR - Was there any thought of the dummy run of any sort to make sure it's all going to work?

Dr SCOTT - I might talk to that. The commissioning of the 28 point-of-care EMU in January this year was, in fact, a dummy run. We set in place strategies ahead of that. Many of those strategies required multiple months lead-in time, which included creation of IT-based map systems for patient tracking - these things take a long time; communication with hospital-wide care teams who may need to come to the emergency department to see patients; as well as communication with the public in terms of how to access both the emergency department and other areas.

We didn't get it perfectly right in January, but we've learnt from essentially operationalising that area in January. That will make us better, more capable to open the other areas.

CHAIR - When I worked there in ICT over a 20-year period, I know that there was more than one occasion where the hospital planned various moves and simply hadn't talked to the

ICT people. I'm assuming that that's not the case in this? You've got good communications going, things like server rooms if they're involved?

Mr LEIS - We had a little tweak the other day because the server rooms weren't quite working together and the clinical team had to have a little bit of adjustment to make sure we optimised that ICT outcome that both maintain cost but would deliver a better service. For size, you might say why is there such a big footprint? Well, all of the machines these days are data-driven and require that higher level of quality for it. Sitting in the middle of the plans that you have is, effectively, four full racks of data right to the roof, with all of the ports out running both downstairs and upstairs and then appropriately backed up and supported.

CHAIR - Will those racks be moved to a different site or do they stay put?

Mr LEE - I think they are four new racks that will be specifically procured, prepared for the new ED commission. The location of the new comms room is on the ground floor. Again, the location of it is heavily considered to optimise its functionality and also value for money. It is not a cheap piece of equipment and the location of it has been considered and worked with the team a lot. What Mark said earlier was that we take some concession from the clinical space but look at the bigger picture: It is enabling the functionality of the ED and a better spend of money.

CHAIR - If it does not work, you don't work.

Mr LEIS - There is a separate comms room that runs the EMU as well.

Ms BUTLER - That would be water-tight, the comms room?

Mr LEIS - It is water-tight. We put a little [inaudible 2.41.39] down the bottom and it has got everything, don't you worry.

Mr HARGRAVE - I can show you some very funny photos about that.

Mr LEIS - Is that right?

Ms BUTLER - How many comm rooms do you have across the site?

Mr LEE - The hospital ICT policy is that each building aims to have its own comms room. That is from a maintenance perspective. So, the J block will have one main comms room and H block, as Mark was saying, there's already a comms room in place. And there is an A block comms room already existing. As part of this project, they require a couple of upgrades for the existing comms room but we are building a brand-new comms room just to support the main ED building.

Mr LEIS - This footprint, just for ED, will have three comms rooms. The rest of the hospital, each of the areas, effectively, has its own, floor by floor as a general rule, or where able, over two floors.

Ms BUTLER - Have you been able to find that technical expertise here for that work, without giving away any of your tendering? It is hard to find those people.

Mr HARGRAVE - Yes. Health ICT is one of our key project stakeholders. They have been very much involved in this project. I can't speak specifically around their contractors and who they have had involved but, generally, they have sourced competent and capable people in a timely manner.

Mr LEIS - They have brought a new person on for this project, given the complexity of it. They are augmenting other resources that are doing quite a few other infrastructure upgrades at the moment. But she has been great in terms of helping us understand and work through the detailed planning. So, very much understand that it needs all of us to work together well to deliver it.

CHAIR - What about other third-party systems like Honeywell stuff and all the rest that might be onsite that is not Health department's ICT people?

Mr LEIS - Yes, Honeywell is a key aspect to that. More recently, as well, there is a security risk assessment that we are working through at the moment. Our site is a critical infrastructure item. That has been a new thing recently that we have got a consultant on board to help us deliver the aspects of both physical and infrastructure security. We've got plenty of these people helping us get it right.

Ms RATTRAY - I am intently listening to this because I am not sure who is going to pick up the IT baton after May next year. Mr Wood, Ms Butler, you are intently listening.

CHAIR - Okay, project budget stakeholder consultation program.

Mr LEIS - I may just speak to the consultation side of things. We have RPS on board now, a national stakeholder specialist consulting group.

Ms RATTRAY - That is their name, RPS?

Mr LEIS - That is their name, RPS Consulting. We've had them on other projects and they are helping us complete a stakeholder and community consultation program. We've already done a large level of consultation both within the department and within the areas that need to work in this project. But we are certainly taking that to the next level as we move through this project because, obviously, we will impact the way the community will need to interact with the site, especially through the transition period. And then, ultimately, to how they use the site afterwards. That will be a key piece that we are working on at the moment to make sure that we absolutely get it right.

CHAIR - Your stakeholder meetings, quite clearly from the diagram on page 26, there is a fair bit, although it is very difficult to read.

Ms BUTLER - Didn't photocopy that well.

CHAIR - We have the health executive, the infrastructure oversight committee, the project steering committee, the project team, the project reference group, clinical and consumer stakeholders -

Ms RATTRAY - And the football.

CHAIR - strategic planning and performance unit -

Mr LEIS - That's us.

Ms RATTRAY - You are the football?

Mr LEIS - Yes.

Ms RATTRAY - You are the ones that get kicked about.

Mr LEIS - Yes. That's the way we like it.

CHAIR - clinical reference group. You've got all the bases pretty well covered there. And organisational strategic plans and health service plans feeding backwards and forwards into that.

Mr LEIS - It has been good having a close look at that. We have found lots of other bodies -

CHAIR - Live ones, I hope.

Mr LEIS - Dr Scott would know them well but I didn't know they existed, which is the non-emergency patient transfer people. Through the work that we are doing, we find these groups to make sure that we are talking to them and are considering the way they interact with the site. It really is quite surprising at times.

CHAIR - The stakeholder list is a couple of pages long or more.

Mr LEIS - I'd imagine the SCEP, which is your stakeholder engagement report, will be quite lengthy but it is an important part of the success of this project. We are certainly moving the framework of town around as well as the Royal.

Ms RATTRAY - Must be reasonably successful thus far because we are only in receipt of one submission, which is yours.

CHAIR - We haven't got our stakeholders coming in saying we need to talk with these people because they haven't got it worked out.

Ms RATTRAY - We often hear from stakeholders, through references, that there has been a lack of consultation.

CHAIR - It is an opportunity for the public to come in and talk to us and they do on some projects, certainly roads projects.

Mr HARGRAVE - They certainly did when we had our steering committee for the Burnie ambulance station.

CHAIR - Yes, they did. An interesting one, that.

Ms RATTRAY - And the Burnie court.

Mr HARGRAVE - Obviously, I was not at that one but I have fond memories of the Burnie ambulance station.

CHAIR - Yes, it was interesting. So, we are not going to hear after the event that there is a major part that has gone wrong here because someone did not consult?

Mr HARGRAVE - Mark mentioned what we call the SCEP, or the stakeholder communication engagement plan. We do these for all of our projects now; we have stakeholder engagement as a key part of the project team. What we find is that the model of engaging early and often actually helps inform the design and project's success because you are identifying and consulting and listening to those people who are your key stakeholders. It works.

Ms RATTRAY - Music to our ears.

CHAIR - Looking at your figures -

Ms RATTRAY - Do they add up, Chair? That is your job.

CHAIR - They do. I have been through them, the construction costs and the contingencies. In the contingencies you have design, construction, escalation and market. Market is an interesting one. It is 36.2 per cent. Usually for a contingency we would see 10 per cent or maybe 15 per cent, but this includes escalation and you are putting in 36.2 per cent. Is this because it is over a two-year period, therefore, a lot is going to happen in that period of time? How have you arrived at that 36.2 per cent?

Mr HARGRAVE - I'll let Hanz talk a little bit to this but it is significant at the moment and a lot of that is to do with where we are in the development of the design. We've got a concept design at the moment and that design and this estimate - and I note that the contingencies are high - informs our business case to our project sponsor that sits within this governance over here. As we move into subsequent stages of the design, we should be able to firm up or remove risk that we've priced or made allowance for in the contingency. As we move through that there's hopefully an opportunity to get a better feel or reduction of that contingency.

CHAIR - Some might say you're a bit premature here before you get that sign-off from your major, why this time, why this structure?

Mr HARGRAVE - We believed that we had enough information to inform a referral and getting a date for these can be difficult. We wanted to be able to come and present to you on the basis of the information that we've got now with a view that once we've had this hearing and subject to the determination of the committee, we can continue to roll on into the design and hopefully call tenders early, or I think we're saying the middle of next year, we're hoping to be able to go to the market.

You're right, the contingency is a bit higher than you'd normally allow and there is a bit of uncertainty in the market as well. We've seen a lot of cost escalation. We've been seeing it in our project and we've also been observing it -

CHAIR - Because of a glut of work?

Mr HARGRAVE - Yes, demand is high. There are still some supply chain issues as a result of COVID-19, so logistics remain a problem, but mainly because everybody's busy. If you're lucky, you get someone who has a gap in their workbook and they really want the work. If you're not so lucky, you get one tenderer only and they know they're the one tenderer. We have to try to work through that.

Ms RATTRAY - How do they know they're the one tenderer?

Mr HARGRAVE - They guess.

Ms BUTLER - Maybe they all met for beers on a Friday night and talk about this.

Mr HARGRAVE - I wouldn't suggest that they collude but the market's small in Tasmania and people have a good understanding of who's doing what.

Mr LEE - If I may add, chair, the contingency was developed in consultation with a professional quantity surveyor. I think we lean on his expertise. He's not only involved in one sector of work but also across multiple sectors, for instance education, health care, major infrastructure and private development as well, so -

CHAIR - You've got to understand that we see all of those types of projects and we see schools. We always use this of late: the Brighton High School, which was $39 million and then ended up being $70-something million. Quantity surveyors were involved in all cases. That's probably about that same distance out when it first commenced construction I think. So, I'm thinking to myself 'are we going to see this end up at $300 million rather than $149 million?' If it did, by the time you got to putting a spade in the ground or putting a crowbar into a wall, would this be, sorry we can't do this? Is there room to pull this project if it's way overpriced or not?

Mr HARGRAVE - Yes, absolutely, part of the tender evaluation process is this value-for-money test that we have to put over the tender evaluation.

CHAIR - That's the question you'll get at the end of this too.

Mr HARGRAVE - If we received tender prices or a tendered price that was significantly above, double, as you've indicated, we would have to withdraw the tender. It would be very hard to demonstrate value for money, I think, if you received a tender at $300 million.

CHAIR - It's an interesting thing isn't it because we're talking about lives being involved in this.

Ms RATTRAY - And how is Dr Scott going to tell his staff that there will be no new staff room?

CHAIR - It's not likely.

Dr SCOTT - Yes, well I'm sure Andrew and I would have some conversations because we've got a department that's not serving the needs of the Tasmanian public currently and the alternative is many years away if this project didn't get up. But I completely understand we

need realistic costs. If you go back to a drawing board greenfield site, we are looking at 10 - 15 years before we deliver a product rather than two, and we are already struggling.

Ms RATTRAY - I think the greenfield sites might be taken up, earmarked elsewhere.

CHAIR - I think we were talking about the greenfield site earlier and saying -

Ms RATTRAY - I am still talking about them, 15 years on.

CHAIR - even if the greenfield site did happen, it probably would have been being rejigged now because of the capacity issues.

Ms RATTRAY - and new compliance requirements as well, new standards -

Mr HARGRAVE - The Australasian Health Facility Guidelines - AusHFG.

CHAIR - Your post-occupancy allowance is clearly to do with new furniture and equipment and all the rest of it, professional fees and authority fees, ICT, you have got $2 million.

Ms RATTRAY - It is pretty standard, it seems to always be about that doesn't it?

CHAIR - Well it's 2.09 per cent. Tasmanian Art Scheme, just for the record, what are you expecting to do there, small as it is?

Mr LEE - They are work-in-progress ideas and they will be considered in a bit more publicly accessible area like maybe the first arrival point through the entrance, the waiting area. The detail of that is still a work in progress but we have made allowances in the design for that to happen because it acknowledges a piece of critical public infrastructure and deserves a place for public art as well.

Ms RATTRAY - Supplementary to that one, which is always of interest to me, some of the mural artwork that has already been established throughout the newer redeveloped sections, they are lovely pictures and they are good for wiping over and the rest we learnt, but there isn't any title on them. We don't actually know where they are unless we possibly are very close Tasmanian to that area. If you are going to go down that track, I suggest that it would be a good idea to just name them up.

Mr LEE - That definitely is a very good comment and a lesson learnt. I should mention that the artwork will be procured through the government public art protocol and will solely focus on Tasmanian artists and themes.

Ms RATTRAY - We certainly like to see the local Tasmanian artists rewarded in that way.

Mr LEE - So do we.

CHAIR - An opportunity for them and possibly indigenous art, whatever. You've got post-occupancy allowance and furniture and equipment. One is $7.5 million and the other is

$855 900. What's the difference between post-occupancy allowance compared to furniture and equipment? What's included in both of those?

Mr LEIS - The post-occupancy allowance is the transition work, so it's actually allowing for the services to help us basically move the ED around into its transition as well as at the end of the project. There will be two parts to the end of the project, in that we are doing work on H Block North to enable the temporary ED and then we will move back out of that and we will need to finish off that, being the paediatric area, at the end.

CHAIR - It says post-occupancy; in other words, after you have you moved in - .

Mr HARGRAVE - It's a misnomer.

Ms RATTRAY - Perhaps 'post' should come out.

CHAIR - Occupancy allowance. Sorry I'm Mr Pedantic here.

Mr LEIS - It may be a better way to describe it.

CHAIR - That's okay, I'm just querying it .

Ms BUTLER - Do you mean like that transition time back to the EMU when you, say, were having to put in those en suites and I think you were talking about some reconfiguration work, so that would be what that occupancy allowance comes under?

Mr LEIS - Yes, any of those little tweaks for we might have got it wrong or have to make adjustments, as well as salaries for moving, the additional cleaning. There are lots of little parts that go into making that happen. It is effectively a contingency to finish off all those little bits.

Ms BUTLER - The actual moving of a lot of the specialised medical equipment as well, I suppose that would be quite expensive and an expert would have to do that work, I imagine?

Mr LEIS - Correct. We have the biomedical group that works at the Royal that basically has to unplug all of that, replug it in, and do the appropriate testing. The infection prevention control cleans are quite extensive and expensive, as well, to get us to the level we need when we first move in; as well as once everything's moved in cleaning again, to maintain the standard.

Ms BUTLER - It's not really like unplugging a television and just putting it in a different socket somewhere else.

Mr LEIS - It would be great if it was that easy, but it's not.

CHAIR - We've probably captured most of that - unless others have got any questions on the costs and so on? We've covered consultation. Does anyone else have any other questions on the way through before they sum up?

Ms RATTRAY - I think Mr Wood has a question around the time frames?

Mr WOOD - Only that in page 28 - completion of design development December 2023 - I think you mentioned earlier it was still in draft?

Mr LEIS - That's a phased, detailed design. Once we've got to that point we then have to go into production of the tender documents once we've signed-off that design. Hans has promised me that the documentation will all be done at that point so we can go through our approval cycles. Then there's another period of finishing off all of the details before we have the tender package to go to the market to get the pricing.

Mr HARGRAVE - If I can add - we are lagging on that milestone. That might be what you have been getting at, Mr Wood - that one's lagging a little bit, so we will need to try and accelerate that.

Ms RATTRAY - So, these may not be the final design?

Mr LEE - No, the current state of the documentation is more advanced than what we have submitted and we as a leader, the whole consultant team, we're working tirelessly to achieve this target. It's our first priority.

Ms RATTRAY - But the products that are going to be used are still going to be this similar type of product?

Mr LEE - It will be within that allowance, yes.

Ms RATTRAY - A lot concrete.

Mr LEE - It's a work in progress. Again, that's for the purpose of architectural expression. When we come to detailed design there's another process we are undertaking behind the scenes, from a build-ability perspective, whether it's feasible to do that. Again, this is a test whether [Unclear 3:02:44] - is concrete the best use of public money to do this? Is there a better alternative to achieve the same experience, durability and practicality? All that will be developed under the design-development phase.

CHAIR - Going back to one of the initial questions. After you get all of this, you've got an amazingly efficient operating area for emergency management; but if the rest of the hospital is not prepared to take your patients, you've still got that capacity to fill up, in terms of 'plan B'?

Dr SCOTT - There are multiple reviews that you are probably aware of. There is an emergency department review which is erroneously named; it's a whole-of-system review. It looks at -

CHAIR - Erroneously named?

Dr SCOTT - In my opinion. We've heard from the review people that it is looking at the entire system, not just the emergency department. You are looking at the inflow into emergency - hospital avoidance; increased community support; you are looking at the outflow. We are close to getting some recommendations from that review. There's also the transfer-of-care review that is occurring at the moment, looking at ambulance off-load delay, and the reviews from that will be important as well. There's now widespread recognition that this isn't

about emergency departments; it's about the systems and processes set up before you get to hospital, and while you are in hospital, and while you are out of hospital.

CHAIR - Preventative health.

Dr SCOTT - Correct. The appetite across the Department of Health is the recognition that it is not about just building a bigger emergency department - it is addressing all those other areas of need. I am extremely hopeful I do not need a 'plan B'.

CHAIR - That's good. I'm glad you've got confidence; that's important.

Ms BUTLER - I have a question about the triage bays - how many will there be, and what there is currently, and how this will improve that? Because that is the most high-risk area isn't it, as people are coming in: how are they triaged and how they will be triaged? You went through that with us in the tour and I found that was an important change to how the emergency department will operate. It would be good to have that on the record.

Dr SCOTT - The triage event is where a patient arrives at the emergency department and has a brief interaction with a triage-trained nurse, who within two or three minutes decides what treatment category they should receive. In addition to that, they have an interaction with a clerical staff member who checks their identification and lodges their details appropriately.

At the moment, we have two nurse desks, two triage desks and one separate ambulance triage desk. The new rebuild will have nine desks total - six desks facing the walk-in members of public and three specific for ambulance, but cross-capability between those. So, if ambulances weren't there we could have up to 9 triage stations which could be used by either the nurses or the clerical staff members to deal with walk-in people. It's essentially a doubling of capability, and our projections would be that would be adequate out to 2035, given the projected increase in ED demand.

Ms BUTLER - And the different areas, if you could run through for the record, that the triage nurse can direct patients to, with the new system, or the proposed system?

Dr SCOTT - Our current system has a mixed waiting room model, which places challenges on people having to wait in the waiting room. There's a mix of paediatric and adult mental health, forensic, and other people in that waiting room. The new model has a variety of streams within the one department, and many of those streams have their own sub-wait area. For example, patients would have a triage and clerical event; there is a small waiting area if there was extra need for seats while people were queuing to be triaged.

From there, they would then go to a particular stream. We have a rapid intervention treatment zone, which has six dedicated bays, and our intention is to staff that with senior decision-makers to allow early provisions of pain-relief; early assessment; early review of ECG; and early test ordering. That rapid intervention treatment zone has its own waiting room, so people could be directed through there and assessed early and start their treatment and assessment protocol.

Alternatively, people may go straight to the resuscitation area; they may go straight to the acute cubicle area; they may, if they require a mental health bed or zone, they may go directly there; they may go directly to a paediatric area or a clinic area. It's basically a streaming

and a sub-wait and that will avoid having children and adults share the same space. So, we'll be in line with the new safeguarding children and young people guidelines that we're required to abide by, as well as being more respectful and offering greater privacy for people in particular need - such as patients under forensic orders or people under mental health orders.

Ms BUTLER - What would the new process look like to a person who has mental ill health and they present at the ED?

Dr SCOTT - Patients may be brought in by a variety of means - maybe walk-in unaccompanied; they may be accompanied by a guardian or loved one; they may be brought in by a community mental health service; they may be brought in by police; or brought in by ambulance. Regardless of how they're brought in, they would have a triage interaction, either at the ambulance end of the triage area, or at the walk-in end of the triage area. A rapid clinical assessment would be made, patient identification would be confirmed because it is important to know we are dealing with the right patient. Then, for someone who is perhaps acutely agitated or very anxious, there would be a very easy pathway to get them to a quiet and private space - a matter of walking maybe 15 metres around a corridor from the triage area, not through a public space, into a lift, swiping the back end of the lift, and walking straight into a space designed to be appropriate for people with mental health issues such as anxiety, depression or agitation. That journey is specific to that patient group. People perhaps with pneumonia or other illness like that would take a different path out of the elevator. That way, we minimise the exposure for an agitated mental health person to other members of the public.

CHAIR - When the St John's Park facility is completed, we had some introduction to that, would ambulances be simply taking them there? Or would it still mean that they would end up at the Royal?

Dr SCOTT - Again, the Royal footprint is flexible. We have an area that is appropriate for mental health patients but those cubicles could be used for acute patients. Experience from the mainland shows that when you have a centrally located large hospital, you will always have people attending requiring mental health treatment. It may be appropriate that those people can be managed either at the Peacock or perhaps St John's Park. However, the more unwell a mental health person is the more likely it is that they will be managed through the hospital environment. We are certainly planning for that in terms of security, in terms of mental health safe space, in terms of clean admission pathways through to the mental health inpatient services that will still be on site.

CHAIR - Of course, this is only step one in their care in the hospital. It's not [inaudible 3:12:33] get handed on to another specialist facility.

Dr SCOTT - Peacock, certainly, and what I know of St John's Park are a really important adjunct to treating mental health patients. But in the entirety -

CHAIR - You still have the capacity to do it.

Dr SCOTT - And we still need to manage acutely unwell mental health patients, which will be better done through the emergency department, so we are planning for that.

Mr DOCHERTY - There will also still be that group of patients who have got either biophysical or biochemical challenges which might exacerbate the mental health condition or

might be causing it. Therefore, there will always be a hybrid patient who will always come to the Royal Hobart ED because the other mental health facilities won't deal with biophysical care, and such.

CHAIR - No, they won't be able to, they don't have that expertise. That is a good comment.

Looking at page 11, in the environmental considerations, there were a number of areas that you missed near the bottom there: environmental consideration in building materials and minimising the staging of project to minimise building waste.

Do you also look at things like offgassing and consideration for sensitive people with materials being used? Is that something that is considered, that the materials you are using in the construction, the linoleum or whatever they call it these days -

Ms RATTRAY - Vinyl flooring.

CHAIR - Vinyl flooring is what it is. Those sorts of things?

Dr SCOTT - The spaces need to be fit for occupancy. As Mark has pointed out, the infection prevention and control clean is extremely involved and can take several days. From our experience with the emergency medicine unit we opened in January, there was a period where the build was complete. We then inspect for anything that we planned to have done that the builders haven't done. There would be a correction phase. Once that was done, we would then have it cleaned and allow those cleaning agents to dissipate, then occupy the space when there was no perceived environmental contaminants remaining. The very fact that it takes a week or two after practical completion -

CHAIR - Gives an opportunity for that sort of offgassing, if you're using glues and all those sorts of things, to dissipate.

Dr SCOTT - Yes, correct. And the infection control clean because the agents they use tend to evaporate and dry, so you actually absorb a lot of the smells.

CHAIR - Okay, the cultural aspect. You talk in the architectural statement about cultural respect. Can you talk us through that a little bit? We did touch on that on the tour.

Mr LEE - Yes, we engage with the Tasmanian Aboriginal Centre and understand traditional stories and take references of some of the important stories they tell us - like, for instance, the new staff extension makes reference to the yellow cockatoo. That sort of a trend, to take a cue and transfer it into architectural expression. We have continued doing so in the new ED redevelopment. There is some referencing in terms of the water and the landscape. It is still a work in progress but interweave them into the wayfinding narrative.

CHAIR - Thank you for that. I was interested in what sour drink was: 'Significance of the casuarina she-oak forest is something we acknowledge as a communication with the riverbank offering edible fruit and sour drink.' Anyway, I guess we will learn about that.

Building materials and reference images - I don't think there is anything extra there. External noise, cars doing blockies, is it sufficiently insulated to reduce outside noise incursion?

Dr SCOTT - You will still hear an ambulance -

CHAIR - It is on Liverpool Street and Argyle Street and there are lots of kids that do blockies. Not so young sometimes.

Dr SCOTT - The build spec, the material used, we have acoustic panelling in ceilings and the main part of the acute area is underground so it would be protected from sound incursion. The noisy things like large helicopters, ambulances and police vehicles with sirens on will intrude but the more common noises of the city, I don't think, will be any worse than they are now and, at the moment, they are tolerable.

Mr LEE - In addition to that, we have a qualified and professional acoustic engineer in our team.. What he is currently doing is measuring traffic noise and informing the design of how we can insulate from the traffic noise and also look at various places how we can improve sound absorption level to ensure the patients' comfort during their stay in the emergency department.

CHAIR - Another aspect: In the paediatricts area, it did not seem to me in the diagrams, there was any child-centred murals to provide a welcoming atmosphere for kids. Is that something that might be considered?

Mr LEE - Yes, it will be considered.

Ms RATTRAY - The alphabet and the times table would be handy, from my observation.

Mr LEIS - It is a fascinating one when you cross trying to put those playthings on the wall with infection control, saying, 'well, we can't have all of that stuff because it harbours' - we have had some robust debates around that and what is important.

CHAIR - [inaudible 3.19.08] You can have what their murals are like, those lovely murals you have got and the -

Mr LEIS - Just photography but we are working -

Ms RATTRAY - Brendan, what do you think?

Mr DOCHERTY - We have recently updated a lot of our children's services across our system so we have got some lessons learned from that exercise. We have also developed a children's book where the children can actually provide pictures or words about how they would like to receive the care in their environment. That is just about to be launched. We will be using some of that information to help inform -

Ms RATTRAY - Be careful, do not give them too many options.

Mr DOCHERTY - In the ED, they have the eye goggles and stuff for children in ED to help as diversional distraction therapy, used commonly across children's EDs, so we will look at all those things.

Ms RATTRAY - I have a six-year-old and a three-year-old grandchild and we do not have many options when they come to play with me.

Dr SCOTT - I might just add that as part of this phase, we travelled to the Royal Children's Hospital and other hospitals to look at what they do. It is a balance between infection prevention control and appropriate wall surfaces that you can interact with. One of the current things that we are looking at is an interactive television, like a big iPad, which you can wipe down easily; but we are not allowed to have toys or books or things that may pass on infection between children. It is challenging. I think the mural, as you suggest, is key; but hopefully the television - we are liaising extensively with the paediatric team at the RHH, as well, to get advice on what they think works from their perspective.

CHAIR - Was there much that you couldn't do because of the current structural columns that are in the building? This is just for the record - you pointed out that one of the areas in the EMU section had a major column which simply impacted when you came into the room. Was there much that you couldn't do because of the way the building is constructed? Ceiling heights, I know, is one.

Mr LEE - Just back to the column removal, part of the new ED redevelopment will identify the few columns impacting the layout and severely impacting providing service. Our structural engineers are reviewing options removing. We have some options available. Back to the other question, why the cost is so high: is because we are dealing with a lot of unknown; part of it is removing some of the critical structural elements; and contributing high contingency costs in the cost allowance.

CHAIR - In conclusion, flattery will get you everywhere.

Ms RATTRAY - I noticed that, 'esteemed'. I mean, I like it.

CHAIR - It doesn't work. I'll tell you that, it doesn't work.

Ms RATTRAY - Andrew, I took it very well.

CHAIR - If we think there's something that's wrong, we'll say it. Is there anything else that you would like to leave us with in summing up, before I ask you the final questions?

Mr HARGRAVE - There's nothing from me or Paul or Mark, or Brendan.

Mr DOCHERTY - Just to acknowledge, of course, that the emergency department is a small slice through the patient's journey from the community; and that we deal with from zero to over 100-year old patients. It does encapsulate a lot but it is really about that emergency environment. It is fair to say, though, that there are other constructions above our emergency department's and the excellent education and training facilities we've got already built downstairs, that's what magnetises the workforce to work in the new building - with new training and education being part of that build. So, that hopefully will reassure that the incremental opening of the department with the incremental multi-disciplinary team members

coming on board, they want to come and work in the new environment because they know it delivers better quality of care as well as their professional development. I know you got to see the education and training facilities and the simulation room. That will part of the magnetising force for our workforce, just to reassure you.

CHAIR - We've been to a lot of areas and seen a lot of projects but I have to say, the emergency department at the hospital, when you go in there and you see how many people are working in there, and each one of them has a specialised role in such a small space, it's an amazing thing to see. When you think of how busy it can get, we all take our hats off to the people. It's not to say that we just treat this with a 'tick-and-flick'; that is why we ask all the questions, and we'll have to deliberate on this.

Before we do that deliberation, there are five questions that we need to ask in relation to provisions of the Public Works Committee Act 1914. It goes back a long way.

The first of those questions is, does the proposed works meet an identified need or needs or solve a recognised problem?

Dr SCOTT - I would say it absolutely does. I feel that we are struggling to provide the care that the Tasmanian public deserves, at the moment, due to not only a reduced footprint but also the pressures on the system as a whole. The larger ED will provide a bigger footprint and be a temporising measure to allow other systems and processes, both pre-hospital and within the community, to spring up and provide a solution to access block. So, yes.

CHAIR - I would say the way it's on the front page is quite often an indicator of how stretched it must be.

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

Dr SCOTT - Again, to provide that level of care capacity at an alternate site would cost billions, because an ED does not run alone. It needs surgical unit; medical unit; imaging; pathology; clinical services; cleaning; food services - a whole heap of things. You're not just building an ED; you are building an entire hospital somewhere else to provide something that can deliver care to the Tasmanian public. So, whilst the proposed works are expensive it's the best available use of the remaining space on that city block footprint and it will deliver care out to 2035.

CHAIR - And that's a tad over $149 million on the budget. Is that right?

Dr SCOTT - That's correct.

CHAIR - So, that's a yes?

Dr SCOTT - In my opinion, yes.

CHAIR - Are the proposed works fit for purpose?

Dr SCOTT - Yes, I would say they are; I think the level of architecture and planning input as well as the AustHFG -.

CHAIR - Can you just spell that out, for *Hansard*?

Dr SCOTT - The Australasian Health Facility Guidelines. We're building to the nationally recognised, and Australasian, recognised health standard. We've had expert level input from our architectural colleagues; and consultation with a wide variety of groups who are required to use that space. The product - while challenging to deliver on that brownfield site - is the best available use of that space, in my opinion.

CHAIR - And we're not going to get to the end of it and find a critical component which stops it getting its accreditation?

Mr HARGRAVE - No. Lots of planning, lots of interaction with health facility planners, specialist architects. That's their key role - to make sure this facility is safe, contemporary and functional.

CHAIR - Okay. At over $149 million, do the proposed works provide value for money?

Mr HARGRAVE - Yes, and in line with current market expectations.

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

Mr HARGRAVE - I believe they are, yes.

CHAIR - Thank you. To reiterate what I told you at the start, the advice that was given and what you've 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 any comments you may make to anyone, including the media, even if you are just repeating what you've said to us. Do you understand?

WITNESSES - Yes.

CHAIR - Thank you very much for coming and presenting. Thank you for your time.

The committee adjourned at 3.28 p.m.