PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN THE KING ISLAND COUNCIL CHAMBERS, CURRIE, KING ISLAND ON TUESDAY 25 JUNE 2019

STAGE 2: KING ISLAND HOSPITAL REDEVELOPMENT

Mr MARTY VINEY, PROGRAM MANAGER, ASSET MANAGEMENT SERVICES, DEPARTMENT OF HEALTH; **Ms ROBYN BRIDGEWATER**, DIRECTOR OF NURSING, KING ISLAND HOSPITAL; **Ms ANGELLA DOWNIE**, NURSING DIRECTOR, PRIMARY HEALTH NORTH WEST, TASMANIAN HEALTH SERVICE AND **Mr PAUL COCKBURN**, HEFFERNAN BUTTON VOSS ARCHITECTS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Valentine) - Welcome everyone. I have a statement to read that is a formal statement that we need to make prior to receiving your evidence. First, thank you very much for your kind assistance today in the site visit. Everybody found that very informative and it was very good to be able to go right through the whole site and see all the works that need to be done. We were certainly very pleased to hear the evidence you have to provide us on the record today.

Just before we begin, I would like to inform you of some important aspects of committee proceedings. A committee hearing is a proceeding in parliament. This means 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 when conducting its inquiries. It is important to be aware that this protection is not afforded to you if statements that may be defamatory are repeated or referred to by you outside the confines of the parliamentary proceedings. This is a public hearing and members of the public and journalists may be present or come in during the hearing and this means your evidence may be reported. Do you understand?

WITNESSES - Yes.

CHAIR - The opportunity is here for an opening statement from you so that we can then proceed to questions after that. Do you have an opening statement to make?

Mr VINEY - Yes I do. The King Island Hospital is located at 35 Edward Street, Currie. The facility services a population between 1600 and 2000 people providing emergency care, sub-acute medical care, primary health services, and residential aged care for the remote island's residents. More serious, acute issues involves transporting patients off the island to health services on the Tasmanian mainland.

The hospital also coordinates the delivery of a broad range of community services, GP services, visiting services and support groups, such as community nursing, child health, dental health and antenatal clinics.

The current hospital building has deficiencies in space and design including minimal confidential treatment room space, minimal consulting space for new visiting services and

professionals, poor work flow and security risks. The configuration of the ward spaces does not allow for patient privacy, ensuite bathroom access and does not reflect contemporary standards.

The implementation and completion of this project will provide a hospital and community health service with a facility that provides and improves functionality, amenity and ensures long-term sustainability with enhanced capacity for expansion of various health services offered to the regional community while enhancing its capacity to recruit and retain staff to deliver best practice, safe and quality care.

The existing building is a combination of building styles and constructions which have been altered and amended over a number of years. The most recent Stage 1 redevelopment completed in 2012 focused on upgrading the aged care facility only. As Stage 1 redevelopments go it was reduced due to adverse tender conditions and this current project addresses the most important and outstanding issues from that project. Following a SIIRP - a structured infrastructure investment review process - funding of $10.5 million was approved as a 2018 election commitment for Stage 2 of the King Island Hospital redevelopment. The design and tender documents will be completed in July 2019. The aim is to advertise the tender in late July with construction commencing, hopefully, in October 2019. It is anticipated the construction will take approximately 18 months and be completed around March 2021.

CHAIR - Thank you very much, Mr Viney. One thing that comes to mind is to do with the budget. It has been observed by one of my colleagues here that there was not a P50 and a P90 estimation. There is only one estimation here. Could you perhaps address why that is the case? I am not quite sure why there would not be the two figures given. Are you aware of the P50 and P90?

Mr VINEY - No, I am not aware of that. Can you elaborate?

CHAIR - Basically, I cannot think of the technical term. The secretary has advised me that for infrastructure like this it is not usually estimated. Okay. That is enough for me. We have both learned something.

Given that this is on an island, do you perceive that there might be issues with the supply of goods and equipment? Will the contingency provide enough space?

Mr COCKBURN - There are two things in that question. One of them is the logistics of getting equipment here to the island. I don't think that is the real issue. I think the real issue is the interest in the tender market, a bit like it was in the previous development. The previous development was at the Building the Education Revolution stage, which meant that competitive tenders were hard to come by. We are reliant on our cost consultant to put these costs together and build in such things as escalation in the tender and reflect the market conditions. At present, we are on budget. We haven't got the final pre-tender estimate yet because we haven't quite finished the documents. All the lead-up estimates to this point have been within that $10 million.

CHAIR - It is mostly a refurbishment as opposed to new buildings.

Mr COCKBURN - That is correct. I would say it is over 80 per cent refurbishment.

Mr VINEY - The contingency element we have is substantial. Normally, we would only allow about 10 per cent as a contingency and it is double that.

CHAIR - That is fair. That is why I asked about contingency and whether it would cover any possible blow-out in materials or personnel required to undertake the work. This leads to my next question with regard to construction. Is there an issue with accommodation for workers on the island, those coming here to do this work? Is the workforce likely to be imported, as opposed to utilising the workforce available on the island?

Mr VINEY - We expect that most of the staff and contractors employed will come from off the island. We expect that the contractors putting a submission in would build the accommodation costs into their tender. However, we expect that to receive competitive tenders those construction firms would look at innovative solutions to reduce their accommodation costs. The costs are going to be for greater than 12 months, possibly 18 months. We also look at the time frame of the project, knowing that it is 18 months. However, we expect the contractors will aim to reduce that time frame in order to provide a competitive tender and reduce their costs.

Ms RATTRAY - Do you see that the winning contractor might work for three or four weeks, including weekends, with workers then leaving the island for a week, or do you think it is going to be a Monday to Friday build?

Mr VINEY - That's a potential for them but that is basically up to the contractors because it comes down to the wages they would have to pay for weekend work, whether that balances out against their costs of accommodation plus flying back to Tasmania or wherever.

CHAIR - It also relates to the logistics of other matters, too, as to when the work is to happen, such as the operation of the hospital while this is all going on.

Mr VINEY - I am sure there will be times that contractors will work seven days a week to reduce the time frame of works that are directly affecting the hospital.

Ms RATTRAY - Would a seven-day redevelopment build work with the services that are provided at the hospital? There will be fewer staff on a weekend than weekdays.

Mr COCKBURN - The important thing to remember is that when you have a builder's area in a hospital, that is legally the builder's area. They have to take full responsibility for anything that goes on in that area, including access. They are not at the bequest of hospital staff in that area at any one time. We talked about the staging aspect of this project and how that may work itself out. I suspect the builders - and I can't talk for them - want to hit each stage quite hard and any space between those stages is when they would probably take leave. That is my guess.

CHAIR - What sort of process did you go through to decide on the configuration of amenities?

Mr VINEY - We did a lot of research on the need for accommodation because the solution is to assist in the recruitment and retention of staff on the island by providing good-quality accommodation. It is also the type of accommodation we're providing for the term. We don't want to provide short-term accommodation as that already exists. Mid-term accommodation is an issue for staff and in attracting staff. The aim is to provide contemporary accommodation solutions. That's why we've gone with two two-bedroom units and one three-bedroom unit, to provide that solution for families or single people with visitors. The aim is that longer-term accommodation would be found through people seeking their own accommodation, finding rentals throughout the island rather than the solution that we're providing.

CHAIR - Thank you.

Mrs RYLAH - This is the design and tender process we're going to go through. A significant amount of the design has been done, as we saw today, and has been demonstrated. Can you explain to me why it's considered a design and tender document? What's the design we aren't seeing? What is there that we don't know about?

Mr VINEY - To clarify, it's just a construction tender. The design -

Mrs RYLAH - That's not what the document says. In the introduction, page iii, under program it says 'design and tender documents'. Should that read 'construct and tender'?

Mr VINEY - Yes.

Mrs RYLAH - Okay. On the preceding page, the fourth dot point says that there are four acute inpatient rooms. As we saw when we were looking at the plans and walking around today, there will be four rooms but it says on page 9 of the document that it will maintain five single-bed rooms in the same location under the acute inpatient ward. Is that an error in the document?

Mr VINEY - No, just below, on page 3, it says four inpatient rooms and the next dot point is one palliative care room. It probably needs clarity on page 9 that the five single rooms includes the palliative care room.

Mrs RYLAH - Thank you.

Ms RATTRAY - The hospital and the community won't be losing any access to acute beds. Is that a fact?

Mr VINEY - No, I believe there are currently six inpatient beds at the moment and we're reducing that to five inpatient beds. Four of those are acute inpatients beds and one is the palliative care.

Mr COCKBURN - We are picking up two emergency rooms, which can act as additional beds.

Ms RATTRAY - We also heard this morning as we did our site visit that a graph has been done over the last few years. I would be appreciative if Robyn might share those figures she shared this morning so it can be incorporated into the report.

CHAIR - Perhaps you can table that, Robyn?

Ms RATTRAY - I would like to actually hear it.

CHAIR - That is fine. After the explanation we could table the documents.

Ms BRIDGEWATER - The data I have collected has been over my experience of eight years but I have it pictorially here. In the last two years our monthly occupancy has reached 57 per cent on one occasion and 50 per cent on another occasion. So, with our six current beds, that would be equal to occupancy of three beds. I have noted also that there have been very occasional moments

when there has been a requirement for five beds, and I believe there has been one occasion when there was a requirement for six beds but that was for a very short time, a 24-hour period.

Ms RATTRAY - You also mentioned that there is another area of the hospital you would be able to access if for some unknown reason you needed six or seven.

Ms BRIDGEWATER - Certainly. The redevelopment is providing us with two additional emergency beds which could be transferred to an inpatient for a short period of time.

CHAIR - So seven in total.

Ms BRIDGEWATER - Yes, correct.

Ms RATTRAY - So there certainly won't be any need for concern from the community about a loss of beds and services from the hospital with the redevelopment.

Ms BRIDGEWATER - No, not in my eight years of experience.

Ms BUTLER - I want to go back to the construction workers on the site and a quick question about strategies you may have in place to minimise risk associated with sourcing subcontractors. Sometimes meeting the demand and supply with subcontractors can be a real issue.

Mr VINEY - That is a difficult issue. The contract is between the client and the head contractor and doesn't involve the subcontractors, so we don't have that direct relationship with the subcontractor. We can exert pressure on the head contractor to ensure that the subcontractors meet their deadlines and have the capability, are resourced and meet their time lines, but understanding that at times certain trades become a critical trade and it impacts the path of the project. That could be, for example, the plastering trade. One of our strong project management skills is that we ensure the contractor is trying to deliver on their commitments and we keep getting updates and ensure we are able to have commitments from them to be able to complete certain sections by the time frames.

Ms BUTLER - Is there any part of when you are designing a building or a site that you might be mindful of there potentially being a problem with finding subcontractors to undertake a skill such as plastering? Have you designed any areas to compensate for that potential problem?

Mr COCKBURN - Sometimes it is very difficult to do that. For example, with this particular project with plasterers you can't get rid of those; you have wall systems that you have to have within the hospital itself. Whilst you are cognisant of those things you really have to do the job at hand and, to a certain extent, it's for the builder to tender on those documents and arrange their subcontractors. In the process of arranging their subcontractors at a tendering stage the subcontractors will see what the documents are, what the time frames are and whether they can deliver. If someone can't deliver it they won't tender it; we're making that assumption, which is a fair assumption, I think.

Mrs RYLAH - Going back to the same paragraph I was on before, on page iii, in regard to the completion dates it says that completion will occur in March 2021 and defects will end in March 2022. But on page 19 it says that completion of construction will be in December 2020 and the defects period will end in December 2021. So there are different dates. Can you explain that to me, please?

Mr VINEY - Yes, I had a 15-month construction period. I've discussed it with Paul and he had an 18-month construction period so there has been a bit of cross-contamination there.

Mrs RYLAH - Right, so which figures are the ones we should rely upon?

Mr VINEY - We are running off March 2021 as the end completion date.

Mrs RYLAH - And March 2022 for the end of the defects period?

Mr VINEY - Yes, as the end of the defects liability period. We would expect that the program is tighter than that. We expect they will do it well and truly within the 18 months.

Mrs RYLAH - Right. I am keen that we understand which are the dates we're working towards. Terrific, thank you very much.

CHAIR - While we are on page iii, maybe if we work forward from this in case there are questions on each page. That would be the best way for us to do this. I note that you have one single room that will be fitted with ceiling lifting rails. Are we talking about bariatric patients? Can you give us an understanding as to why there is only one? Is that enough in your experience, with the sort of outpatients you expect through the door? What happens if two people arrive and need those facilities?

Mr VINEY - To answer that first from my perspective, it's a cost issue. It's about reducing the cost and maintaining the cost. If we put lifting devices in each of those single rooms we would be up for a considerable cost and we've been trying to keep within budget at this stage. However, if we had competitive tenders and the tenders were favourable, we would then try to put a new bariatric lifting rail in another room as well It is probably one of our priorities we would add in a competitive tender process.

Ms BRIDGEWATER - We also have restrictions in relation to our admission protocols. People greater than 150 kilograms must be able to maintain mobility, otherwise we are required to transfer them. That particularly is in relation to our level of staffing.

CHAIR - Thanks for that. You also mention security for wandering dementia residents. Can you explain the aspects you are putting in place for that, such as the remotely closable doors that you were talking about during the site visit - is that right?

Ms BRIDGEWATER - Yes. I am not sure- have we had final confirmation of the device?

Mr COCKBURN - Yes, I can talk about that. We're looking at an additional set of doors in the corridor linking the aged-care facility to the hospital. It is a set of doors that can close upon a wandering patient, for want of a better word. Walking within proximity of those doors they will simply close. They're not fire doors, because it's a fairly common occurrence for this to happen and fire doors are best left in the open position because of the weight of them. In that corridor between the Netherby Wing and the hospital we have an additional set of doors to deal with that.

CHAIR - So your patients suffering with dementia are likely to be in the Netherby Wing and not within the confines of the main hospital?

Mr COCKBURN - That's how we see it, yes.

Ms BUTLER - For the *Hansard*, could you run through the coordination and documentation of asbestos removal on the site?

Mr COCKBURN - There is an asbestos register that goes out with the tender documents, so the builder has to price the removal of that. The work plan from the builder could probably answer that more than anything else; they have to provide that as part of their tender package. Further to that, if they are awarded the contract, they have to present that to us for approval before they actually start the work, part of which will obviously be talking about the removal process of asbestos and it will be formulated in their program. Their program will be based on the staging aspects of the project.

Mrs RYLAH - I am aware that there was an asbestos removal problem for the cheese factory some time ago and getting it contained and shipped off island caused delays and complexities in what they were doing. Are you aware of any issues for this project?

Mr COCKBURN - No, I haven't.

Mrs RYLAH - How large is the asbestos problem? It was a very significant asbestos problem in that building. Is it a large issue?

CHAIR - It was probably the ceilings and roof, et cetera.

Mr COCKBURN - The bulkiest thing we are dealing with here is the floor tiles. You would have a specialist contractor to come over, remove those tiles, remove the glue, in particular, from the tiles and off the concrete slab. I imagine in the process of doing that they would take all the remnants of that asbestos with them off the island. It has to be shipped off the island, as their equipment has to be shipped in.

CHAIR - With respect to the gas situation, you have gas for heating in certain areas, and you have piped oxygen and suction. How are you handling those sorts of 'hazards'? Can you describe that? They are not being placed within the confines of the building, are they? They are external?

Mr COCKBURN - I wish I had the services engineers to answer in more detail but we looked at the services area towards the back of the building. They are located in that area, away from patient areas, I should say, because patient areas still have some external areas in the building, but not that one. The existing LPG tank sits in the bottom of the driveway of that area, well away from the building. That is probably the most dangerous that we are dealing with.

CHAIR - As far as oxygen is concerned, it might be on an external wall of the hospital, but it has utility rooms between it and the patients?

Mr COCKBURN - It has, and it is a brick wall between the two.

CHAIR - That is sufficient to -

Mr COCKBURN - Yes, and we take advice from our engineers in the location of these things, and they have to do it under current standards.

CHAIR - They have said that that location is fine?

Mr COCKBURN - They have.

Ms RATTRAY - In regard to the sprinkler system throughout the entire building, we were also informed this morning that, even though there are some parts of the current facility that will not be included in the redevelopment, there will be a new sprinkler system throughout. Do you want to give us some more detail around that?

Mr COCKBURN - Yes, the entire Netherby Wing is being sprinklered, as is the hospital. It is a case of building compliance - you cannot partially sprinkler buildings. The decision was made to sprinkler all areas of the entire building, including those that are not having a refurbishment. All areas are to be sprinklered.

Ms RATTRAY - There is a significant upgrade, I believe, on the island at the moment, in regard to water supply, so there will be adequate water supply to maintain a full sprinkler system throughout?

Mr COCKBURN - I believe the pressure is going to be increased with the TasWater upgrade.

Ms RATTRAY - That is fitted very nicely into this -

Mr COCKBURN -That will come online before this, yes.

Mr VINEY - We felt it was reducing the risk for inpatients by having a sprinkler system throughout the Netherby Wing, rather than just sprinkling the new acute ward. They are the inpatients overnight, so we thought that was an appropriate way to reduce our risk with inpatients.

Ms RATTRAY - It is interesting that that did not have a sprinkler system. It is not that old, is it? It is probably one of the really good compliance requirements throughout the whole redevelopment.

CHAIR - I need to clarify with the lifting rails. I'm not hung up on lifting rails, but I need to clarify, and pardon the very bad pun. You have two rooms with lifting rails, one palliative care and one in the acute inpatient room. Is that right?

Mr COCKBURN - That is correct.

CHAIR - I wanted to double check that that was the case.

The upgrade to the heating and cooling to the facility is mentioned here. During the tour we saw some old equipment on the roof. For the record, that is going to be removed?

Mr COCKBURN - It is.

CHAIR - Could you describe the heating and cooling arrangements that are going to be put in place?

Mr COCKBURN - Page 14: each area is described in the report as having heating and cooling essentially.

CHAIR - Is it heat pump technology that's being employed?

Mr COCKBURN - That is correct. A lot of the supply air for the building is being retained. As we said earlier, all redundant equipment is being removed. There's a reasonable amount of that in the roof space. I've been up there. It tends to get left, so we'll look at doing that.

In terms of kitchen areas, we have new exhaust hoods going in there to bring those up to current standards. All service areas will have exhaust systems, but they will be roof-mounted exhaust systems so the noise levels will be reduced in those areas.

There's a lot of stuff in the plant areas that is being upgraded. Again, it would be good to have the mechanical engineer to explain all this in detail. Apart from reducing or removing redundant units we are actually upgrading things such as hydronic heating units and pipework, insulation of pipework, controls and -

Mr VINEY - The heating boiler heats the Netherby Wing. They are retaining that and then using the split systems throughout the acute ward and the emergency areas.

CHAIR - The main boiler is gas as opposed to electricity?

Mr VINEY - Yes.

Ms RATTRAY - Are you going to have any solar incorporated in the actual build?

Mr COCKBURN - There are a lot of solar panels on the building at the moment, which is primarily for electricity, not directly for hot water, for example.

Ms RATTRAY - Any wind power here?

Mrs RYLAH - The island is generating -

Ms RATTRAY - All generated by wind?

Mrs RYLAH - No, not all, but -

Mr COCKBURN - A lot of it is.

Mrs RYLAH - It usually averages about 90 per cent on renewables.

Ms BUTLER - I have a subsequent question to do with energy efficiency and any design that will be part of the new refit to boost your energy efficiency and also any capacity for any future technology as well if this is to last for the next 50 years? This is replacing 50 years now. Is there a capacity, potentially, to replace gas or electricity with say hydrogen and so forth? Have you looked into those kinds of things as part of the design?

Mr COCKBURN - To answer the first one: the building will be far more thermally efficient than it is at present. That is largely to do with the replacement of all the windows and getting external wall insulation into walls where we can.

In terms of future systems to run the hospital, we are basing everything on what our mechanical engineers and our electrical engineers tell us is the most efficient way within budget to work with this building at present. It's the type of building that allows for future flexibility, given its roof space primarily. Access to the building through the roof is pretty much throughout all areas. Any new technology you want to put in there in terms of heating or cooling is able to be reticulated through that roof space fairly easily.

CHAIR - Unless members have any further questions on the initial pages, perhaps we can move through between where we are and page 8, unless anyone has anything prior to that?

Mrs RYLAH - Yes, I have some. We didn't see anything in regard to the dental health issues on the island. I know in the past there have been issues in terms of upgrading. I understood that dental work was done at the hospital. Can you give me some information about that?

Ms BRIDGEWATER - Oral Health has redesigned and refurbished its dental clinic in the last two years.

Mrs RYLAH - Is that part of the consulting rooms in the hospital?

Ms BRIDGEWATER - No, it is quite separate. We didn't go down to the community wing, it's quite a separate consulting area.

CHAIR - But it is contained within the hospital precinct?

Ms BRIDGEWATER - Yes, within the hospital, totally maintained and serviced by Oral Health.

Mrs RYLAH - Right, so nothing needs to be done in this build to ensure that upgrade has taken place?

Ms BRIDGEWATER - No.

Mrs RYLAH - I understood that it was well below standard some years ago.

Ms BRIDGEWATER - Within the last two years there has been a refurbishment of fixtures and fittings and suction pumps, et cetera. They are working now with RFDS to provide ongoing dental services for the community. That was announced only last week.

Mrs RYLAH - And Flinders Island is included in that too?

Ms BRIDGEWATER - Yes, it is very exciting.

Mrs RYLAH - What is the time frame for the nursing accommodation to be built, in a broad sense?

Mr VINEY - We aim to advertise a tender at the same time as the main construction tender for the hospital. We expect the tender process will take three months for a contractor to be engaged and commence on site, so we're talking late October. We have a four-month construction period for that.

Ms RATTRAY - Can I have some indication of why it wasn't all put together, particularly when it was included in the development application? Is there some rationale for that? I'm sure there is.

Mr VINEY - Yes, there is a prequalification stage to do works at the hospital, so it is the value of the contract. The greater the prequalification, the fewer firms you have that have that prequalification. We thought to increase our opportunities for smaller, local north-west Tasmanian contractors, they could submit a tender for a prequalification category around $1 million, whereas the hospital prequalification category would be over $5 million. The aim was to increase opportunities and competitiveness for our tender environment. We also think the larger firms that tender for the hospital will also tender for the smaller accommodation project, knowing they can gain some efficiencies by having one site established and teams. That creates another opportunity where they would be quite competitive in that tender as well. Essentially we think that by doing that process it will open the opportunities for smaller firms and create a competitive tender environment for us.

Ms RATTRAY - Is there opportunity for the local building industry to take up the opportunity?

Mr VINEY - If they're prequalified with Treasury.

Ms RATTRAY - Okay, so you have to have a certification or a tick, if you like?

Mr VINEY - You do, yes.

Ms RATTRAY - They may be subcontractors but they may not get the full contract. I understand.

Mr VINEY - They can be subcontractors, yes.

Ms RATTRAY - I knew there would be a perfectly good explanation.

CHAIR - Page 8? I don't know that there is going to be a lot there.

Mrs RYLAH - I have one question. The second-last dot point in 3.1 says upgrading of hotel services and adjacent services. What hotel services does a hospital provide?

Mr VINEY - We call hotel services the kitchen, cleaning and laundry services.

Mrs RYLAH - Right. I thought you were leasing out the rooms.

Mr VINEY - No.

Ms RATTRAY - Can I ask about where it says the key risks associated with the current hospital will be eliminated, including the minimising the risk of adverse clinical - on 3.1?

CHAIR - Work health and safety events, is that what WHS means?

Mr VINEY - Yes

Ms RATTRAY - Can I have some explanation about what that is referring to?

Mr VINEY - There are risks, as we have described previously, that the ward space does not allow for easily moving patients and the lifting devices. All those are around work health and safety issues. There are issues with the tight en suites, getting patients into and out of the toilet, both for the patient and staff.

Ms RATTRAY - We saw how tiny and narrow they were.

Mr VINEY - Yes. That is a risk for both the patient and the staff.

Mr COCKBURN - There is a risk of infection control as well in that we don't have isolating rooms at present.

Ms BRIDGEWATER - And potentially shared bathroom areas.

CHAIR - You talk about greater security of access to health care services for the King Island community. I'm presuming that is referring, in part, to the emergency services screening that is going in place as well, and possibly the dementia doors that are going in, if I can call them that - I don't know if that is a politically acceptable term - to cope with wandering patients. Current telehealth access is a slightly different type of access to what we are talking about here, but is that being improved or simply being maintained? We talked about this during the site visit but could you just talk us through that?

Mr COCKBURN - It is being relocated and maintained.

CHAIR - Okay. So there is no necessary increase in service. The amenity for the service provision, would you say that is being improved or simply being maintained at current level?

Mr COCKBURN - I think it has been improved in the sense that its relocation is next to the foyer area. Those who use that space - and other than telehealth there are other aspects to that room - are immediately off the foyer rather than being dragged through the acute ward. That improves the situation. With regard to the technology, it is being maintained and obviously these things get upgraded over time as they are required to.

Ms BUTLER - Can I ask a quick question in relation to the medical storage area? What design specifications will be included to make sure you are compliant? The current situation looks a bit higgledy-piggledy and certainly will be upgraded as part of the upgrade. I was wondering if you could run through what you need to do to ensure that is compliant with current standards for medication storage.

Ms DOWNIE - Our medication room? We will follow up further with our clinical pharmacist, however at the moment we have been informed that there was policy regulation in 2018 that described storage and access and also security that it is to be maintained in a medication room. We will be looking at making sure we meet the standards required there. There are also discussions in regard to policy around how we maintain and manage our medication areas - cameras, for example, and swipe cards.

Ms RATTRAY - I have a question in regard to the general disruption at each stage of the proposed works. We talked a little bit about that this morning and it would be good to get it on the record about how you see that working, albeit there will be a builder or a firm that will take on this

project and have their own ideas. I would particularly like you to share with us how you see the services being maintained at the hospital with as minimal disruption as possible.

Mr COCKBURN - We had a number of working sessions through the project working group with Robyn and her staff and Marty as well to do with the overall design of the hospital. Embedded in that process is a design process to work out the staging and the logistics surrounding that.

Whilst we're making certain calls on a builder's behalf in terms of how they would actually construct that, we think those discussions we had have got us to a point where we think it's feasible to do it that way. I think that's the important thing from the point of view of putting a set of tender documents out, that the builder knows they have to allow for those stages and allow the infection control issues surrounding that and the disconnection and reconnection of services. We believe there's enough information in the tender documents for the building to embody that in their tender.

The final detail of how that eventuates on site is something a builder will have to put a work plan together with, and to submit to, the superintendent for sign-off by the department.

Ms RATTRAY - The builder will take some advice from the information that's already been gathered from those discussions. I note this morning Robyn said there's a full commercial kitchen somewhere else, perhaps here at the council chambers, that may be utilised while the kitchen work is being undertaken. There will be a temporary laundry on-site but there's opportunity for a backup plan if that doesn't work out. All those things are being considered. Will that be passed on to the successful tenderer?

Mr COCKBURN - The arrangement of the kitchen, if it happens off-site, is probably not the builder's responsibility.

Mr VINEY - That would need to be managed by us and our corporate services division, which manages hotel services, laundries and kitchens, to relocate and remain compliant - you have the cold food chain and the warm food chain - in delivering food to the hospital correctly.

Ms RATTRAY - The successful contractor will need to know they have a certain number of weeks to get that area up and running?

Mr VINEY - That's correct.

Ms RATTRAY - It's going to take a lot of communication for this to run as smoothly as possible. We don't want to end up with a Royal scenario.

Mr VINEY - No. Staging the decanting is the most challenging element of doing a redevelopment within a live hospital environment. For example, in one of the stages we need to close three of the beds we have on the acute ward and redevelop those three beds whilst we keep the other three beds operational. There's hoarding, all the infection control procedures in place and then you're able to move from the newly opened area and operate out of that zone whilst they redevelop the area you've just left.

Services are one of the main challenges; maintaining the hydraulics, the power and the mechanical services you need in a live hospital environment. For example, if they needed to work on a switchboard or the like we would do that early in the morning, probably at 6 a.m., knowing they probably have a minimal changeover period of two hours and the power to a zone would be

shut down for two hours. We'd have all our strategies in place to mitigate risk in the event that anything happens.

CHAIR - The acute inpatient ward is listed on page 9. It says acute inpatient rooms include a palliative care room with adjoining family area, including kitchenette and sleeping provision. I assume that is for relatives of an inpatient, is that correct?

Ms BRIDGEWATER - Correct.

CHAIR - Is that only one room?

Ms BRIDGEWATER - Yes, but there will also be the adjacent sitting area that will have multiple reclining chairs and that will give people the option to stay longer.

Ms BUTLER - I have a question regarding the emergency department. If a person who is mentally unwell presents at the emergency department, can you run through their journey from presentation at the emergency department, where they would enter and where they would sit, once the redevelopment is completed?

Ms BRIDGEWATER - Certainly, they would initially enter into the emergency room. I would suggest the third emergency development that is fully self-contained with an ensuite. Potentially, they could in fact remain in that room given that we have two alternative areas for emergency presentation. They would be 'specialled', so it would be a one-on-one nurse/patient arrangement until such time as they were retrieved and taken back to Tasmania. If that room was required for any other presentation, they could be maintained quite satisfactorily in the observation room. It is still within that central area under the observation of the nurse on duty.

Ms RATTRAY - I have a question regarding community health. We heard this is an extension of the current facility, which is a key community facility that is accessed by many user groups. There are a few changes in the activities that are required now and that would be important to put into the report.

Ms BRIDGEWATER - It has been an interesting expansion to the traditional HaCHC day centre program, where people traditionally came from their homes to spend a day with others. They have a meal and entertainment of some sort. There were a couple of workers in that area who lead the water-based exercise groups here on the island and everyone knew that. There was a request for some exercise programs to be added to the day centre programming. We now have three exercise groups - and that is sit and be fit, active ageing, and I can't remember the next one. Hence the request for the wider day centre room, to enable ladies and gentleman - and gentlemen are coming - to undertake their exercise groups. They exercise for an hour or an hour and a half, then they head off to town and have coffee together so they are meeting several needs and it is a growing group.

CHAIR - Is there a swimming pool on the island?

Ms BRIDGEWATER - There is a swimming pool at the school that can be accessed for water-based exercise, and there is a swimming pool at Grassy.

CHAIR - Are they outdoor pools?

Ms BRIDGEWATER - No, both indoors.

CHAIR - They don't handle hydrotherapy.

Ms BRIDGEWATER - We don't really have hydrotherapy as such. We have community members who offer water-based exercise. I wouldn't suggest it's hydrotherapy.

Mrs RYLAH - In regard to external works, is there adequacy in the parking arrangements that are going to be proposed with this build? I am particularly asking about the bitumen and hardpan resurfacing, et cetera, as a lot of that pavement is broken straight out of the entrance. Could somebody explain plans for that?

Mr COCKBURN - All of the sealed areas will be resealed. All the parts that require strengthening will have a new base put in. There is only a small area to the south-east that requires that. In terms of parking, we discussed rationalisation of parking earlier such that line marking or dots might be appropriate. It is something we may not have looked at as yet but I will take it on notice as something we need to determine in a more orderly fashion, how people park.

Mrs RYLAH - We did observe today parking on the grass.

Mr COCKBURN - We did - two cars.

Mrs RYLAH - And cars spread out more perhaps than is an efficient way of doing it.

Mrs RATTRAY - Can I suggest you use lines? People just don't get the dots. They can't work out how to get in a dot but they'll get in a line.

Mrs RYLAH - In regard to the external lighting around the hospital, we noted the area for nurses, both male or female, walking to and from the accommodation. I want to confirm there will be adequate lighting so that no-one is walking in the dark between the accommodation and the hospital.

Mr COCKBURN - Whilst I haven't got the exact electrical drawing with me to check that, I will do so and ensure that lighting is covered from that pathway from the entry of the hospital to the accommodation.

Mrs RYLAH - Thank you.

CHAIR - With respect to the King Island Community Reference Group, can you run us through the consultation with them, what sort of consultation it was, and how much input they had into aspects of this development? It is mentioned in 4.1, on page 10.

Mr COCKBURN - As part of our consultation process, various members of the community were brought in and before the development application stage we presented everything we had been doing over the previous few months.

Ms BRIDGEWATER - We held a general community information session. I also had the plans at the local post office for viewing. Staff have had access to the plans and multiple meetings over the period of time. The community reference group is a group that has been reformed in the last 12 months.

CHAIR - How many individuals would there be?

Ms BRIDGEWATER - There are seven and they have been involved on a couple of occasions during the planning process.

CHAIR - What areas do they come from in the community? Are they just general interest groups with what happens in the hospital? How do you choose those seven?

Ms BRIDGEWATER - We advertised for people to express interest. Those people who expressed interest were accepted as a general cross-section from the community.

CHAIR - Were any of their suggestions taken on board in the project?

Ms BRIDGEWATER - Indeed. One gentleman had just had a palliative passing of a friend and he was extremely pleased to see we were going to be providing a more private space for family and friends. He found it quite confronting to be with his friend in a room and then having to move down the corridor to the sitting area, so he is very pleased at the planning for that palliative space.

CHAIR - Good. How did the open forum with the architects go?

Mr COCKBURN - It was interesting. It was a good response, a lot of people turned up and the questions were good.

CHAIR - No negative feedback?

Mr COCKBURN - No negative feedback that I can recall; either that or I've screened it. I think it went pretty well. The community was generally pretty good about what was being proposed and understood the logic in doing it that way.

Mr VINEY - It was pretty much a question and answer situation where they would ask why we chose to put the palliative down the end, or why we chose to set up certain areas. They just wanted to understand the rationale.

CHAIR - And the project working group?

Mr COCKBURN - That has been an ongoing thing for quite some time and has involved Robyn and her staff and various staff members coming in to talk about specific areas of the hospital, for example.

CHAIR - With you as the architect, you mean?

Mr COCKBURN - Definitely; we convened it, and Marty as well. Robyn sat in on quite a few of them, as did Kathy, who no longer works there. It was important to get everyone's input at the early stages of the design, specifically from those who operate in that particular area. For example, for the laundry we had Tanya in, and for the kitchen we had the kitchen staff in. In those sessions we were able to project our drawings onto a screen and move them, so they weren't just a simple PDF. They were an actual electronic file we could edit and manipulate with their input, so they felt ownership of that interactive process.

CHAIR - So all staff at all levels, virtually - is what you're saying?

Ms BRIDGEWATER - Yes.

Mr VINEY - We also involved as part of our working group regional infection control, the regional engineering manager, the regional corporate services manager, the regional hotel services manager -

Ms DOWNIE - And a work health and safety consultant.

CHAIR - So local people and local staff had as much opportunity to have an input as those higher-level people, and those higher-level people weren't seen to be simply overriding local wishes?

Mr VINEY - No, not at all. It was really driven from the local people; that's the feeling I took out of the whole design process.

CHAIR - Good to know.

Ms RATTRAY - In regard to the hospital auxiliary, I guess that's what they're called, or the friends of the hospital?

Ms BRIDGEWATER - They are the Ladies Auxiliary, which is quite separate to the interest group.

Ms RATTRAY - That's why I'm interested. They're usually an integral part of small communities and what happens at the hospital. They've raised a lot of money over a long time and they feel some real ownership of the facility in general. Have they been engaged?

Ms BRIDGEWATER - I attend each of their meetings. The plans have been taken to their meetings and I have gone through the plans with them. They've expressed their excitement about helping us out with the furnishings - the nice-to-have things.

Ms RATTRAY - The few nice furnishings, the little extra bits -

Ms BRIDGEWATER - Yes, indeed they have.

Ms RATTRAY - that the Government can't pay for.

Ms BRIDGEWATER - Yes, like the lovely waiting area with the paintings and the chairs. That was a product of the Ladies Auxiliary.

CHAIR - You also mention consultation with all key service groups, other internal stakeholders and associated services. Can you briefly describe that landscape? It's right at the bottom of page 10.

Mr VINEY - The project working group is essentially staff from the hospital. The key services group is our engineering, corporate services, infection control services -

CHAIR - The regional folk you were talking about?

Mr VINEY - The regional folk I was talking about, and other internal stakeholders like Ange were also involved.

Ms DOWNIE - GPs.

CHAIR - And GPs as well.

Mr VINEY - Yes, associated services, GP services.

CHAIR - Pathology services and those sorts of people?

Mr VINEY - Yes.

CHAIR - Anything on page 11, 12? You mention on page 12 the North-West Capital Works Steering Committee. Are they the people we've just run through?

Mr VINEY - No, that's an executive group from the Tasmanian Health Service that oversee capital works across the region, which is the Mersey Community Hospital, North West Regional Hospital, and all the rural sites. We, as project managers, provide a project status report which highlights how we're meeting our milestones, financial issues, any work health and safety risks, and any associated issues or risks with a project. We'll discuss that and we also go through the design and ensure that the executives sign off on the proposed design so we're not just heading off on our own little direction.

CHAIR - Thanks for that. You have other nominated representatives, comprised responsible delegates from other services that operate in the King Island Hospital including Ochre GP practice and allied health services together with consultation with the King Island Council on an as needs basis. How many allied health services would use the hospital? Obviously physiotherapy do.

Ms BRIDGEWATER - Physiotherapy, podiatry, they were both involved in discussions because they have particular needs.

CHAIR - Are they external service providers, or are they internal?

Ms BRIDGEWATER - They are THS internal. They come across from Burnie but their particular needs were noted and addressed in the planning.

CHAIR - Thanks. Across to page 13, any questions there?

Ms RATTRAY - I have a question in regard to the colour and natural materials. Paul and I had a conversation yesterday at the airport about the materials that will be used. Obviously, you want materials that are probably easily assembled. Can you give us some indication of the types of products, and are we having any shades of purple? It is a really important issue.

Mr COCKBURN - Not on my watch.

Ms RATTRAY - We are probably more focused on the materials. I know that somebody will sort the paintwork.

Mr COCKBURN - There is another level of consultation we need to go through in choosing colour selection and we would make up colour boards, for example. We have not done that as yet because I think that -

Ms RATTRAY - That is getting ahead of yourself?

Mr COCKBURN - If it is paint you can choose it a week before so that allows us time to work with the hospital and the staff and others to come up with a palette that is suitable and appropriate to this hospital.

Mr VINEY - Nice natural colour tones.

Ms RATTRAY - The staff did not mind the purple chairs. They just thought the wall was a bit of stretch.

Ms BRIDGEWATER - It was a staff consultation that came up with that colour.

Mr COCKBURN - In terms of the other fittings and fixtures, a lot of the stuff that goes in is probably manufactured in a workshop somewhere to minimise on-site construction time. Where you see efficiencies you tend to go for it.

Ms RATTRAY - Like the new types of cladding and that sort of thing?

Mr COCKBURN - Yes, that sort of thing. It is a kit path for a builder and they will install it on site.

CHAIR - You talk about public access to the facilities under Architecture and Interiors:

> … is maintained in its current location will receive a major upgrade. The adjacent emergency entry will be adequately separated to ensure access to the building is unambiguous and easily negotiated.

Do you plan on having signage above the emergency entry as opposed to the main entry to the hospital? How do they determine which door they have to go through?

Mr COCKBURN - It is an inherent problem this hospital has because an emergency entry is not associated with a main entry. Early on in the piece we looked at putting emergency around the back of the hospital. We have been round and round and came up with the conclusion that we are better off keeping it where it is for a whole bunch of reasons.

In terms of signage, yes, emergency signage is great. It is something that needs to be done in making that unambiguous and clear, as opposed to the new entry. The new entry is going to have some art work as the backdrop to that new entry and that is going to help define the new entry, or the existing main entry, as the main entry as opposed to the emergency one.

CHAIR - If somebody comes up the drive and they are holding their finger, it has just been chopped off, and they want to get into the facility, if it says 'ambulance only' that is not going to work for them is it? They are going to go in through the main entry.

Mr COCKBURN - There is an after-hours aspect to the emergency entry.

Mr VINEY - During business hours we would probably need to have a good, clear emergency entrance sign so they do not drag their finger through the main entrance.

CHAIR - No, that is right. Sorry, I am just using it as an example. It is probably a good example as people are using circular saws or whatever they are doing.

Mr VINEY - That is right.

Mrs RYLAH - And are unfamiliar with the island as with more tourism and golf is involved if they are coming in from an accident.

CHAIR - Fly-in workers, or whatever. Nothing else under page 13 - nothing else on the environmentally sustainable design you talk about? Hot water systems: do you have evacuated tubes heating for them, or is that part of the boiler system that was mentioned earlier.

Mr COCKBURN - It is part of the boiler system, I think.

Mr VINEY - It is not evacuated tubes.

Ms BUTLER - Is there any capacity for the community to acquire some of the - with the kitchen upgrade or the laundry upgrade, there may be machinery which they may be able to use in a community capacity that is not up to scratch for, say, a hospital?

CHAIR - Which page are you on there?

Ms BUTLER - On page 15.

CHAIR - Can we do page 14 first? Just moving through. We will go back to that. Anything on page 14? We are talking about the acute inpatient ward and the exhaust systems. Because you are having the split systems, is there likely to be noise issues for patients with those split systems?

Ms BRIDGEWATER - We currently have two rooms with split systems and it works well. We have not had any comment about noise.

CHAIR - Fans running on those split systems and the noise those fans make is not likely to cause an issue for patients, you don't think?

Ms BRIDGEWATER - There has been no comment to those particular rooms, no.

CHAIR - Do you know how those systems are fitted? Are there fans on the roof maybe and therefore not directly outside the rooms?

Ms BRIDGEWATER - No, I believe they are directly outside the rooms.

Mr VINEY - In the current design, they are directly outside the room, but that is a good point for noise.

CHAIR - No noise problems, so that is good. If there is nothing else on page 14, we will move on to page 15.

Ms BUTLER - I am sorry I jumped a page ahead there. In relation to equipment and whether or not the community may be able to acquire, whether it is a tendering process, any equipment which they potentially could use still but would not be up to scratch to use in the refurbished hospital. I noticed there was some equipment in the kitchen and laundry. Some of it was very old but some of it may still be really useful.

Mr COCKBURN - Is this fixed or loose equipment?

Ms BUTLER - Both.

Ms RATTRAY - Once you take it off, it will not be fixed any more.

CHAIR - But will it be fixed?

Ms RATTRAY - If it is going.

Mr COCKBURN - It is the builder's property. If we do not indicate this on the tender documents as being specifically something else, it remains the builder's property. To be honest, if you think about it, they are not going to want to take it back to mainland Tasmania, so I imagine they would be very interested in someone coming and getting it and removing it for them.

Mr VINEY - I would clarify that normally we complete a site tour with our services department to ensure that any equipment they wish to maintain or retain, that it is our responsibility to take that out first. In the event of community groups, we could take out the washing machine, take out the freezers, but I am personally unsure of the process THS has to go through for disposal of its assets or equipment.

Ms BUTLER - Make sure there is no liability down the line for that.

CHAIR - There would be a protocol.

Ms RATTRAY - It seems a shame to dump things that still have a purpose, particularly for a community group, et cetera.

Ms BRIDGEWATER - I think the items Jen is referring to are very old. There is a combi oven that is over 10 years old, the gas oven is around 30 years, and the dryer is around 30 years old.

Ms RATTRAY - There are freestanding fridges.

Ms BRIDGEWATER - Yes, correct.

CHAIR - The local football club might like the washing machine.

Mrs RYLAH - Can I seek assurance that that will be defined in the document?

Mr VINEY - Yes, it will be.

Ms RATTRAY - We will not see things on the tip and then the local member has to field the calls. People dislike waste, including this one.

Ms BRIDGEWATER - Agree.

Mrs RYLAH - On page 16, it says the diesel generator will run for general lighting and power only. If the transmission line went down between the power station and the hospital it would be a major concern and you would need to switch to the diesel generator. What about heating and cooling and any other equipment; for example, the morgue, the fridges? Will it have sufficient capacity?

Mr COCKBURN - It is a question for the electrical engineer. A lot of this is down to the cost of a generator to run everything. I believe the one that exists now is three-quarters of the way through its life - correct me if I am wrong, Marty - and that has a reasonable capacity to do everything to run the hospital; light and power and other aspects of the hospital as well. The discussion around this was to do with the cost of a new generator being substantial and whether you look at one that does the essential light and power, given that would buy you enough time to address the power shortage. That was my understanding of the discussion with the electrical engineer at the time. The bigger capacity generator and the more redundancy you want to build into the system, it simply costs you money.

Mrs RYLAH - Of course. What I wouldn't want to see is the hospital losing vital equipment and services needed to keep people healthy - food and the like. What is the history of outages on the island, what duration are we looking at?

Ms BRIDGEWATER - Rare. In my time here the outages have decreased markedly.

Mrs RYLAH - Okay, we are happy about that.

CHAIR - You say the diesel generator is three-quarters of the way through its life. Do you exercise that every so often to make sure it is in working order?

Ms BRIDGEWATER - Yes, it is. Maintenance has that on their schedule.

CHAIR - Is that weekly, monthly or quarterly?

Ms BRIDGEWATER - It is run at least every second week. It used to be weekly but it is now fortnightly, based on some advice received. Yes, definitely.

CHAIR - How long do you think that can cope with an outage?

Ms BRIDGEWATER - As long as you keep topping up the diesel tank, it is ad infinitum.

Mrs RYLAH - I understand diesel has to be either moved, reticulated or changed to be sure it does not get water in it because diesel degenerates over time. That program is a part of your program of maintenance?

Ms BRIDGEWATER - It is on the maintenance program, yes.

Mrs RYLAH - It was a major issue at the repatriation hospital in Hobart. The big diesel tanks weren't exercised.

CHAIR - New body protection power will be provided throughout the acute consulting and treatment areas. Can you tell us about that?

Mr COCKBURN - Those circuits in hospitals have to be body protected. It goes beyond residual current device, which is what you have in your house.

CHAIR - It is 100-millisecond switch-off?

Mr COCKBURN - It is the next level up.

CHAIR - Okay.

Mr VINEY - You will find that operating theatres and ICUs are cardiac- and body-protected, whereas the wards are just body-protected for inpatient use.

CHAIR - Alright. They haven't forgotten but we don't understand the finer points. It also lists the existing Panduit Racks with cable management system as suitable for reuse. We have talked about sprinkler systems and the digitally enhanced cordless telecommunication system, which is simply a wireless phone system, is that correct?

Ms BRIDGEWATER - I have walked out of the hospital with mine. The DECT phone was put in place with the last redevelopment and it is probably the best thing that nurses could have. It also provides us with a local duress system because in this remote locality we don't have a security firm to link into so. The DECT phone system has a duress ability that will notify your co-worker that there is an issue.

CHAIR - A co-worker, as opposed to the police.

Ms BRIDGEWATER - The co-worker should then investigate and ring the police.

CHAIR - Domestic cold water services on this site are classified high-hazard as this is a health care facility. I believe it is not drinkable water but it may be desired, is that right?

Ms BRIDGEWATER - The current water is drinkable but it is not very palatable due to the mineral content.

CHAIR - Okay.

Ms BRIDGEWATER - There is a project in place to pipe fresh water from Grassy. It will to go through a filtration system that has just been built in Grassy and it will be world-class water.

CHAIR - That sounds like good news for the hospital and the patients within.

Mr VINEY - The new water main will run past the entrance to the hospital.

CHAIR - It will be easy to access.

Mr VINEY - Yes.

Ms BUTLER - Is this a water supply issue on the island in general?

Ms BRIDGEWATER - No, not in my experience.

Mrs RYLAH - The hydraulics, the morgue refrigeration room, is not mentioned on page 18, yet we heard it was being upgraded during our discussions on the tour.

Mr COCKBURN - It is being upgraded in its same location.

Mr VINEY - It would be mechanical, I imagine.

Mr COCKBURN - The insulator panels are being replaced and the unit that cools that area is to be replaced as well. The new rack is a stainless steel item that wheels in and out so it is being modernised. People make them and you can buy them off the shelf.

Ms RATTRAY - There were some lovely stained glass windows that had been contributed to by families or the community and they're going to be incorporated or remain in place.

Mr COCKBURN - They will remain in place in the observation room.

Mrs RYLAH - Is the viewing room being upgraded?

Mr COCKBURN - It is.

Mrs RYLAH - In both design and looks?

Mr COCKBURN - Yes, we're trying to make it a bit friendlier.

CHAIR - You say trade waste works are being limited to replace the existing kitchen grease interceptor trap lid with a new sealed Gatic lid system. Can you explain the benefits of that and the accessibility of that by truck, if needed, to clean it out and those sorts of things?

Mr COCKBURN - The existing grease interceptor trap is adequate but the lid is unsealed, so it's not a great look outside a kitchen. Whilst we're putting in a new concrete slab throughout that area we will actually put a proper lid on the grease trap. In terms of truck access, the rear canopy of the hospital is sufficiently high enough to get most trucks on the island underneath it. It will currently take the council garbage truck, so we figure we can get a medium-sized truck in there to pump out a sealed pit.

CHAIR - With a truck operating that close now it is going to be roofed and blocked from one side, is there any concern about exhaust gases?

Mr COCKBURN - There's a considerable opening on the eastern side that essentially means it is still classed as an outside space; it is unenclosed.

Mr VINEY - The entrance to the acute ward has an airlock as well; it's a double-door entry there.

CHAIR - So that will stop any major incursion of diesel fumes into the hospital environment?

Mr VINEY - Yes.

Ms RATTRAY - Chair, I have found my question on page 19. It is about the art site scheme. We were fortunate to be able to see some of the examples of the last redevelopment and the practical art components of that. I am very keen to push more practical art projects. We know that part of that last redevelopment has to be removed, one of those glass panels has to be removed, to accommodate the new staff area. It is worth having on the public record what that will consist of and what is planned. I know you have already mentioned that part of that art component for the new one is going to be around the entry as well, so I would like you to touch on that for the committee.

Mr COCKBURN - The glass itself, the existing art work, is being relocated from the window that we need to remove to the adjacent wall in the waiting area just in front of the nurses' station. We have had a look at that and measured it and believe it fits. So we will get that glass put in a frame with an appropriate backboard to accommodate that. With regard to the new art, I haven't read the final brief from Arts Tasmania on that but the discussions up until this point have been largely associated with the external entry area to the hospital. We are putting a new wall in there - en suites go from the emergency area - and we believe that wall will form a really good backdrop or a potential artist's canvas, if you like, to the entry.

Ms RATTRAY - Do you envisage taking up that allocated funding for that one piece, or do you think there might be an opportunity to get something more practical in newer spaces somewhere?

Mr COCKBURN - Not necessarily; I think there is -

Mr VINEY - I think we'll take on board your comments about that and push that element.

Mr COCKBURN - For example, the last one I did on a hospital job was at St Helens and that was split in half. There were two separate artists doing two things and that worked quite well.

CHAIR - If local artists have an opportunity to have an input that would be appreciated.

Ms RATTRAY - That was my next comment. If you get a local artist involved in whatever that might look like, there would be more connection to the community because it is a local person; they might know that person and it gives it a bit more meaning.

CHAIR - Do you see any problem with the project schedule under 6.1? Obviously the development application has gone to the council.

Mr VINEY - It has been approved.

CHAIR - Completion and design development has been approved. Obviously the tender documentation can't go out just yet, but how long is it likely to take to put that together?

Mr VINEY - Following the potential approval from the parliamentary standing committee, we would expect it would take a matter of weeks following that to advertise for tenders.

CHAIR - Okay, so you are still looking at final completion for December 2021?

Mr VINEY - We have changed that to March 2022. There was an error there.

Ms RATTRAY - An extra three months.

CHAIR - Okay, we will update that. Regarding staff amenity and meeting rooms, what sort of major changes are happening there to improve things?

Mr COCKBURN - Essentially the staff area has been consolidated into one zone. At the moment the staff room is separate to the admin area. That was one of the key things. The admin area is way too small in its current form and the foyer area which it addresses is also far too small in its current form. The proximity of the staff room to being centrally located to the Netherby Wing in the hospital was seen as quite important, particularly when you have staff numbers down at certain times of the day. The other aspect is an external connection from the staff room into the main courtyard, which is the sheltered courtyard. That was considered important as well. Other staff facilities include a kitchen, some male and female toilets, and relatively close proximity to the Director of Nursing's office.

Mr VINEY - I also note that the reception administration staff were very involved in the design of that new zone to make it fit for purpose for them for both privacy and security of the new entrance because they don't have a lot of that at the moment. They're very confident that that addresses their needs.

CHAIR - The last part was the screening in the Netherby Wing. Is that for privacy reasons as well?

Mr COCKBURN - It is essentially for privacy and stopping residents of the Netherby Wing walking in behind the counter.

CHAIR - Fair enough. How often does an audit of the hospital take place?

Ms BRIDGEWATER - Which audit are you referring to?

CHAIR - You talked about an audit when we were in the laundry or the kitchen.

Ms BRIDGEWATER - For food safety we have an external auditor come every 12 months.

CHAIR - Okay. What was the result of the last audit and does this meet every aspect that they may have picked up as being inadequate?

Ms BRIDGEWATER - Yes, it certainly does. Every audit that I have had has cited the inappropriateness of the tiles in the kitchen and also the wooden storage shelving. Both of those issues will be addressed in this work.

CHAIR - The kitchen staff are happy, I think?

Ms BRIDGEWATER - They're very happy and he will be happy; he won't have anything to report next year, although he might have to wait until 2022. It might take a bit more than next year. He was very happy to know that it was being addressed in the forthcoming developments.

CHAIR - That draws our questions to a close. Is there anything else you would like to make as a statement?

Ms DOWNIE - I would like to add in regard to audits, we are also are accredited under ACHS for the national standard.

CHAIR - The ACQS?

Ms DOWNIE - No, not that aged care. We have two, of course, because we have the Aged Care Standards that we must comply with that are changing on 1 July, so we will be ready for that. Then we do have the national standards which are around our hospital and acute. We were recently accredited in December 2018. There was quite a lot of discussion in regard to our laundry facility and the functionality of that in regard to infection control. This work will certainly rectify any issues that we have in the future around that. That was something they really focused on and also on our kitchen as well. The assessors were quite interested in what we were doing to upgrade those areas. This work will certainly go towards the recommendations that came out of that work.

CHAIR - Excellent. Any other statements or any other information you wish to impart?

Thank you very much for coming. We have really appreciated the effort that you've gone to. It's been very informative. We don't often get to sit on the hospital renewals - I think St Helens and this one are the only two.

Ms RATTRAY - Repat?

CHAIR - I wasn't on the Repat, but you were. It is very good.

Ms RATTRAY - Thanks for the hospitality. It has been lovely.

CHAIR - We need to retire and consider the matter, but there are a couple of questions that I do have to ask you prior to you departing.

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

Messrs DOWNIE, BRIDGEWATER, VINEY and COCKBURN - Yes.

CHAIR - The answer is yes to that? Okay. Are the proposed works the best solution to meet identified needs or solve a recognised problem within the allocated budget?

Messrs DOWNIE, BRIDGEWATER, VINEY and COCKBURN - Yes.

Ms RATTRAY - In other words, there's no gold-plated stuff, is there?

Mr VINEY - Absolutely not.

Ms RATTRAY - A former committee member would have asked that a long time ago.

CHAIR - Are the proposed works fit for purpose?

Messrs DOWNIE, BRIDGEWATER, VINEY and COCKBURN - Yes.

CHAIR - Do the proposed works provide value for money?

Messrs DOWNIE, BRIDGEWATER, VINEY and COCKBURN - Yes.

Mr VINEY - In its location.

Ms RATTRAY - Good point.

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

Messrs DOWNIE, BRIDGEWATER, VINEY and COCKBURN - Yes.

CHAIR - Thank you. I remind you again, before you leave, about the parliamentary privilege statement that we made earlier that anything you say outside of this hearing is not necessarily protected by parliamentary privilege and you should be aware of that.

Thank you again for coming and we will now retire to consider the report.

THE WITNESSES WITHDREW.