PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET AT THE JOAN MARSHALL BUILDING, KINGS MEADOWS COMMUNITY HEALTH CENTRE ON MONDAY, 12 MAY 2025.

INQUIRY INTO KINGS MEADOWS COMMUNITY HEALTH CENTRE

The committee met at 12.59 p.m.

CHAIR - Thank you very much. I'd like to welcome everyone here. Before we commence the hearing, I would like to introduce members of the committee. I will start from my right: Simon Wood, almost what you'd call local member, given his office is just down there over the fence; Dean Harriss, member for Huon; Tania Rattray, member for McIntyre. We have Jen Butler, who is the member for Lyons, and Helen Burnet is a member for Clark. Thank you very much.

We also have with us our secretarial support - we have Scott Hennessy and Kiah as well. Thank you very much for being here. Harrison is taking the *Hansard.* We have no apologies.

Mr Secretary, would you please read the message from Her Excellency, Governor-in-Council, referring the project to the committee for inquiry? Thank you.

SECRETARY - Pursuant to section 16 (2) of the *Public Works Committee Act 1914*, the Governor refers the undermentioned proposed Public Works of 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 $10 million. Kings Meadows Community Health Centre.

CHAIR - Thank you very much. The committee is in receipt of two submissions and they are from the Department of Health and Carolyn Gutteridge.

Could I ask a member to move a motion that the submissions be received, taken into evidence and published?

Ms BURNET - So moved.

Motion agreed to.

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

Mr JON HUGHSON, DIRECTOR OF PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, **Ms FIONA LIEUTIER**, CHIEF EXECUTIVE, HOSPITALS NORTH, **Ms REBECCA RAMAGE**, PROJECT MANAGER, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, **Ms JULIE SEEBER**, NURSING DIRECTOR FOR SUBACUTE SERVICES, HOSPITALS NORTH, **Ms ROSE MACE,** NURSE UNIT MANAGER, RENAL SERVICES NORTH, DEPARTMENT OF HEALTH AND **Mr CAMERON BURBIDGE**, ASSOCIATE AND PROJECT LEADER, ARTAS ARCHITECTURE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. Before we commence, it is part of our committee process that I provide this statement before the evidence is taken. Again, thank you for appearing before the committee, and the committee is very pleased to hear your evidence today. Before we begin, you giving your evidence, I would like to inform you of some of the important aspects of committee proceedings.

The committee hearing is proceeding in parliament. This means it receives the protection of parliamentary privilege. This is an important legal protection that allows individuals giving evidence to a parliamentary committee to speak with complete freedom without the fear of being sued or questioned in any court or place out of parliament. It applies to ensure that parliament receives the very best information when conducting its hearings. It's also important to be aware that this protection is not accorded to you if statements that may be defamatory are reported or referred to by you outside the confines of the parliamentary proceedings. This is a public hearing and members of the public and sometimes journalists may be present, and this means your evidence may be reported. Do you all understand?

Witnesses - Yes.

CHAIR - Thank you very much. Would somebody like to make an opening statement? Thank you. Is that something that's been prepared?

Mr HUGHSON - We don't have an opening statement, but we do have a presentation, a brief summary presentation, if that's alright, thank you, Chair.

CHAIR - That's fine. Who is going to make that?

Ms RAMAGE - The presentation's on the screen behind. I'm mindful that people would have to turn, so perhaps I'll give a brief introduction. It might be easier.

CHAIR - That's probably easier, particularly for the people who have taken the opportunity to come today, so thank you.

Ms RAMAGE - Welcome to the site. The project is the redevelopment of the Kings Meadows Community Health Centre, mainly the renal facility, which will be located on this site where we're sitting now, which is in the Joan Marshall building. The aim of the project is to extend the existing services to meet the demands for renal clinical practice in the north. The Australian Government has provided $10 million for the project.

CHAIR - Thank you. Nothing else to add to that at this stage?

Ms RAMAGE - No.

CHAIR - We very much, on behalf of the committee, appreciated the opportunity to look over the site this morning, so thank you. Rose hosted us at the actual facility that provides the dialysis services, and we were welcomed into that area. Again, we thank you for that opportunity and acknowledge on the public record the work that you do there for our fellow Tasmanians. It's very much appreciated, so thank you.

Our usual process in this committee, that we inherited from the previous Chair, is to start at the beginning. We'll go to page 6 of the submission. That certainly talks about the project summary, and goes on to talk about the existing renal dialysis service delivery that's currently being housed there and will go to the new proposed building, if that sees favour of this committee.

Members, I'll open it up to questions.

Ms BUTLER - Thank you, Chair. Looking at 1.2 in the project summary, the second dot-point talks about the construction of a purpose-built 18-bay renal dialysis unit, and just going on your introduction to us then, you talked about the demand. What is the projected demand for renal dialysis units for the area, or to service Launceston and greater surrounds?

Ms RAMAGE - I might have to defer to the clinicians for that type of response, I'm sorry.

Ms SEEBER - The current data that we [inaudible] the current build would support our current patient list. We've taken a little bit of pressure off the LGH. We certainly don't claim that this is going to be a complete futuristic goal to meeting our demand because, unfortunately, chronic disease is constantly continuing. I don't have the actual data in front of me. I'm happy to provide it at a later date, as I would not want to give you inaccurate information.

Ms BUTLER - We would appreciate that because we want to make sure that what we're investing in and the decision we make today is based on as much fact as we can get, so I'd be very appreciative.

CHAIR - The Committee Secretary will provide a letter of request at the end of these hearings in regard to that. There might be someone to start work on that.

Ms BUTLER - Just on that line of questioning in further pages - we will be going back to how many renal dialysis units there actually are - but just for the record that what we're looking at today is an increase of two chairs within this project scope, is that correct? At the moment they're at 16 and it will be going to 18?

Ms SEEBER - Yes.

CHAIR - Can we have the explanation around that the two chairs, but it's actually two extra services each day or two actual time slots, can we have that on the record as well?

Ms SEEBER - The way renal dialysis works at the moment is they do morning sessions and p.m. sessions, and each patient does three sessions per week. We're basically - for one

chair, we can double the patients. Does that make sense? We have three sessions per week for each patient. One chair would do one patient there, two, so that's four.

Ms BUTLER - Do you leave a chair or a spare as part of a matter of process? How many chairs do you use at one time?

Ms SEEBER - All of them.

Ms BUTLER - All of them are used at one time?

Ms SEEBER - Rose is happy to put input here as well if she wishes. From the Kings Meadows perspective, they're always looking at booking all of the chairs. Our LGH unit, we try to allow flexibility for that in case we have acuity increases or urgency that needs to be fitting. The hospital-based chairs are the ones that run slightly under. These ones are all booked to capacity to ensure that community members are getting through.

Ms BUTLER - It's my understanding, and I stand to be corrected, that as a matter of good process, a chair is left spare in case there's an issue with some of the other chairs; is that correct?

Ms SEEBER - Not to my knowledge. I'm not an expert in renal dialysis. I will openly say that. I'm happy to send that through to Rose.

Ms MACE - On any given shift, so Monday, Wednesday, Friday, morning or afternoon, there's often that 16th chair is there for that patient who's late; the patient who couldn't come in the morning, they come in the afternoon. Also, we need, for the throughput of patients, three machines as spare plugged in, having done their cleaning cycle, ready to go. That third one is there so if a patient needs to come off a machine that's failed during a run, they can just be moved across to that 16th spot. We do use the 16th spot for holiday dialysis, so people ring up from another unit around Australia that want dialysis, we often accept them into that 16th spot if it's not needed for someone else. On any given day, there are always 15 in each of the seats, with the 16th one used on an as-needed basis, which some weeks can be that it's spare, but it's a good spare to have to be able to move a patient that's hooked up to dialysis. We can disconnect them and just move them around into that spare spot. If we got up to 64 patients that would make it trickier, but as Julie said, we would move patients to the LGH if they had capacity there to take the pressure off here.

Ms BUTLER - Sorry, Chair, just one more question. I'll move on. I am jumping, though, onto this page here, but I was -

CHAIR - Given it's Monday, I'll allow it.

Ms BUTLER - It's the same subject area. I just don't want to jump too much and make sure we stay focused. We've been given data around existing treatment phase and those calculations - my reading and the information that we just learned then, they're based on 16 treatment bays and 18 treatment bays and they're based on those treatments per week. Is the 16 really accurate in that data, or is it more like 15 and with the 18 being more like 17? Is this data accurate?

Ms MACE - We'll actually have a tech room that will have spots to keep the three spare machines, so we will be able to run the 18 that have been factored in. We'll be able to go up to 74 patients - 72, because we won't need to have the spare out on the floor, the spare machine out on the floor.

Ms BUTLER - The 36 treatments per day, six days a week, 216 treatments per week, that's on the 18-treatment bays - that's accurate data? That's what it will look like. Okay. Thank you.

Ms BURNET - Thank you, Chair I'm interested to hear just the current use and how that changes, and also - it might be for later - but how that transition might occur during any sort of build as well. What happens to the current uses in this building, including this meeting room, and where do the clinicians end up going?

Ms RAMAGE - The midwifery group will be moved offsite. They currently use two of the rooms here, the small meeting rooms. They'll go to a leased facility, which we're currently undertaking hunting for; that will be organised, and we'll pay for the lease for that, for the 14-month duration of construction; and the renal CNC and social worker will go to a demountable unit, which will be onsite.

Ms BURNET - And this room?

Ms RAMAGE - This room -

Ms BURNET - Which is a meeting room.

Ms RAMAGE - It is a meeting room, and this facility would essentially not exist in the new renal clinic. However, when the renal team comes out of the existing building, there will be space, and what we do with that space is yet to be determined.

Ms BURNET - Could you just describe for the committee the age and, maybe from a clinical perspective, the challenges that this centre, Kings Meadow Centre, has delivering renal outpatient services?

Ms RAMAGE - Just from a building perspective, I can give it on that, but not necessarily the clinical side of things. It's an ageing building. It's got many problems with it, where it's located, with drainage, rising damp and things like that. It's certainly not to best-practice standards for a renal facility, which is probably what you saw when you went for a walk through there this morning. It's just not keeping up with demand or standards.

Ms BURNET – And from a clinical perspective?

Ms SEEBER - It's worth noting that we actually have Kings Meadows as a risk on our risk register as well, due to the lack of visibility of our clients when they're sitting in the chairs and nurses needing to be constantly walking around. They've got some things put in place to counteract it, but from a clinical perspective, that's not something we'd like to see, whereas the new design is all about the open plan and the visual across all aspects.

CHAIR - The demolition of this building that we're in today, the Joan Marshall building, and - forgive me for not doing any research on Joan Marshall - the discussion with the family

about having that name continue on for a new facility, can you just give the committee some understanding of what that -

Ms MACE - Last September, the previous project officer, Craig, asked me to contact because Joan Marshall's granddaughter became a renal nurse and worked with us for a while and she moved to Queensland, so he asked me to ring her, so she gave me her uncle's contact. I think Craig's got that written down somewhere, so that from what I gather, the family were understanding why the building needed to be demolished, and that down the track, a community room might be named after her - not necessarily this new building, but a community room, that was her focus. She was a community nurse, so they were going to be happy with that.

CHAIR - On our site visit, I did suggest that somebody take a photo, and there's some interpretation in the new building to acknowledge that this building was originally the original Joan Marshall building. I think that would be highly appropriate, and I got a couple of nods out in the site visit and I'm getting a couple here now, so thank you.

Ms BUTLER - Could be part of the art.

CHAIR - Could well become part of the arts scheme.

Ms MACE - We do have ongoing contact with the granddaughter, and if we've lost her uncles - she didn't nominate her dad because he was poorly but her uncle was happy to be the contact.

Ms BURNET - I've got another question. The renal facilities now, what happens to that space?

Ms RAMAGE - That hasn't really been determined just yet. Midwifery will have to return to site, so that space could be adapted for them if we need other things. There's allied health in there at the moment, so there's podiatry, physio and dental. It would be a discussion with those groups as to what happens with that space.

Ms MACE - And home therapies is -

Ms RAMAGE - And home therapies is remaining there in that centre.

CHAIR - Have there been any discussions about what might be added to that current facility?

Ms SEEBER - We've had some broad discussions with the project team. I've put through some requests in regard to maybe looking at redesigning our space for our PD nurses, and our social worker attached to the renal won't have space within the new building. That's definitely something that's being raised and considered as well.

CHAIR - And my second question is about the provision for additional footings at ground level to facilitate future expansion of the new renal unit. It tells us that there'll be a space for six more treatment bays and, given that we had a look at the plans prior to the lunch break, I'm just interested to understand why that facility does not just have the roof cover because it's having the footings, and just not have it fitted out. I would expect that if your initial build is

where your first cost is, so why wouldn't you put it all under the one roof and then fit it out at a later time? I'm not sure who's in a position to answer that. Thank you, Jon.

Mr HUGHSON - Thanks, Chair. We've been through a fairly exhaustive process to get to where we are with a number of redesigns that actually fit within the funding that's been provided from the Australian government. We believe we've reached a good point to provide a building that facilitates that future expansion but, unfortunately, within the budget that we've been provided, we're doing the best with what we've got.

CHAIR - Right. My follow-up question would be, that given that the $10 million budget is from the Australian government, has there been any number crunching on how much the state government might like - or could put forward to facilitate those additional six beds?

Mr HUGHSON - I'm not aware of those discussions occurring.

Mr HARRISS - Just on that with the footings, it notes there, as the Chair said, that the footings are at ground level, I suppose is that standard? That seems unusual to me, that you'd put in footings for additional one and, on top of that, what are the compliance issues with putting footings in now that may not get used for five years? Is there any compliance issue that they will become non-compliant and be required to be redone when you come to build it?

Mr BURBIDGE - They would be put in the ground at the moment and they're covered over so, basically, you're not going to see them and they're not going to be a hazard to anyone walking around that area. It's hard to tell if they'd ever become non-compliant because we don't know what the building code is going to do in the future, but we would do everything we can to futureproof for that. The main reason we're putting them in now is to prevent us having to come back later and redo the car park.

You're going to need some sort of heavy machinery to do the footings, and we don't want to drive an excavator down there when the car park has been redone and ruin all that, and then have to redo that. We're trying to say, while we've got the excavator here doing the footings for everything else, putting in a few more just to save it down the track and make it a bit easier for the next builder to come along and put the addition on without doing destructive works to the car park, because they need to get an excavator or heavy machinery down there.

CHAIR - As the architect for this project, has there been any discussion, given that this is a few iterations down the track for what's been proposed, in regard to actually putting those extra six additional treatment bays undercover, straight up, and then just not fitting them out?

Mr BURBIDGE - No, there hasn't, but again, that comes back to Jon's point about the funding. I'm not sure what the figures would, be but there'd be a fair bit of money in just building the shell. There's a lot of concrete and stuff in it to get that to work. It would certainly be easier down the track to add onto if the shell was already there, but yeah, we're trying to work within the budget we've been given.

CHAIR - Any more questions in regard to that? We can move over to page 7. We've sort of gone across some of this as well. It's often what happens. The project location - was this always the only site ever considered for this upgrade?

Mr HUGHSON - Sorry, what was the question, Chair?

CHAIR - I said: was this site at 22 McHugh Street the only site considered for this new upgraded facility?

Mr HUGHSON - Yes. The funding was provided to upgrade this facility at this location.

Ms BUTLER - Can I quickly go back to that?

CHAIR - Back to page 7?

Ms BUTLER - To 1.6, it does tie into location as well. That $10 million that was allocated by the federal government through the CHHP, that was in 2019, so some six years ago. Why did it take six years for this to come to fruition because $10 million six years ago for a project probably would have given you a lot more bang for your buck than six years later, and with the escalation of costs for building, can you, for the record, talk us through that? That's a good place to start.

Mr HUGHSON - I haven't been in this position for more than about a year and a half. I was aware that there were a number of proposed designs that looked at upgrading the main facility, performing an extreme amount of maintenance to try to make it suitable, knocking down the main facility, and I think those designs probably took at least a couple of years through progression. I think there was about 12 to 14 different designs. All of those landed outside the budget.

Ms BUTLER - Noting in this submission, there is quite a lot of reference to the future addition to the renal unit as part of the submission, but it's not funded. There's no surety about whether there will be any future funding for that, so I'm curious as to why it's in this submission, because it doesn't relate to this actual project in itself because it's not funded. There's actually no evidence that we have that this will even eventuate, so I'm curious why it's in the submission at all, the future plan?

Mr HUGHSON - It's about the philosophy that what we're doing is essentially a stage. We adopted a stage model, but it is reliant on the Australian government providing more funding, which we will lobby for in the future.

Ms BUTLER - Okay. Is that unusual to have it as such a prominent part of this submission even though it's not funded? We have no certainty about it at all. It looks like the designs, even being mindful of that future add-on, the last back section and with the additional beds - but there's no funding for it at all?

Mr HUGHSON - I can confirm there is no funding for it at all at this stage. Correct.

Ms BUTLER - Have there been inroads made - because it's been six years - on the state level? Surely it wouldn't be that many more millions of dollars required to finish it off?

Mr HUGHSON - I'm not aware of the conversations, sorry.

Ms BUTLER - I just think it's important we have that on the record because we're being asked to make a decision on this project, but that's a whole different project. It's not actually part of this at all.

Ms BURNET - Can I just ask a question relating to that? The renal dialysis beds, are they like hospital beds, you can only have a certain number?

Ms RAMAGE - Certain numbering what? Sorry, what? So each station that you saw has a machine and a chair.

Ms BURNET - No.

Ms MACE - Are you talking about distance?

Ms BURNET - No, not distance, no. Actual hospital beds, so licence for hospital beds versus outpatient facilities.

Ms SEEBER - So you're talking about as far as funded chairs?

Ms BURNET - Yes, that's right.

Ms SEEBER - My answer would be no to my knowledge. Fiona might be able to assist with that.

Ms LIEUTIER - I don't believe so, but the funding obviously needs to be adjusted as we can, determining the workload that is occurring at the time, and the rebates that can be sourced back through Commonwealth funding as well.

Ms BURNET - Sure, okay, and then that would be the clinical staff and all that sort of thing, so a significant amount of money associated with that. Just in relation to: 'The progress to date includes', 1.6, there are a number of things there and I note that there's a 'Development of a Stakeholder and Community Engagement Plan.' Could you just step through the community engagement that has occurred, please?

Ms RAMAGE - I'd like to say that there hasn't been any, and that's an oversight of the project to date.

Ms BURNET - I'd be very curious to know why there's been such a significant oversight since this is such an important community project, really, and given the department has community stakeholder representatives and that may be a question for perhaps Fiona?

Ms LIEUTIER - I don't think there's any logical reason that we can give that there wasn't the community consultation that we would've expected. As project sponsor, I take ownership of that. It's been unfortunate in that we thought that community consultation had occurred, but it's quite evident that that hasn't occurred.

We have taken some remedial action. We have a community consultative engagement committee that sits within Hospitals North, which is made up of community representatives. They have now been engaged, and we also have Carolyn Gutteridge on the community consultation committee as well. That committee is going to have its first meeting next week. It's already arranged and then we will be bringing the community up to speed as much as we can.

But yes, it was an oversight. We thought community consultation had commenced for the project and it hadn't.

Ms BURNET - Is there an organisation who looks after it, like the Kidney Foundation or like any organisations?

Ms BUTLER - Like an advocacy group?

Ms BURNET – Yes, other advocacy groups who you'd engage with?

Ms LIEUTIER - Certainly, and I'm looking at Rebecca because I think your team prepared the stakeholder consultation.

Ms RAMAGE - We have a SCEP for all of our projects, and that's prepared by an independent consultant.

CHAIR - So, the independent consultant was that company, that organisation, responsible for the community consultation?

Ms LIEUTIER - No, the project manager was.

CHAIR – The project manager.

Mr HUGHSON - The Stakeholder and Community Engagement plan should certainly step out at a point in time when the project should consult with the community, which clearly didn't happen.

Ms LIEUTIER - Obviously, and I don't know off the top of my head, Rose and Julie may have a greater awareness of any advocacy groups, but certainly more than happy for any identified groups to be incorporated into the community consultation.

CHAIR - Is there input now only at the back end of the project, hence the development application has been submitted and approved, is that correct, by the Launceston City Council? So now it's really a matter of making a submission through that process for anyone who has an objection of some relevance.

Ms LIEUTIER - Certainly, but I think we would encourage people to - and we'll find a mechanism to do that - to let us know if they would like to be involved in further participation in the decisions that we can now make, and it might be the aesthetics, it might be the layout as so far as can fit within the development that's already been approved.

It is an unfortunate set of circumstances. Certainly, I'm very much about transparency and consultation, whether it's staff or community and, unfortunately, we've failed in this aspect.

Ms BURNET - Presumably unions, I think there was some mention of unions having a bit more input into the process? It's a really important component as far as I'm concerned.

Ms BUTLER - Turning over onto the project cost, we will come back to this, but there has been $51,200 allocated for stakeholder engagement. I'm curious as to how much of that stakeholder engagement cost has already been outlaid.

CHAIR - And to whom?

Ms BUTLER - And to whom, because that's quite a significant amount of money where there hasn't been any community consultation.

Ms RAMAGE - I can talk to that. RPS is the consultant firm and I've spoken to them about their fees. We've still got money in the kitty, if you like. We're looking at how we manage communications from here on and through construction.

Ms BUTLER - We're looking for how much has already been spent.

Ms RAMAGE - There's $15,000 left in their budget.

Ms BUTLER - If the community consultation has been lacking, have the actual clinicians and users of the facility, what does that consultation look like? Is that also lacking?

Ms RAMAGE - I've taken the project from November of last year and I've been up here a couple of times to speak with the clinicians and I've done a number of Teams meetings with clinicians and also Julie in finalising the design. We've actually got another one coming up shortly to finalise the last few bits and pieces.

Ms BUTLER - I believe Burnie has a really good facility. I think it's Burnie. I haven't been there myself to view it, so I'm just speaking from information I've been provided - but were informational learnings provided from that project to this project to inform at all.

Ms RAMAGE - I'm sorry, not to my knowledge.

Ms SEEBER - To add to that as well, I've been permanent for the last six months, so I'm new into the project as well, but I can confirm that once we got to plan stage, which is where I've come into it at that level, I've gone out to all staff within the renal unit from all levels from HSOs to admin to nursing. I put out an expression of interest for any who wish to be part of the committee that was looking at the structure and the redesign and any changes. From that, I think, it's a team of eight I have, I have to check to correct the number, who all expressed interest and all people appointed to the committee. They've been meeting with me and architects and Rebecca and going through the plan and giving us input and we've made several changes around that aspect. They've shown the team around here and seen what they like and what they don't like and sort of what excites them and what doesn't as well. To let you know that that's occurred.

Ms BUTLER - So, when was that?

Ms SEEBER - That's been happening for the past – when did we stand that team up?

Ms RAMAGE – Early January.

Ms SEEBER - Once the plans had been drafted into the position that's when it came out.

Ms BURNET -That's all well and truly past the development approval and the amendment to that development approval from council.

Ms RAMAGE - The development application was approved, was it in November?

A witness - last year

Ms RAMAGE - and then we did a minor amendment to that with some of the internal layout.

Ms SEEBER - But there was consultation with the previous project management prior to that here. There were two sessions as well prior to that happening.

Ms LIEUTIER - There's also been an ongoing reference group for, I'd say, at least the last 18 months and Rose has participated in a lot of that consultation along with along with her staff.

CHAIR - So any further changes that may have been put forward by people who are on the ground, if you like, using the facility on a day-to-day basis, they can still be facilitated without going back to amend the DA again?

Ms SEEBER - They should be able to.

CHAIR - Is that the internal? You put the wall here and not there, that type of arrangement?

Mr BURBIDGE - It depends how big the changes are. If we're mirroring the whole building or something like that, then we'd need council approval, but generally if they're minor, internal things, moving the wall here or there.

CHAIR - Like you might do when you build a house and the doorway might be better off there and not there.

Mr BURBIDGE - Exactly. That's all stuff we can we can work through and we don't need council approval for, but if we're making the building bigger or smaller or anything like that, then we need council approval.

Ms SEEBER - We have another one of those either this week or next week, where we're reviewing all of those suggested changes that have been put into place from the staff.

CHAIR - Members? They're virtually overarching questions. We've lost our pages completely. I said this might happen.

Mr WOOD - I have one about the car parking. Obviously, with the new building going down through the car park north from here, with possibly 10 to 12 car parking spaces to be lost, is the ratio still going to be appropriate in terms of the availability of car parking? Is there any opportunity to perhaps do some landscaping works to incorporate maybe a few more, to get that number up?

Mr BURBIDGE - Currently there are 60 car spots on site and, once this building's done, there will be 77 plus two drop-offs, so we're increasing the car park numbers, and we are -

CHAIR - And less front garden.

Mr BURBIDGE - Yes. On the eastern side, between the community health centre and the golf course, that's where the majority of the car parking is going to be, so there's going to be a lot less garden through there. Then we are planting more garden around the perimeter of the site, where we can, to increase the nice views out so you're not just looking into neighbours and stuff.

Mr WOOD - Just on that, on the site visit earlier today, there's plenty of light in that area but not a lot of windows. Obviously if you're a client using the chair for five hours or so, and you're looking at a brick wall - and I know there are TVs - but it sounds to me like there's going to be better vision out into the gardens and landscaping. It is going to be a very positive thing, I would think, for clients.

Mr BURBIDGE - Yes, so every renal bay that's on a perimeter wall has a window, where applicable. There's two on the other perimeter wall that don't, but all the other ones that don't have a window have a skylight above them. The consumers have a choice of a window or skylight to look out to and get some views out past and through the building.

CHAIR - You wouldn't have seen much earlier this morning in Launceston. It was a bit foggy.

Can we talk about the demolition and the way that you're going to be able to facilitate, because we heard this morning, when Rose took us around the actual unit, that the actual units will have to remain in place, and new units will have to be put into the new facility, because there's no transfer time; it doesn't work. How's that facilitated? Do you just order the new 18 units and then the other 16 that we have now are on-sold? Is that how it works?

Ms MACE - It's just the central water processing unit that we need a backup one in the new building, then we can on-sell the old one.

CHAIR - It's not 18 units, it's one central unit?

Mr BURBIDGE - Essentially, it will be a staged build. It'll be: knock down this building we're in now, build the whole brand-new renal building, get it commissioned and fully functioning, then on a Saturday they finish up in that building and on Monday they're in the brand-new building working. They need to keep operating. Then they'll bring the units and chairs and stuff over from there into this building - a few things they need to move over. Essentially, it's a turnkey building they walk into and start operating.

CHAIR - Do you want to walk me through the fact that this building is going to be appropriately repurposed or recycled - the materials?

Mr BURBIDGE - We've called for it in our documents for it to be dismantled, not demolished, so not just run an excavator through it and trash it all. We've called for the builder to dismantle it and sort -

CHAIR - It's called 'demolition' in your submission.

Mr BURBIDGE - We've called for it to sort all the materials appropriately, so metal, timber and masonry we'll reuse where we can, and then recycle into the appropriate different recycling streams so we're not just putting it all into landfill.

CHAIR - Are community groups able to access any of those materials or would it be purely a contractor arrangement with the contractor?

Ms RAMAGE - Purely contractor. There may be some scope for some of the fittings inside. Tomorrow I actually have a meeting with Lesley to look at what's in this building and whether we can repurpose that or donate it.

CHAIR - I don't like waste.

Ms RAMAGE - No, I don't like waste either.

CHAIR - My committee members know that.

Ms BUTLER - I was just wondering if you could, for the record, talk us through the reverse osmosis and the difference between what's currently in place and what that will look like in the new facility? It will have a separate room and space and entrance, will it not?

Mr BURBIDGE - Yes. It has its own dedicated room for the unit to be in, and a dedicated entrance from the exterior for the car park, so the people servicing it can come in and out and move the big filters and whatever else they need to. Next to that will be a tech room where the spare equipment and stuff will be, where the technicians can come and service the equipment and everything so they don't have to go into the RO room.

Ms BUTLER - I imagine that would be a really expensive part of this particular project. Is that correct, or is it a whole new room that is built? Can any of the existing equipment, I suppose, be used, or is it all for new technology and so forth?

Mr BURBIDGE - Everything's brand-new again because they can't have any shutdown time. Initially we were hoping we could steal that equipment and put it in our new building and use it, but because there's no shutdown time, there's not enough time to take it out of there and install it and commission it for these guys to operate.

Ms BUTLER - The existing would be about 20 years old already, would it not be?

Ms MACE - Fifteen.

Mr BURBIDGE - My understanding is the RO equipment's not 15 years old in there.

Ms MACE - No, some of the filters. The actual RO was replaced about seven - it feels like just before COVID we had the ROs replaced. The idea is that it has a continuous loop of water, so we can't stop that with taking that RO out, because then you've let bugs into the system, and it needs about a 10-day heat disinfect, then test the water. It takes about six or seven days before the pathology can say, or microbiology can say, it's good to go.

The time delays in switching off a water unit and starting it up again - that's why it has to be new. We can on-sell, or if someone else in the state is doing a rebuild, they can have that in their rebuild, so if Hobart was building or Burnie down the track.

Ms BUTLER - I gather it would be very much specialised technicians who would be working on that equipment and installation and so forth.

Ms MACE - Yes, it's part of our contract. We have a water contract with what was Baxter, but now it's Vantive.

Mr WOOD - Just back to the car park.

CHAIR - He's worried about where he's going to park.

Mr WOOD - In terms of clients leaving late at night, finishing, I think, at 8 o'clock -

CHAIR - At 9.30 p.m.?

Mr WOOD - Lighting upgrades for the car park and the accessibility and so on, that's being addressed?

Mr BURBIDGE - Yes.

Mr WOOD - In terms of safety and so on?

Mr BURBIDGE - Yes, lots more lighting in the perimeter - lighting around the car park to light it up to the relevant standards.

Mr WOOD - Okay. Thank you. The individual renal bays, there's going to be quite a lift in amenity there for the clients, in terms of they have control of their own lighting and that sort of thing? Is that the case?

Mr BURBIDGE - Yes, they'll be able to dim their lights above their bays, USB chargers for devices, TV hanging from the ceiling, and again, looking out the windows or the skylights.

Ms BURNET - Those current bays, is that height about 1.2 metres? You referred this morning to -

Mr BURBIDGE - No, the dividing wall within those ones, I think is 1.5 or 1.6, so it's quite tall. The dividing wall with the new design's 1.2 metres.

Ms BURNET - That'll be better sight for nursing staff.

When we went around today and saw the infection control team cleaning a couple of the beds, how are some of those kinds of clutter and infection control issues addressed in streamlining the design?

Mr BURBIDGE - Lots more store room. A fair bit of the stuff in there is lack of storage, so just finding spaces for it. We have clean stores/medication room and a general store. We also have a dirty utility area as well, and then the tech room, too, so lots more storage.

Ms BURNET - Then there'll be two bays that are enclosed?

Ms RAMAGE – Yep.

Ms SEEBER – Yeah, so there's a lot more back-of-house space for storing linen and all those sorts of things out of patient zones. That makes infection control a lot better, as well as

our rooms for washing and cleaning, and even down to our drinks and food stations - they're stored a lot more appropriately. There are a lot more handbasins easily accessible through this as well.

Sorry, the last question you asked was about -

Ms BURNET – Storage – infection control.

Ms SEEBER - The two rooms. They're not negative pressure rooms, but they are rooms that have the sliding door, which can go across, so we can put patients that require isolating into them and separate them. If it's a high risk, we still have the capacity to use the McMonty hoods if required, but it's about being able to isolate away from other patients safely. They're a nice, full glass so that people don't feel as though they've been locked in a darkened area.

Ms BURNET - That's not an infection control mechanism?

Ms SEEBER - It is, because you're isolating. That's all been reviewed by our infection control team, and they're very supportive of the arrangement. It's quite a common arrangement to have it done like that. I believe the room we have now is also not negative pressure.

Ms MACE - Correct. It used to be but not now, at the LGH.

Ms SEEBER - There are a lot of facilities that do work without negative pressure rooms.

Ms BURNET - Say if somebody has COVID, how do you treat them, currently?

Ms MACE - They're currently going into the LGH into that separate room. We're looking at doing the well outpatients, the ones who don't need admitting, under the McMonty hood with space, but it'll be easier in the new build than it will be currently.

Ms BURNET - That might be somebody who might have sensitivity issues, or neurodivergent, or whatever?

Ms SEEBER - Anyone who's immunocompromised who you're concerned about can potentially use that room as well.

Ms BURNET - Or immunocompromised, yes.

Ms SEEBER - It could go either way. It could go protecting the rest of the staff or the rest of the patients or protecting that patient.

Mr HARRISS - I'll just go back to a point that Jen made about the increase of the six units throughout the - that hasn't been costed at all? I'm struggling to understand how it becomes part of that, and it's future funding, but we haven't costed anything. We don't know how much additional cost it would be by not building it now, I suppose is what I'm getting at, as opposed to - if we were to include the extra six bays in this build, there's been no cost analysis done between doing that and what it may cost six years down the track. The additional cost is where I'm trying to come to.

Mr HUGHSON - No, I don't believe we ever did a design for 24 beds. Would that be correct? For 24 bays, sorry. If we never did a design then it wasn't costed.

Ms LIEUTIER - There was previous design and it was costed. It was literally double the price of where we're at now, from my recollection. It was some time ago.

Mr HUGHSON - That would be at least three to four years ago when we were going through a number of reiterations of design, and those costs were coming in around $20 million.

Mr HARRISS - Right. For six additional - that was only to cap at 24, yes?

Ms LIEUTIER - Correct.

Mr HARRISS - How big an area, floor size, are those six additional bays? How much floor area would that add on, or that footprint, because that footprint's outlaid, isn't it, in the footings? How much floor area?

Mr BURBIDGE - Roughly 72 square metres, 75 square metres.

Mr HARRISS - That was going to cost $10 million for 75 square metres of stuff. Is that what we're trying to say?

Mr HUGHSON - I'm not sure that a design was ever done with this current design for 24 units. What Fiona's alluding to is we did do previous designs that involved either upgrading the existing facility or knocking down the larger building. They were the costs to achieve 24 with those particular -

Ms LIEUTIER - Wasn't the Jane Marshall building, though.

Ms MACE - It was everything - it was social work, physio. It was the whole - the plans that I saw were everything. Basically, put where it is now, but we had to have renal somewhere else for a while before we could move back in. Craig would have access to a lot of those plans.

Ms BUTLER - Thank you, Rose, because that goes to my next question. I was just going to clarify for the record the location of the social work area. The renal social workers will be moved into the demountables in the car park area and - where will the renal social workers be at the completion of the project? Are they actually within the facility, or is there a space for them?

Ms SEEBER - That hasn't been determined completely yet, that's still open. There is one social worker who works across here part-time and at the LGH as well. There is only the one who we're talking about. Then we also have the one renal -

A witness - [inaudible].

Ms SEEBER - Yes, sorry, our kidney disease nurse who works here as well. Currently, they use the rooms part-time here, so the thought was to put them into that. There is a capacity that there is potentially an office space that they could utilise within the new build on that part-time base and there's also discussion around whether - if there is a refit completed in the old space, that we could set something up in there.

Ms BUTLER - Because they are currently in this building that we are sitting in, which is going to be knocked down. Within the design - so the renal social workers who are really

important to the function of the facility, I imagine. How come that - a decision hasn't been made on their trajectory through this whole project? There's no dedicated space for them. Potentially, they could be sitting in a demountable for - because we have seen it at a lot of our schools across Tasmania, of course.

Ms BURNET - And hospitals.

Ms BUTLER - And hospitals.

Ms SEEBER - Totally agree. I guess, from my perspective, in an ideal world we would've had them in a bigger build within the team. That's a dream location for all supportive services for renal and we don't have that capacity with the new build.

I haven't had the opportunity to discuss with Rose in regard to her office spaces what she wants to be able to do with those - as of yet - with that new design. I was also waiting for projects in relation to what the plan was going to be with the old facility. That's why I said there had been discussions about improving those supportive services within that building with an office space in there.

Ms BUTLER - Currently, there is maternity allied health services that are provided through this building, which is also going to be knocked down. Do we know where those maternity services will be relocated to? They're not related to renal? Just to clarify for the record.

Ms SEEBER - No, they're midwifery. They're midwives, yes.

Ms LIEUTIER - They're midwifery. We're actually looking for a lease at the moment for a house. They'd actually prefer to be in a house as it will accommodate them and their services better. We may make a decision, but they don't return to the building here if resources -

Ms BUTLER - They can't anyway because there is nowhere for them. Sorry.

Ms LIEUTIER - No, no. When the new building is finalised, it may be that they don't return to the site and that we keep them in a leased house. They feel that - our maternity services feel that that's a much better environment for the services that they provide.

Ms BUTLER - Right. Just for the record, we can clarify that the renal social workers and where they are going to be located, and funding for that, is really not part of this project?

Ms SEEBER - I would say it is considered another project.

Ms LIEUTIER - I think it is considered part of the project.

Ms SEEBER - But we don't know where they are going to go.

Ms LIEUTIER - We will work through where they are operating from. As Julie said, they're not full-time FTEs who are here five days a week, eight hours a day. It may be hot desking with an ability to go into a dedicated room when they have clients who they need to speak to. Those things haven't been finalised yet.

Ms BUTLER - No, because at the moment there is a permanent space for renal social workers within this site and this is meant to be an expanding project to enhance services, yet there's uncertainty about where social workers would go. At the moment, they actually have a dedicated space. It looks like that is a bit undercooked, I suppose.

Ms SEEBER - I guess, to note, one of the things that we have done is work very closely with the primary health team, which has a lot of the services within the building and that we have even gone so far as to draw up a timetable of when they're occupying rooms. There is potential that we can share those rooms around the part-time capacity of some of their allied health. I would not be suggesting that we have nowhere for them. What I would be suggesting is that I'm looking for the best location for them to ideally give them some permanency to that space to allow flexibility in their work rosters as opposed to having to lock them into that shared space.

Ms BUTLER - Or having them working out of the demountable.

Ms SEEBER - Yes.

Ms LIEUTIER - The demountable is definitely not the long-term solution. It's the short-term solution.

Ms BURNET - Because multidisciplinary team is what we're talking about, so is renal dialysis, is that nurse led?

Ms MACE - It is in the satellite unit, yes.

Ms BURNET - In the satellite unit. Are there any physicians involved?

Ms MACE - They're based at the LGH and they see the patients, but they don't visit out here.

Ms BURNET - They don't visit, right, but it's important to have that multi-D team presumably with your - what was the other - the kidney?

Ms MACE - A chronic kidney disease educator. She talks to the patients before they choose a modality.

Ms BURNET - Okay, right.

Ms MACE - She might do home visits or be based here.

Ms BURNET - And social work is clearly an important component of that multi-D team as well.

Ms MACE -Yes.

CHAIR - Thank you.

Moving on to the project costs. I'm no mathematician, but I'd suggest that the figures don't add up in the subtotal. I'm interested to have some understanding of whether it's about

$91,000 short in the first 9.538, subtotal one? I'm not sure if someone's doing their maths as we speak?

WITNESS - I've got the calculator.

CHAIR - I think we've checked it three times.

Ms BURNET - And the other question was, is there any sort of contingency - which is usually what we see when a budget is provided to us?

CHAIR - I gather from the representation that some people have not been on this project for the entire journey. We acknowledge that as well, and we normally are able to see various parts of the project clearly defined. For instance, the design and management fees. That appears not to be the case in this one.

Mr HUGHSON - Separated out?

CHAIR - Yes, separated out. I'm interested if that's for any particular reason.

Mr HUGHSON - Not for any particular reason that I'm aware of.

CHAIR - No. I mean, we have project fees (project manager/superintendent), which is $644,000. Does that include design and management fees or is that included in the $7.2 million?

Ms RAMAGE - It's included in the $7.2 million.

Mr HUGHSON - And I believe there's also a contingency within that.

CHAIR - Is it possible for the committee to have a more -

Mr HUGHSON - Certainly, not a problem.

CHAIR - expanded project cost and the honourable member is quite right in saying that we normally have a contingency and there's usually percentage, so if that can be provided as well. I'm happy to be taken for wrong for my additions. I said I'm no mathematician.

Ms LIEUTIER - No, you're correct.

CHAIR - Thank goodness for that. I don't want you to think I'm trying to help the state's budget and I can't add up.

Ms LIEUTIER - You're out by $45,000 or we're out by $45,000.

Mr HUGHSON - We'll provide an amended budget with a lot more detail to the committee afterwards.

CHAIR - Alright, okay. It's been picked up in the subtotal, too. That's why I've good people on this committee. They know what they're talking about.

Mr HARRISS - What's the total floor area of the new build? I couldn't see that in there. Do we have a total floor area at all?

Mr BURBIDGE - Yes, give me a minute, I'll find it.

CHAIR - Cameron will have his calculator out any minute. Correct, Cameron? While Cameron's finding that, the $45,000, will that come from the department or will that come from a request for additional funds?

Mr HUGHSON - I'd say it's just an error in transposing the budget onto this table.

CHAIR - Right, so it will be firm at $10 million?

Mr HUGHSON - Correct.

Ms BURNET - Do we know when that estimate was written?

Mr HUGHSON - What was the question, sorry?

Ms BURNET - The project cost, when was it written by the overall cost estimate? How long ago was it written?

Ms RAMAGE - Last Friday.

CHAIR - Given that, while Cameron's still looking for the square footage, given that there's no requirement for $80,000 to be spent on an art purchase because this is a federally funded project, is there any thought to paring that back in some way? I know sometimes they use furniture or they'll use something to do with landscaping, or it may well be interpretation, as Ms Butler said earlier, for the moving over of the building as it is now to the new building. Is there some thought around that?

Mr HUGHSON - It's an indicative figure only, based on what our normal project requirement is. We haven't given a lot of thought on that.

CHAIR - It's a requirement for the state, but this is not a state project -

Mr HUGHSON - Correct.

CHAIR - and there's a note saying that it's not a requirement -

Mr HUGHSON - Correct.

CHAIR - hence there's an $80,000 allocation. We've already seen that perhaps there's $45,000 short somewhere. Is there some thought about paring that back?

Mr HUGHSON - We can pare it back if we need to, to fit within the available budget. Yes.

CHAIR - I'd suggest that there's plenty of local artists who would love to be paid $45,000 or $40,000 for a piece of art to put in a new building, or whatever that might look like, but that'll be up to that consultative group to come up with something, of course.

Mr BURBIDGE - About 570 square metres, but I'll confirm that. I'll just double-check that my number's here are correct.

Mr HARRISS - I didn't write it down before, you said 75 square metres for the additional six bays, is that right?

Mr BURBIDGE - Yes.

Mr HUGHSON - Would that include support square metres or is that just purely the six additional bays?

Mr BURBIDGE - That's the six additional bays and the corridor between them.

CHAIR - Any other questions about the project costs, any of those areas that members would like to drill down into? I think receiving an updated project cost - set of costs would be really useful for the committee to consider; we very much appreciate it.

Mr HARRISS - Can I just go back to the budget?

CHAIR - You were using a calculator. I should've waited.

Mr HARRISS - On the 570 square metres, we're saying that's roughly $12,631 per square metre, so if I added the 75 we'd be looking at $950,000 for those additional six bays. Is that a fair statement? You'd push your external walls out - I'm just trying to get an understanding of - to achieve because at the moment we're not well, to my understanding, we're not futureproofing, we're meeting current demand, is that right? With the 18 bays we're meeting current demand. For $950,000, roughly, on the figures that we have, we could potentially have the additional six bays. Would that be a fair - from an architect's point of view, is that fair?

Mr BURBIDGE - Yes, based on those numbers.

Mr HARRISS - Thank you.

Ms BUTLER - As a supplementary to Mr Harriss's question, would that be a better spend in the long run? That additional $1 million spend, or potentially $1 million spend, now as opposed to later on down the track then having to rebuild that section that would be a lot more expensive than spending that extra $1 million now, would it not? Does my question make sense?

Mr BURBIDGE - Yes, I would imagine it would be more expensive building later down the track. It would, if the money was there, totally make sense to do it now. It would be less disruptive as well.

Ms BUTLER - Would you have to reconfigure such items as say roof design and so forth? It would probably be cost a lot more money to put that additional space on at a later stage than making a part of the design now.

Mr BURBIDGE - No, the way the design is now is you would just continue the roof on the same plane as it is. It's not redesigning, it's just continuing the portion that's missing, essentially, and then you'd build a new one. It's just continuing on with the structure of the building form that's already there.

Mr HARRISS - It'd have to cost a reasonable amount more for construction to happen after the fact, wouldn't it? You've got all your construction, you've got your set-up costs, you've got whatever, it would have to cost a lot more than the $950,000.

Mr BURBIDGE - Yes, definitely cost more.

Mr HARRISS - The principal's insurance, $50,000, it's a reasonably small amount, but what's that in relation to? It's just got in the brackets, 'construction material damage and construction liability.' I would have thought that was covered under the principal contractor's sums.

Mr HUGHSON - The government takes out the building works insurance on behalf of the contractor.

Mr HARRISS - Do they? Is that a standard thing?

CHAIR - Since when?

Mr HUGHSON - Correct. We have to take out principal building insurance.

Mr HARRISS - When you say principal building, for a new building, they cover that? I'm just trying to understand. From a principal contractor's point of view, they would have their insurance and if -

Mr HUGHSON - They have their own builders' insurance.

Mr HARRISS - That's right. If any materials, because it's got it in the brackets there, 'construction material damage or construction liability.' As a principal contractor, I would've thought, normally, I'm responsible for that site and if some windows get stolen, that's my problem. But you're saying that the government covers that? Is that what you're saying?

Mr HUGHSON - I'll have to confirm that.

Mr HARRISS - Right. Thank you.

CHAIR - I've not seen that before, so it'd be interesting to have that feedback.

Another one of the matters that usually comes up when the committee is undertaking these inquiries is the relocation of services and particularly when you need to be engaging with TasNetworks and TasWater. Are those negotiations, conversations ongoing? I know TasNetworks work on their timetable, not anyone else's. That's a fact.

Ms RAMAGE - We have commenced those conversations with TasNetworks and TasWater.

CHAIR - We were told this morning you have a firm price which we found interesting.

Ms RAMAGE - As much as we can at this point, yes. We know that's a little bit elastic when it comes to those services.

CHAIR - Very elastic. There's some indication that if this proceeds, that their obligations or necessary works will meet the time frames, because for them to connect from a disconnect on Friday to a reconnect on Monday, wow. We'll see. Thank you.

Project cost, members? Looks like people are really itching to get to the facade of this building.

Ms BUTLER - I had a question about the consultation with clinicians in the architectural design. It was raised with us this morning, when we had a tour through the renal unit and raised the importance of ensuring that ambulances have sufficient space to be able to access the unit - and ambulance officers when they're taking patients in or out of that unit. Could you run through some of the design for providing that space for ambulances to be able to come in and out of that entrance area as well as ambulance officers with patient delivery and drop-off?

Mr BURBIDGE - There's the undercover drop-off area just off this southern car park, which is to the south of the building. Two spots there that an ambulance can - so they are just designed for either someone to come up and drop someone to come into the dialysis or for an ambulance to pull up and either take a patient away or whatever they need to do. Then, there's obviously eight car spots out at the front there as well, trying to maintain some very close proximity to the building.

Ms BUTLER - Is that space where it is - I gather it's like an arch - I am just speaking it out loud for the record for the *Hansard.* An ambulance would be able to come in in an enclosed area of sorts to drop off or pick up patients?

Mr BURBIDGE – It's more like a carport. This has just got a roof over the top of it, so it is not enclosed on the walls, it is just covered by roof over the parking bays and paths around it. If it's raining, no-one gets wet. Then they can drop them off there or pick them up there; whatever they need to do.

Ms BUTLER - And there's adequate space for an ambulance to be dropping off or picking up someone, as well as someone who might be dropping off a family member who's coming in for four to five hours?

Mr BURBIDGE - Yes. There's two car parking bays and then there's a footpath on the three sides of them that aren't the road.

Ms BUTLER - That's all under shelter and enough space to deal with if you might get two or three cars there at the one time wanting to drop people off or an ambulance?

Mr BURBIDGE - Two cars, yes.

Ms BUTLER - Two at once?

Mr BURBIDGE - Yes.

Ms BUTLER - Your consulting indicated that that's adequate. Happy with that design from a clinical perspective?

Ms SEEBER - Yes. We don't tend to have a lot of high acuity delivered to the facility. There'd be low acuity patients who would be arriving by ambulance. It's more about the appropriate access to take away if required. That's all been discussed through [inaudible] with the clinicians.

Ms BUTLER - Also as part of that design emergency evacuation that's all being counted, you have to evacuate people from the facility quickly. Can you talk me through that?

Mr BURBIDGE - Yes. The doors are actually a lot wider than we need under the building code and that's to allow for the couches to be wheeled out and the machines to be wheeled out, whatever it is. More room around the exit path to travel then we actually require under the building code. We have enough space for people with wheelchairs or if they're still in the beds to be wheeled out through the exit doors.

Ms BUTLER - Is the site potentially prone to flooding? You have a rivulet close by. Is that an issue? Mr Wood might be able to help me out with that one. Is the site potentially an area which could flood?

Mr BURBIDGE - I think there is a 1 per cent chance or a one in 100 on the very north-west corner.

Ms BUTLER - That is pretty good.

Mr BURBIDGE - Yes.

Ms BUTLER - Thank you.

Ms BURNET - Is there only the one entrance into the building apart for the techies?

Mr BURBIDGE - There is the one main entrance through the airlock and double doors.

Ms BURNET - Yes, so, essentially where we came in today at this building?

Mr BURBIDGE - Yes, roughly where we came into this building now. There's also another exit/entrance on the western side, south-western corner, near the dirty utility room, which could be used for deliveries or goods coming in and out of the building for delivery purposes. Then there's also an exit up through the staff room as well. There are three exits out of the building.

Ms BURNET - That staff room is up high; are there steps?

Mr BURBIDGE - No, what we've done is put a walkway around the north and eastern side of the building, which connects you back up with the undercover drop-off area. We didn't want steps because, again, if someone's in a wheelchair or on a bed; on a couch still, you can't get them down the steps.

Ms BURNET - Yes.

Mr BURBIDGE - And the ramp was going to be 75 metres long, something ridiculous to make that work. The best way was to have that walkway around the eastern side of the building.

Ms BURNET - I see, so that's the really the back side of the building -

Mr BURBIDGE - Yes.

Ms BURNET - from the entrance, or from the entrance side and the McHugh Street side.

CHAIR - A question about the facade: I note that you haven't shown any brickwork at all, and I'm interested in why you wouldn't try to blend the two facilities together in some respects. Render looks lovely when it's new, looks schmicko, but as it ages it gets a bit tired pretty quickly. Was there any thought about trying to blend some brickwork into that?

Mr BURBIDGE - We're trying to keep it lightweight to reduce the structural requirements and therefore the cost. The building, and what it is, is concrete foundations and columns, concrete first floor, or ground floor, and then it's lightweight timber frame above that with a little bit of steelwork in it. We have render on the McHugh Street facade and then around the rest of the building is Colorbond, so we're trying to keep it lightweight to reduce the structural requirements and increase the speed of construction.

CHAIR - But the facade is still render, well, you render over a brick, don't you?

Mr BURBIDGE - No.

CHAIR - It's not rendering over a brick?

Mr BURBIDGE - It's fibre cement sheet.

CHAIR - Right. Okay. That makes sense then.

Ms BUTLER - Noncombustible.

CHAIR - Noncombustible, of course.

Mr HARRISS - The building materials and reference - I'm going back a little bit, but we're talking about facades. Are there any buy-local requirements in that or not, like when you're selecting products to use?

Mr BURBIDGE - Yes. As architects, we generally do that because lead times are an issue, so we try to source, specify everything as local as we can so we know that it's not going to be an issue when it's coming up to be built, so that's something we do. I'm not sure what the -

Ms RAMAGE - We have a buy-local policy as part of the procurement strategy as well.

CHAIR - There is quite a bit of a list on page 26 about compliance, and it talks about Commonwealth and state legislation meeting the Building Code of Australia. The noise issue would only be during construction; is that correct?

Mr BURBIDGE - Yes.

CHAIR - That will encompass some of that direct stakeholder, adjoining neighbour conversations that are going to occur with the consultant with the remaining $15,000?

Ms RAMAGE - There's a letter that's going out. Yes. There's a letter that's been drafted that will go out to local residents at the same time the tender is advertised. There are posters that will come here and a flyer as well that will be delivered. There's a 1800 that's on the flyer if there are any people who have been inconvenienced or have complaints about noise, dust suppression, that sort of stuff; they'll be able to ring up and we'll be able to deal with that in that way.

CHAIR - Who answers the 1800 number?

Ms RAMAGE - That goes through to our consulting firm, RPS.

CHAIR - Straight back to them?

Ms RAMAGE - Straight back to them.

CHAIR - Heritage, Aboriginal and historic: no impacts, it says in our information; none that's been identified?

Ms RAMAGE - None that's been identified.

CHAIR - You've got advice from the Tasmanian Aboriginal Heritage Council?

Ms RAMAGE - Yeah. Also, going forward for any consultation, I have been in touch with those groups as well.

CHAIR - If there are no further questions - and we may need to invite you to come back after we've heard from the other proponent of the submission - just if we need to answer some questions, but before I do that, just in case we don't have you - well, we will have you back at some time, but I just wanted to let you know that at the commencement of the evidence, what you did say to us here today is protected by parliamentary privilege, but once you leave the table, that privilege is no longer attached. Does everyone still understand that? We have some questions that we ask at the end of the inquiry, so we will have you back, but I just want to - if you decide to go out and get on the phone, we just want you to be reminded.

We shall suspend for five minutes while we have a change at the table, and invite Carolyn Gutteridge to come forward, so thank you.

The committee suspended at 2.23 p.m.

The committee resumed at 2.26 p.m.

CHAIR - Welcome, Carolyn Gutteridge. Before I ask you to take the statutory declaration. I want to thank you for appearing before the committee; the committee is very pleased to hear your evidence and acknowledge that you have provided something written as well in regard to this proposed facility.

Before I begin, it's my obligation to inform you of some of the aspects - and I know you heard it previously, but it's still part of the process - of committee proceedings. It is a proceeding of parliament which means it receives protection of parliamentary privilege. It's an important legal protection that allows individuals like yourself giving evidence to a parliamentary committee to speak with complete freedom without the fear of being sued or questioned in any court or place out of parliament and it ensures the parliament receives the very best information when conducting its inquiries. It's important also to be aware that the 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 and members of the public are here, perhaps journalists sometimes, and this means your evidence may be reported. Do you understand?

Mrs GUTTERIDGE - Yes.

Ms CAROLYN GUTTERIDGE WAS CALLED, GAVE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Would you like to make an opening statement?

Mrs GUTTERIDGE - Pages.

CHAIR - We probably won't have time. All members have received your information.

Mrs GUTTERIDGE - No, this is a more detailed one. I do think I need to speak.

CHAIR - I think you need to speak about it.

Mrs GUTTERIDGE - Yes, I really do.

CHAIR - But not read the whole thing because we will be still here at evening time. If you just -

Mrs GUTTERIDGE - It will be 10 to 15 minutes at the most. If you could please give me that opportunity?

CHAIR - That's fine. Yes.

Mrs GUTTERIDGE - Thank you for the opportunity to address my concerns with the proposed new renal facility. I understand that the aim of this afternoon is to help you understand whether the funds are being used wisely, and my comments will surely indicate the opposite.

Before going further, I would like to have it on record that my endeavours to address my concerns with the relevant ministers in the state government have been extremely disappointing

and frustrating. I reached out to Mr Ferguson, who met with me willingly, Mr Barnett, Mrs Petrusma and Mr Rockliff. My correspondence with Mr Rockliff remains unacknowledged and unanswered.

It appeared that Mr Barnett only reached out for a meeting with me after Ms Bridget Archer intervened on my behalf in May 2024, and Mrs Petrusma only met with me after Ms Janie Finlay asked questions in parliament in November 2024. They both subsequently visited the centre prior to my meetings with them.

I have received help from Ms Rosemary Armitage, MLC, Ms Bridget Archer, and Ms Cecily Rosol. I also corresponded with Dr Lee Archer, the acting CEO of the LGH.

There has been ample opportunity for the ministers and the department to contact me to arrange a patient/carer perspective. I am unsure that my concerns will amount to much as this whole project is a classic case of the horse has already bolted, with the project ready to go to pre-tender. I'm not sure what will be achieved with the further meeting on Wednesday between the architect, planners and this community engagement committee. I will be just one public voice at this meeting.

I will give you short background why I'm addressing this meeting today. My husband Peter, sitting there, was diagnosed with chronic kidney failure about four years ago. His kidneys steadily declined to the extent that his only options were dialysis, whether this was at Kings Meadows, at home, or supportive care. We obviously did all we could to avoid going down the dialysis path, and attended seminars, met with the excellent and passionate nurses here who explained what home dialysis was all about, had a tour of the current haemodialysis centre here, and talked about supportive care, which is if a person elects not to have dialysis or opts to stop dialysis.

Peter and I have also been involved in a kidney research group at the Menzies Centre in Hobart over the past two years. Unfortunately, Launceston and the north-west do not have access to a renal dietitian, renal pharmacist or psychologist, all of whom are necessary for helping to delay or avoid dialysis. I understand that patients in the south of the state may possibly have access to these professionals.

Home dialysis for Peter was not an option for various reasons. He had a fistula created by a vascular surgeon in Hobart in March last year in case of needing to start haemodialysis. Luckily, we have private health cover which enabled us to have this procedure done in Hobart, as Launceston did not have a vascular surgeon at the time and appointments were continually being rescheduled at the LGH. I'm not sure if Launceston has a vascular surgeon now, which would definitely help kidney patients.

At one stage, Peter was adamant that he would refuse dialysis at Kings Meadows as walking through the centre was extremely depressing and we immediately noticed that it was not a purpose-built medical facility, with no line of sight of patients from nurses, a lack of windows, high walls in the middle of the room, and the general age of the facility.

However, in the end we had no option and Peter started dialysis in May last year; firstly at the LGH, as he had been admitted to emergency, and then at the centre.

My first contact with the state government was prior to the elections last year when the government promised $120 million to build a new cardiac unit in Launceston. I contacted Mr Barnett's office to inquire whether any funds had been allocated to the ageing renal facility and was advised that $10 million had been allocated. It was only my research that discovered that this $10 million was in fact federal funding from the Scott Morrison government in April 2019.

A quote from the press release from Mr Ferguson at the time said that:

> The $10 million was to redevelop and extend the Kings Meadows Community Health Centre to meet increased demand for renal and oral health services. Importantly, the redevelopment will increase the number of dialysis-based chronic patients.

I questioned why it had taken so long to deliver a new unit and was told the usual 'COVID got in the way' story. My response was that COVID certainly didn't get in the way of fast-tracking the proposed stadium, the allocation of $375 million for this project and the subsequent setting up corporations to oversee the stadium project and associated expenditure.

After the election, I met with Mr Ferguson, Treasurer at the time, who seemed surprised the renal project had not been delivered and indicated that further funds had been allocated. I never got an answer about these further funds.

Ms Rosemary Armitage asked questions to Mr Barnett at an Estimates committee meeting on 23 September, and I have a copy if you're interested.

At my meeting with Mr Barnett in May 2024, I explained my reasons why $10 million allocated in 2019 could simply not cover the cost for a new build in 2024-25 without additional funds from the state government. I asked why no further funds had been set aside. I never received a proper answer. I also asked whether the risk assessment had been carried on the current facility and what the backup plan was if something went wrong with the water treatment unit, for example. Again, no response was received.

He advised that the new facility would have 18 dialysis chairs, an increase of just three - that's in one of his letters, but I'm assuming it was just two - when it is a known fact that 24 chairs are required now to meet the current budget. While home dialysis is a cheaper and, for some, a preferred option, there are many that will need in-centre dialysis and, without adequate chairs, it becomes a case of living or dying. Does a person who's ready for haemodialysis really have to wait for another person to die before they can access treatment now?

I had a follow-up meeting with Mr Andrew Hargrave, deputy secretary of infrastructure of the department, which was a pointless meeting as he offered no real solutions other than that further funds were a matter for the politicians. I asked to view the proposed plans but this was met with a negative answer. He indicated that the nursing staff and clinicians had input into the plans and that this was good enough.

A change of portfolios saw Peter and I finally meeting with Mrs Petrusma in December after Ms Finlay asked questions in parliament, and I came away more hopeful. Mr Dale Webster, secretary of the department, attended this meeting via Zoom and we received

frank answers to our questions. Mr Webster indicated that a patient advocacy group would be assembled in early 2025, but my numerous emails to both Mr Webster and Mrs Petrusma have gone unanswered and obviously no patient input ever came about.

I stress that the plan should be put on hold until adequate additional funds can be found that will see stage 2 being part of the whole project.

To get to the actual project, question: how has a project got to pre-tender stage without any public meetings? Have the government and departments simply assumed that the nurses and clinicians are the only people who could speak for patients and that their input is all that counts? Did the architects ever visit the renal centre in Burnie which is a standalone facility? Peter recently had a treatment there and we found it properly designed with a nurse's station in the middle of the room with the chairs around the outside, and the feeling of spaciousness was immediately evident.

A modern medical facility simply cannot be built with just $10 million. Another idiom comes to mind of making a silk purse out of a sow's ear. I have to sympathise with the architects who were given an unfair brief to design a proper renal centre with just $10 million. As at September 2024, Mr Barnett advises that $541,921 has already been spent on fees, which means that allowing for demolition costs and additional fees, we are now looking at possibly under $9 million to build the centre. The state budgets for 2024-25 and 2025-26 indicate that $4.1 million had been budgeted in 2024-25 and $5.3 million in 2025-26. This appears to be simply the allocation of the $10 million federal funds and not new state government expenditure. The shortfall of $600,000 has been attributed to the money spent on fees already. This was one of the questions Ms Armitage had asked.

A proper futureproofed centre requires the specialised water treatment unit, 24 chairs, adequate windows for all patients, and not just the occasional skylight, easily accessed lockers for all patients, adequate parking, and having all renal professionals under one roof. Standalone home-therapy training rooms need to be part of the plan and home-therapies training should not become part of a nurse's office. Regarding the windows and patient visibility, I see that there are some windows, but this will depend on how exactly the chairs are positioned.

The current centre, as you have seen, does not have adequate space for patients. Patients often have bleeds or require resuscitation and their privacy needs to be respected during this time. Paramedics also have to have adequate space for trolleys when transporting patients to the LGH. What is a proposed space per patient in the plans?

Given that there are no private dialysis facilities in Tasmania, the 18 chairs will not allow for any interstate visitors who wish to holiday in Tasmania to undertake dialysis. Hobart, too, is limited in accommodating interstate travellers.

The department can shed light on how many people are waiting for dialysis now and the future demand in the next few years.

Mr Barnett, Mrs Petrusma, and Mr Webster all referred to the stage 2 project that will deliver the additional six chairs and home therapies, but this is obviously in a completely new area, which possibly means a new water treatment unit and the fact that nurses will be required in two different sections. This is the first time I've actually heard that footings for the six additional chairs are part of this plan, because I haven't actually been able to see those plans.

Mr Webster had indicated it was going to be in a totally different section, so I'm not sure on this.

It is simply not practical and staffing nurses is a current problem, it makes sense to have all nurses on duty under the one roof. Just to give me an idea, it would be interesting to know exactly how big this room is. I've sort of roughly worked it out to be maybe 78 square metres, which means, according to the architects, this is going to cost another $1 million.

Coming back to nurses, we've already noticed an increase in agency nurses and they are not the answer to the patient care when they do not possess the full patient history with fistulas and low-blood-pressure episodes, as my husband has experienced.

No mention has been made of sourcing funding for stage 2 apart from Mrs Petrusma indicating she was writing to the federal Health minister in December 2024. Going by current timelines, we can't expect funding and delivery of stage 2 for another few years.

The parking assessment, as I noted, is a desktop assessment and based on aerial photography without an actual survey of patients who drive themselves to and from dialysis, and the carers who drop them off and collect them. Are we really expected to park in McHugh St and ask quite sick patients to walk a distance to their cars? This shows a real lack of understanding of the life of a person on dialysis. On Saturday just gone, there were 12 cars parked and two taxis waiting on Peter's arrival at 2.00 p.m. and 13 cars parked when I collected him at 7.15 p.m. A person was also waiting for a taxi. There are four spaces plus a disability space immediately indicated in the plans right outside, which is obviously not enough just for the patients.

Again on parking, encouraging staff and able-bodied clients to use active and public transport isn't going to work - in talking about parking issues. Public transport for staff after 10.00 p.m. is impossible and I'd love to know how many dialysis patients arrive by public transport, not counting community cars and taxis. A suggestion was made in the parking assessment that carpooling should occur and I really wonder how many people here have ever carpooled to get to and from work, especially working shifts.

Nearby council off-street parking within a short walking distance from the renal unit could possibly suit other users of the community centre but not dialysis patients. McHugh Street is a residential street. During the week cars are parked on either side, making access difficult for delivery trucks, disability taxi vans and others. Safety of staff is also a concern and they too should not have to park any distance away from the centre, especially when they finish their shifts at 10.00 p.m. on a winter's night.

Are there adequate safety procedures in place with this proposed centre? It appears that there is no real entry barrier to the dialysis unit and anyone can walk into the unit. Currently, because it is part of the community centre, there is a receptionist, who people need to see before entering the dialysis unit. There is no room allocated for a future admin person and the proposed centre's asking nurses to take on a security role. Nurses will have to be drawn away from their duties to answer the bell each time to verify the identity of people entering, which is not ideal.

This was touched on before: did the Health department ever consider a new site for the renal facility? There is no requirement for the renal facility to be attached to the community centre and a flat piece of land surely must be available in Launceston for this. Being nearer to

the LGH would be preferable as there isn't a doctor on duty at the current centre and having easy access to a nephrologist when there is an emergency would be ideal. Peter has experienced this problem.

Evidence just this week shows that the government can easily find millions of dollars to fast-track a project. We all know that the initial $90 million for the *Spirit of Tasmania* berths blew out to $375 million and literally overnight another $120 million has been added to the project. If these funds can be found for such a project, surely a few more million dollars can be found for dialysis patients to take this facility into the future.

I'm also a person who has advocated that it's better to do things once and properly and this is how we design our own homes. We're talking about the quality of people's lives here, not stadiums, high-performance centres or berths for ships. Can anyone here imagine what would happen if the government turned around and told their potential AFL team that, 'Sorry, while we know you possibly need 20 treadmills, four changerooms, dining room, et cetera, et cetera, we're only going to give you five treadmills, two changerooms and no dining rooms.' Imagine the outcry by sportspeople who are using these facilities only to earn their livelihood.

To put the $10 million into perspective for the renal unit, I have come across the following funding for projects:

- as stated before, $375 million plus borrowings of a further $375 million for the proposed stadium
- The *Spirit of Tasmania* blowing out to $493 million
- $21.5 million for the Elphin Sports Centre
- $43.6 million for the sports hub at Mowbray
- $70 million for the high-performance centre in Kingston with just $10 million coming from the AFL
- $28 million announced last week for the Glenorchy Sports Centre.

And health projects, which are all worthy of funding:

- $8 million for the Healthy Tasmania Fund
- $7.6 million for the mental health hub in Devonport
- $82.5 million for the 40-bed Older Persons Mental Health complex
- $90 million for the mental health facility at the LGH
- $20 million for the palliative hospice in Launceston

and then a mere $10 million for the renal unit, with no additional funding from the state government.

What about dialysis patients for whom a decent facility means them living the best life they can while they can? What exactly are the priorities of our state government? Why do staff and patients have to settle for second best with this proposed renal facility? Thank you.

CHAIR - Thank you very much. You've certainly put a lot of work into your submission. Yes, there were some additional points that you made. I'll open it up to members of the committee now to ask any questions that they might have.

Ms BUTLER - Thank you for your submission. Yes, that was very well researched. I wanted to ask you about the entry barrier and whether you could run through that again for our committee. Thank you for raising that because that was something that I didn't pick up when we went through and had a look today, and looking at the designs, it's not quite clear. We will go back to the other submission after we've spoken to you, but can you talk about what is there at the moment and how that works functionally for yourself, because - and how many years has your husband been visiting as well?

Mrs GUTTERIDGE - Peter started dialysis 20 May last year, so we've basically been coming here three times a week for all this time. Currently during the day, as I said, there is a person sitting at the reception centre. The doors open, you just walk in and there's an airlock area. During office hours, people just walk in and they obviously get seen. If they need to go somewhere with the receptionist, they can go.

The dialysis centre is off to the left-hand side, as you can see, so it's not easily accessible to every other person, just to dialysis people usually - because no-one else needs to go there. After hours, there's a bell on the side that you've got to press. There's a camera that the nurse's station picks up on and if they recognise you, they will click the thing and there's a door there that we can open, and then we pass through the airlock and you can enter. That's it at the moment, but the nurses are still in charge of viewing that camera at all times.

Sometimes what's happened in the past is that the nurses moving in between - maybe from their staff break or whatever, they see us at the door, they'll come and open the door for us, or the one of the aides will come and open the door for us, but they get to know you after a period of time, so it's much easier. That's it.

Ms BUTLER - This would be the design here - would be very open?

Mrs GUTTERIDGE - Well, the way I see this design is simply they're walking through the airlock and straight into the full renal unit. That's the way I'm reading it, but I haven't actually ever been able to talk to any architects, even though I've asked every minister if I could. I would have loved to have seen some of these plans well before they went to the DA approval.

Ms BUTLER - Just one more quick question. I was curious where you were talking about the projected demand and you came up with around the 24 chairs, around that and where -

Mrs GUTTERIDGE - Let's put it this way: I've made inquiries through Dr Matthew, our nephrologist, who was the director of nephrology and they all know the figures, and this is where I really ask - it's been indicated the department will provide those figures, which I thought they would have had, so yes - and it's all clearly stated that we have a desperate need for 24 chairs now, not in six years.

CHAIR - Now. Thank you.

Mrs GUTTERIDGE - The actual numbers about how many patients need dialysis, how many are in training - those need to be broken down by the department.

Ms BURNET - Thank you so much for your deputation. It really filled in a lot of gaps in knowledge that certainly I have, I can't speak for the rest of the committee. It really added so much value to what we're considering. Ms Butler's talked about the airlock. You talk about getting here after dark; have there been security issues or concerns that you've had in that relatively short time?

Mrs GUTTERIDGE - Yeah. I mean I think - just the layout at the moment is quite - there's so much shrubbery over there, there's no visibility as such. I mean I do make sure that when I step out of my car - let's put it this way, you do see some people walking through the car park in the evenings and you sort of decide, do I get out or not? Unfortunately, there aren't many other people walking through, so you take the gamble of getting from your car to the front door.

Ms BURNET - You don't have that passive surveillance.

Mrs GUTTERIDGE - No.

Ms BURNET - And it probably won't be helped in this situation.

Mrs GUTTERIDGE - No, I don't think so, because the way I'm seeing it here is that the architect indicated eight spaces, but the eight spaces are around that whole archway, so there's only five, which I'm assuming one's a disability one, and if those spaces are filled at night by patients' cars who have already got there, where do I park? Do I have to park on the other side of the archway, walk over when Peter's ready to be picked up, go and get the car? All those very simple things that make life easier.

Ms BURNET - Are you surprised there hasn't been that community and public consultation?

Mrs GUTTERIDGE - Definitely. As I've said, I have started this process from past the election last year. I've met with ministers; they know my concerns. I've asked for the plans to be - could I see the plans and I've been told, 'No, the clinicians and the staff have okayed us, so that's okay.' I've got to settle for that. They're all aware of my entreaties to have a look and have proper input and to include other people who may be concerned. That hasn't happened. As I said, when Mr Webster said, 'Yes, there'll be a public advocacy group early in the new year', I was hopeful. It hasn't happened.

Ms BURNET - It seems to be contrary to what the department usually does anyway. In relation to the $10 million and no input from the state government - and I think you might have said that you don't think that it can be built to adequately service the demand.

Mrs GUTTERIDGE - No.

Ms BURNET - Can you just expand on that some more, please?

Mrs GUTTERIDGE - As it was touched on before from Ms Butler, $10 million in 2019, anyone would have expected this project to have got underway then - a start to the whole process. The whole thing was obviously put on hold because everybody obviously got too busy with COVID. But as I said, other projects did start. So $10 million in 2019, with the possible expenditure and delivery by maybe 2022, may have seen an optimal development for

$10 million; but did that $10 million - it seems to be only focused on the 18 chairs, not meeting the demand. This is why I would like an answer for - we've sort of tried to establish, well, how much more room would six chairs take. I'm not sure what the allocation per chair is. Is it four metres? Is it six metres? I'm not sure. I don't know. What's the size of this room, 70-odd square metres; is that going to take another additional $1 million to be added to the budget?

Ms BURNET - I think it was $10 million.

Mrs GUTTERIDGE - It's just 10 million, and they say another $10 million to bring in six more chairs? I just can't reconcile myself to that.

CHAIR - Again, thank you, Carolyn. I note in your submission that you provided to us at an earlier time that you'd only just been made aware of this hearing today.

Mrs GUTTERIDGE - Yes. Well –

CHAIR - I mean they're always in the public notices, but that's usually a little bit -

Mrs GUTTERIDGE - I'm not actually sure when - let's put it this way: the only reason I knew about this meeting was through Ms Butler, who had been approached - I think she must have asked Ms Finlay about, you know, 'This meeting's coming up, are there any constituents who I can talk to or would be aware of it?' Through that, Ms Finlay gave Ms Butler my number. Ms Butler rang me maybe a week, 10 days ago and said there's a public meeting. I said, 'Why haven't I been told about it?' That was the first I knew about it. Then Ms Butler provided the information to Mr Hennessy, who contacted me to put in a submission, which closed Monday last week. He gave me a 24-hour extension, so that was my rushed little submission. I'm told it was obviously put in *The Examiner* at some stage.

CHAIR - They are put in the three dailies, yes.

Mrs GUTTERIDGE - I mean at some stage, I don't actually know the date of that, but, yes, we do get *The Examiner* at home, but that might have been the one Saturday I didn't read it, but that's not adequate in these days because a lot of people do not get *The Examiner*, so that's not really effective advertising.

CHAIR - From memory, I think that you are part of the consultative committee that's being formed.

Mrs GUTTERIDGE - Then Rebecca contacted me after this meeting to say could I attend a meeting on Wednesday this week at 4 o'clock, but I've never heard of this committee before, never.

CHAIR - You thought that it was happening in January, was that -

Mrs GUTTERIDGE - Well, that was what Mr Webster said - that there was going to be a patient advocacy group and that's what I was expecting to be part of.

CHAIR - That hadn't happened.

Mrs GUTTERIDGE - Nothing's happened. This new meeting on Wednesday, I really don't know the point of it. To me, if the plan has been approved, the DA has been approved; how can adjustments be made now?

CHAIR - Thank you. Any further questions, members? Again, thank you very much and certainly you must have a lot to deal with, with your husband three times a week coming into the centre. Again, thank you.

As I've stated earlier, please be advised that the evidence that you have provided here today is protected by parliamentary privilege, but once you leave the table, that privilege is no longer attached to your comments that you may make to anyone, including the media, even if you're just repeating what you've said to us. I do note that you did a very good letter to the editor back in last October when you were probably trying to engage with other people. Do you understand that?

Mrs GUTTERIDGE - I do.

CHAIR - Thank you very much.

Mrs GUTTERIDGE - Did you want the copies of *Hansard* or anything or would you be able to access all that?

CHAIR - We have access. We have a copy of the letter that was provided to the honourable Rosemary Armitage. That was provided as well, so thank you. If the committee needs any further information, we'll certainly reach out to you through the committee secretary. Thank you very much.

The committee suspended at 3.00 p.m.

The committee resumed at 3.01 p.m.

CHAIR - Thank you and welcome back. Obviously, you have heard the evidence that the committee has. Before I ask for any comments, I just want to advise and have on the public record that the advertisement went into the three dailies on 12 April. Obviously, you don't see every advertisement, and it was on the public works committee website in March, just for clarity about that. Thank you to the Committee Secretary for providing that information. Does anybody who's before us want to make any comment in regard to the information that's been provided, or do you just want the committee to ask questions? We're in your hands. Thank you.

Ms SEEBER - I was just going to make a comment in relation to the Burnie facility because it's been mentioned a couple of times now. That facility, whilst it looks nice, is actually, from a clinical perspective, not a suitable facility, so I just want the committee to be aware that that actually isn't a good facility, particularly for our staff or for the services they provide. My understanding is that we're going to be moving from that facility at some point in the near future.

CHAIR - I'm not sure we really wanted to hear that, but anyway we've heard it now.

Ms RAMAGE - From a patient perspective walking in, it's a very well-designed floor plan for the dialysis. For some of the back-of-house things, they suffer the same constraints with lack of space, lack of storage for some of their medications and fridges, and staffing and all those sorts of things, and access to toilets; absolutely an amazing dialysis space with a great view, but I'm just noting that it certainly comes with its challenges as well.

Ms BURNET - I think we were told that it had a greater number of the multidisciplinary team, like is that -

Ms MACE - No, that's the south. The south has access to psychologists, dieticians and pharmacists.

Ms BURNET - Right, okay, but that's kind of the ideal model, to have that complete multidisciplinary team?

Ms MACE - Yes.

CHAIR - Thank you. I think, Jon, you were going to add something.

Mr HUGHSON - Yes. We did discuss consultation earlier today, and I apologise on behalf of the department for the lack of consultation that's occurred in relation to this project. It would be common practice for us to hold community consultation with drop-in sessions. That's the usual process that we do follow. It's definitely been an omission with this project, so I apologise again on behalf of the department for that occurring.

Ms BURNET - If there's that consultation, what is the likelihood of that informing further projects, because I mean it's all very well to have consultation, and we've seen consultation run in previous projects, but it's not necessarily that it's taking on board some of those important components. I'm thinking of multicultural communities, as well as Aboriginal communities, particularly with renal failure, renal disease and those end-stage complications, diabetes. Are they all going to be involved in consultation as part of this consultation project?

Mr HUGHSON - I'm not sure of the actual plan moving forward.

Ms RAMAGE - Yeah. I have spoken to a group that speak with those groups up north, and I'm waiting on their names at the moment.

CHAIR - I'm happy to launch into some questions.

I think the parking matter that was raised by the previous speaker is a really integral part of any medical service. I think all of us have been to the LGH and just about pulled our hair out, but anyway, I believe there's a new car park coming there sometime. These are, as has been stated, unwell people, and with carers and family collecting. Is there some opportunity to make more space available at the front of the centre for collection? You know, pick up and drop off. I mean, I think it's a really valid point if you can't get close to the building when you're picking up and if you're at 8.30 or 9.00 p.m. at night in the Tasmanian winter, even if you've got a voucher, it's not going to help.

Mr BURBIDGE - Yeah. We did spend a lot of time trying to maximise parking for the site. With the location of the existing building, we were a bit snookered into where we could put the new building. So that's kind of why it's where we're sitting right now, and trying to get more parking was proving to be difficult or nearly impossible. We tried to maximise what we could, and then making sure that the new parking that's on the eastern side of the main building is accessible, so it has an accessible path of travel to it, and it's all very - a lot more lighting and security in the new car parking than there is at the moment with a lot better sightlines.

CHAIR - My second question is about the issue that has been raised about walking through the airlock straight into where the chairs or the sections are placed. Is that a standard?

A witness - They would be walking in and be presented by the nurses' station, where the goal, at some stage, would be to have an admin person there during the weekdays. It's very similar to what happens in Burnie, where they ring the doorbell and they let them straight in. They do go straight through to the unit. There are a couple of small seating spaces, which would have restricted view of the patients behind the wall area where the lockers and wheelchairs can go. In that actual airlock, there are some seating spaces as well where we can, if need be, hold to do swaps out. Generally, the renal teams do try to roster around like a changeover period between them so that they sort of have one lot of patients come off and do their cleaning before they bring the next lot of patients on as well.

CHAIR - You're not necessarily walking straight into where the treatments are taking place?

A witness - No, you're walking into the centre of the building. Correct me if I am wrong, Cameron.

Mr BURBIDGE - Yes. You are walking straight - you're walking into this - basically the centre - of the floor.

CHAIR - I have my little map here.

Mr BURBIDGE - Yes. That is why the staff station is positioned where it is. It is directly opposite the airlock or opposite the waiting area. When you walk straight in through the airlock

into the waiting area, you turn left, you are looking directly at the staff station. It is right there. Beyond that, over the back of the staff station, you would be able to see dialysis bays, but you're not walking directly into them. The airlock is going to have video intercom on them as well. Depending on what the staff want to do, they could just do it - you have to press the video intercom and get let in that way, or the doors can just be free-opened when you walk up to it. Whichever model the staff want to do. Then there'd be a receiver in the staff station and we're going to put another one up in the staff room as well. Once someone presses the doorbell, there are two opportunities - two different spots the staff member can answer it and let them in.

CHAIR - My final question before I let others is around the actual renal clients waiting list. We heard some information that you can talk to a doctor who deals with their patients on a regular basis and they're already saying that you need 24 now, not into the future. Is there a waiting list for the service?

A witness - To my knowledge, we have no current waiting list. We are meeting the demand, unless Rose can elaborate on that?

Ms MACE - What happens is people have a projection of what their Estimated Glomerular Filtration rate is. I can be waiting to start dialysis, but I don't need it today. I might need it in three or four months.

We know how many people might need to start this side of Christmas, for instance, but then there'll always be people who've had a transplant that may fail in a few weeks. We need to have a contingency for those. We have periods of time when we may start 10 patients in a matter of six months. Then we might have a period when we only start five patients because people are monitored by the chronic kidney disease nurse and the nephrologist. The doctors have all got a list of - we get presented this at our Tuesday multi-D meeting when we know how many people are needing accesses for dialysis to be established and how many might need it. We don't have an exact date. Patients can't be on a waiting list - like if I am waiting for a hip surgery or knee surgery or an elective thing, we hear those horrible, sad stories of people waiting many years for that. Once you need dialysis and you are symptomatic, you're short of breath, you have a high potassium level, things that make it critical - we can't put people on an actual waitlist. People have different stages of kidney failure and we know what preparation they need to be ready.

In an ideal scenario, if you picked a home therapy, you might get your peritoneal dialysis started for home or home haemo started, or something may cause you to need to start more quickly, so you need a temporary line in before we can get an access established. It's all about how many people do we have at the different stages of kidney failure. At stages 4 and 5 are where we need to be ready to put them on dialysis.

At the other end of this, we do actually have patients who have been on dialysis 15, 20, 25 years who will eventually pass away. Again, in a six-month period we might have 10 patients that die and we may have 15 that go on to dialysis. There are both that happen. There are patients who are eligible for kidney transplant. They may be on a dialysis spot for 18 months to two years, or they may come off earlier if they've had an offer from someone in the family or a paired exchange. We're very much focused on keeping the stay in the dialysis unit quite minimal for those who are eligible for a transplant.

Home dialysis, whilst I know we're keeping it in another area, as long as they can expand within that, the staff are wanting to promote that so the patients aren't - if there's a delay to taking on home dialysis or they start dialysis on haemo, they very quickly see it as an alternative. 'Oh well, I won't do home now but I can come here three times a week, it's easier for my partner', or anyone out of town, so Scottsdale, Westbury – you don't have to travel - desperately wants a home therapy because they don't want to travel three times a week for dialysis.

We don't allow patients to die waiting for dialysis. We watch their progression to needing to start dialysis. We're getting better at that because of the chronic kidney disease nurse input, the advanced training nephrologist sees the patients more regularly in their clinic, specialist clinics, and we have the conservative care model where patients in their late 80s, where dialysis might not be the best option for them, they may choose for conservative care symptom management, so they don't actually go on to dialysis.

Mrs Gutteridge explained about Peter not really wanting dialysis to start with, but then he decided that he wanted it. He got to meet all the people in all the different areas, so we have very passionate, dedicated nurses doing all these things. It'll just be wonderful to have the new facility to do it all in.

CHAIR - Thanks for that explanation, it's helpful.

A witness - A good example of some of that changeover is our north-west office, which has gone from being full within their chairs to actually having a vacancy at the moment within the chairs, so we're not full down there because the patient need is not there at the moment, but of course that could change.

CHAIR - Tomorrow or next week.

Ms LIEUTIER - The north-west is actually managed out of the north, so we cover the north-west as well.

Ms MACE - When that opened in 1999, we didn't think that the unit in Kings Meadows that opened 14 years later would fill up quicker than that unit because there's quite a high degree of chronic kidney disease and heart disease in the north-west, so it's quite interesting that they have a whole shift of available spots, whereas our unit fills up and then decreases depending on where people are at.

CHAIR - Anything else that anyone would like to leave with the committee just for our consideration as we take into our consideration all the evidence that's been provided today?

Ms LIEUTIER - Thank you for your time and for your interest, and we really do look forward to having a modern facility for our staff and our patients.

CHAIR - I have a list of questions that we like to ask. I indicated that at an earlier time, and we're happy if just one person answers that, so you might provide a spokesperson, so thank you, Fiona. Do the proposed works meet an identified need or needs or solve a recognised problem?

Ms LIEUTIER - Yes.

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

Ms LIEUTIER - Yes.

CHAIR - Are the proposed works fit for purpose?

Ms LIEUTIER - Yes.

CHAIR - Do the proposed works provide for the state of Tasmania value for money?

Ms LIEUTIER - Yes.

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

Ms LIEUTIER - Absolutely.

CHAIR - Thank you very much. As I've already indicated, and this will be your second time for this one, that the commencement of your evidence, what you've said here today, is protected by parliamentary privilege, but once you leave the table, be aware that privilege does not attach to your comments that you make to anyone, including the media or even if you're just repeating what you said to us. Do you all understand?

Mr HUGHSON – Yes.

Ms LIEUTIER – Yes.

Ms SEEBER – Yes.

Ms MACE – Yes.

Mr BURBIDGE – Yes.

Ms RAMAGE – Yes.

CHAIR - Thank you very much, and I want to thank everyone who's come along today and been part of this inquiry process. It is a really important process. As you've been informed, it's part of the parliament and we take our job very seriously. We appreciate the input, particularly providing a submission, and thank you to the department and those people who undertake really important roles in our community. We certainly do appreciate that.

On behalf of the committee, I'd like to thank Harrison of Hansard and our Secretariat support, so thank you all. We are concluded here, but we still have some work to do.

The witnesses withdrew.

The committee adjourned 3.17 p.m.