PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON MONDAY 23 JUNE 2014.

DEVELOPMENT OF GLENORCHY INTEGRATED CARE CENTRE

Mr BRAD WHEELER, MANAGER INFRASTRUCTURE INVESTMENT, DEPARTMENT OF HEALTH AND HUMAN SERVICES; **Mr FRED HOWARD**, AREA SERVICES MANAGER COMMUNITY CARE AND COORDINATION, THO SOUTH; AND **Mr ANDREW GRIMSDALE**, PROJECT ARCHITECT, LIMINAL ARCHITECTS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Brooks) - Thank you for appearing before the committee, gentlemen. Before you begin your evidence, I want to inform you of some of the important aspects of the committee proceedings. The committee hearing is a proceeding of Parliament and receives the protection of parliamentary privilege. It is an important legal protection that allows individuals giving evidence to a parliamentary committee to speak with complete freedom without the fear of being sued or questioned in any court or place out of Parliament. It applies to ensure the Parliament receives the very best information when conducting its inquiries. It is important to be aware that this protection is not accorded to you if statements that may be defamatory are repeated or referred to by you outside the confines of the parliamentary proceedings. This is a public hearing and members of the public and journalists may be present and this means your evidence may be reported.

Mr Wheeler, would you like to make an opening statement?

Mr WHEELER - On top of the statement, we also have a short presentation to give you some background. This ICC development began to be planned approximately in 2007, from memory, when the budget first was announced for updating our community health centre in the Glenorchy area. In the last two years it has been through an intensive process of defining the service in greater detail and talking closely with the Glenorchy City Council to resolve the solution for the construction of this ICC and has involved numerous stakeholders, particularly within the Department of Health, in the service units to provide the service we are now providing.

In terms of the service, and correct me if I get anything slightly incorrect here, it is intended that the ICC will supply support to the Royal Hobart Hospital acute services, much the same as the ICC we already have at Clarence. We have another one slated for Kingston. Glenorchy will play an important part in supporting acute health services by providing services closer to where the community lives and will also take pressure off the hospital itself.

In terms of the services, would you like to run through the services in more detail, please?

Mr HOWARD - To go back a little, the ICCs act as a hub for a network of community health centres, so the Glenorchy ICC will act as the hub for centres in the Derwent

Valley, Brighton, the Southern Midlands and Central Highlands; that will be its catchment area. We have done a lot of planning around the services and they are based on the needs of the community.

A proposed service model was put together in 2012. We have done more work on that and there is probably going to be a new version of that prior to commissioning the building. The services will be the same but it is basically looking at how we deliver the services in a more integrated way. We are constantly testing new models so that when we open the doors we will be able to run the models. It will not impact on the set-up of the building as it stands at this time. We have taken that into account.

The services range from the typical primary community health-type services all the way through to sub-acute services; we are looking at services like community nursing and community allied health through to the four specialist services where clinics are presently being delivered at the Royal Hobart Hospital for this area. They will now be delivered in Glenorchy. It would be things like respiratory-type services delivered by a respiratory physician with a team approach. At this stage we are looking at Pathology South being on the ground floor, a reception area which will manage the whole building and an ambulatory care centre which is about administering medical and surgical procedures for vascular access and involves infusion of some medications for specific complex treatments.

We are also looking at having a minor injuries clinic which would operate 12 hours a day for minor ailments; it would be a nurse-led clinic although we may improve the medical governance and we may drop its working hours at some time in the future. We are still negotiating with general practice regarding that.

On the next floor up we have the allied health services - social work, podiatry, physiotherapy, occupational therapy - and there is also an area set aside for child and adolescent mental health. We also have what we call a Chronic Conditions Program Activity Space - there is a physio gym and we also have a chronic disease gym; that is a gym that will be used for groups like cardiac rehabilitation and respiratory clinics where we try to encourage exercise to improve the outcome and condition of the sufferers.

On the top floor we have the Child Health and Parenting Services, which will be coming out of the old centre into the new environment away from the youth, and also we will have the paediatric dental service. Currently we only have two chairs in the whole of Glenorchy for paediatric dental; we will have six chairs in the new building. That service is mainly being funded by the Commonwealth Government, which is a bonus.

Mr WHEELER - In terms of the development process, we have a number of consultants besides our architectural consultant. We had a traffic management consultant who did a significant amount of work as well as a heritage adviser.

CHAIR - We will go through the consultation process and period, including clinical consultation, to make sure it is going to work. I am not saying this will not, but this committee may explore that.

Do you want to go through your presentation first or, Andrew, did you want to add anything beforehand?

Mr GRIMSDALE - I am happy to do an overview of the design.

CHAIR - No problems at all.

Mr GRIMSDALE - The design has been generated on a number of levels. First there is an economic level and a square building is a good economic outcome, the cheapest form of building you can get. It is a big urban design exercise -

CHAIR - You have read my contribution to the George Town Hub, haven't you, where I questioned the corners and the curves on the building.

Mr GRIMSDALE - The location of the centre at the front of the site was to maintain an urban streetscape, which is prevalent along the Glenorchy strip that radiates off to the side of this building. It also gives a street frontage address for the centre.

It is a three-storey building. We have zoned the high-level usage zones as the ambulatory care and minor injuries clinic on the lower floor, plus some of the areas where there is a high turnover like Pathology South; they are on the ground floor so that they are in and out. There is also a 24/7 renal treatment area on the ground floor, so they have their own access after hours - any time of the day when they want to do their dialysis.

The building is a cube with a series of cut-outs in it and those cut-outs are designed to allow natural light into the centre of the building. It is focused around an atrium which goes through the three levels and that helps bring light down to level 1 or the ground floor where the concentration of services is fairly high. On the upper floors it is a bit easier to get a centrally loaded corridor-type of situation.

The square, compact nature is also so that we can have only one point of access so it is easily controlled, but also radiating out from that point of access it limits travel time so that you do not have to walk long distances.

The centre is served by two lifts. At least one of them will be designed to take stretchers. There is ambulance access to the back of the building. The clinical spaces and most of the interior design are following national guidelines for the design of health centres. We have large, wide corridors which allow easy access for wheelchairs but also access for stretchers.

The selection of materials at this stage is we have proposed a brick building, which is ecologically sustainable and relatively maintenance free. Once it is there, it is there but it also picks up on a palette we have noticed as we did our research through the central area of Glenorchy, where a lot of the significant public buildings are brick. We thought it would be the way to keep that context going.

CHAIR - I have some questions on that but we might leave those. Did you want to finish the overview?

Mr WHEELER - Sure. It is just an overview. The presentation we have, because those plans are a bit difficult to read, is also a bit about the site and a bit about what services

are where in that building. We also have some large-scale plans if you want to have a look at those.

Glenorchy is a spread-out suburban area but its central precinct is the area that is surrounded by the black dotted line on that slide. It is bounded by Humphrey's Rivulet on one side and a couple of more significant roads with the road main going through the middle of it. That is where all the shopping centres are. Once you get to either side of that, the urban scape breaks down a bit. The original scheme was to work within the blue precinct zone. It was originally to have a police station, refurbished council chambers and a redeveloped community health centre building for Glenorchy. That was the plan in that precinct area. The idea was that the Glenorchy City Council building would have been partially demolished. A police building would have been built on the site next to the bus mall. The Glenorchy City Council would have rebuilt its development and our ICC would have been the third, which is the 2 Terry Street development. We would have built into what was the council building as well. Our development depended on Police and Glenorchy City Council being developed before we could start our construction. We could do all the planning before that but the construction would have to wait until those two stages had occurred.

Through more detailed discussions with council, it became clear there were some real concerns about the density of services and the car parking in that area. Also, the Police proposal did not quite match their understanding of what would fit on the site. Soon after, Police withdrew and are now developing a site elsewhere in Glenorchy. At that point we talked to council about how they saw this working. We agreed there was potentially a better solution for both them and us. It did not put them under pressure to develop their building in a certain time frame and also allowed us a longer-term plan. That was to look at purposing the site on the corner, which is coloured blue. It was still within the broader precinct and made sense to us. It created a bit of a full-stop from an urban point of view but it was also close enough to existing services and the way the community developed. At the time, it also provided us with a strategic option for 2 Terry Street in that we knew we had free space there. We have since made decisions around some of that. But it freed up an area where we knew a lot of services were needed - and finding pieces of land to build on is not easy.

That is the site we visited this morning. It has the original child health centre on it, a building which was tenanted by Anglicare at the time, the little skateboard bowl, and some car parking. We are planning what is now an ICC rather than a community health centre towards the front end. That is obviously diagrammatic - it is not exactly like that - and the entry is at the midway point.

Mrs TAYLOR - You have bought that entire site, including the rest of that car park?

Mr WHEELER - Yes.

Mrs TAYLOR - That is public car parking.

Mr WHEELER - Yes, it is.

Mrs TAYLOR - Will that continue to be public car parking?

Mr WHEELER - Essentially it will because stakeholders will be using it.

To explain how complicated it is in a place like Glenorchy where land is difficult to find, the picture on the left is Clarence ICC. It gives you an idea of the scale. It has a couple of parts that are two-storied, but it is primarily a one-storey building. Clarence is probably a bit more spread out. One of the things we have found is to have that spreading out is not necessarily a good thing, so we have gone the opposite way, without making it cramped. The idea is that it feels bustling and busy and has a sense of community.

Mrs TAYLOR - The same number of square metres, more or less?

Mr WHEELER - It is slightly less, to be honest, but the Clarence one had a superclinic attached to it.

Mr GRIMSDALE - A GP superclinic as well as an ICC.

Mr WHEELER - Glenorchy ICC does not have that.

Mr GRIMSDALE - It also had a lot more administration work, too.

Mr WHEELER - Yes, it did. We have stripped our administration down to super efficient.

CHAIR - Excellent.

Mr HOWARD - Basically this is what we have talked about earlier. This is the entry into the building but we might go to the next one and this is the first floor. At the top right-hand corner you have the administration area which is basically reception, front-of-house and opportunity for storage of records and the like. Moving to the left, we have the ambulatory care centre which has 12 bays and two clinical rooms. This is when we look at statistics of where patients are coming from for this type of care; a lot of it comes from the northern suburbs, so it makes perfect sense to have an ACC here. Then we move down to the bottom left hand and we have the MIC, which is minor injuries and complaints clinic - six bays and two rooms again.

Mrs TAYLOR - What is the difference between an ACC and an MIC?

Mr HOWARD - There is a big difference; the ACC is all about vascular access and the MIC is about minor injuries.

Mrs RYLAH - Sorry, I don't understand this.

Mr HOWARD - Basically it is procedures which require, for example, infusions for arthritis. They do cannulations for the -

Mrs TAYLOR - What would you do with, say, people who need their dressings changed?

Mr HOWARD - That would probably occur in the MIC.

Mrs TAYLOR - It is not a minor injury - it is neither of those.

Mr HOWARD - It is a minor injury and complaints clinic, so you would have specialist wound care operating out of MIC as well.

Mrs TAYLOR - Yes, thanks.

Mrs RYLAH - Broken bones and things - where do they get dealt with?

Mr HOWARD - Broken bones are sent to emergency. We did toy with the idea of having an X-ray facility here but there is sufficient public X-ray close by. Even if we diagnose that someone has a fracture they would probably need to go to Hobart for the plaster application.

The final little bit on the left-hand side is renal dialysis which is self-dialysing. People are trained to manage their own dialysis and that is a 24/7 access.

Mrs RYLAH - How do they access - I was looking at that bottom plan - or could we discuss that later?

Mr GRIMSDALE - There is a door in that little indent at the right-hand side of that unit so -

Mrs RYLAH - They will have a card?

Mr GRIMSDALE - Yes. They will have a swipe card which will give them entry and there is a secondary door that prevents them getting access to the main centre; after hours they can only use that suite.

Mr HOWARD - The last bit on the right-hand side is a bulk-billing pathology practice.

Mrs TAYLOR - Is that the same as pathology that is further along the road next door to the X-ray now?

Mr HOWARD - No. This one comes out of the Royal Hobart Hospital.

Mrs TAYLOR - Why would we duplicate pathology and not duplicate the X-ray?

Mr HOWARD - This is bulk billing where the one along the road is not, from memory.

Mrs TAYLOR - Yes, it is. It does not cost you anything.

Mr HOWARD - Okay. That is a good point, but I don't know.

Mrs TAYLOR - It is the same thing; if they work on an X-ray or the pathology you go along with your doctor's referral and it does not cost you anything. It just does not quite add up, that is all.

Mr WHEELER - My understanding was that with Pathology South there was extra business out there needed at that time and this was one of my discussions with Pathology South. They were identifying people from the northern suburbs coming into the Royal Hobart Hospital

CHAIR - So it was demand-driven?

Mr WHEELER - Yes.

Mrs TAYLOR - You consulted with the primary operator?

Mr WHEELER - We consulted with Pathology South.

Mr HOWARD - There are also meeting rooms on this floor that are available for the community. This floor mainly services chronic disease management. The top corner is for child and adolescent mental health. It was to be adult mental health until there was a decision made about retaining 2 Terry Street and that gave us the opportunity to co-locate all those mental health services into the one building. On the left-hand side is physio, with a gym and treatment spaces. Down from that will be the chronic disease gym for cardiac rehab, respiratory rehab et cetera. We then have podiatry and further along, occupational therapy and general allied health, including social work.

On the top floor is oral health services. It is mainly paediatric but they may operate some adult services there as well for complex clients. They are building six surgeries there, which improves the continuity of surgeries we need in the northern suburbs. There is also social work and the Child Health and Parenting Service. There are two more rooms which are mainly set up for the arts and craft type services for arts in health. We like to encourage that because it is one of those primary interventions. There are other spaces set aside for an art group as well.

Mr WHEELER - All the blue dots and lines on those drawings are showing the circulation points are very tight and central - the lifts and stairs, waiting rooms et cetera.

Ms OGILVIE - I am interested to know where the funding is coming from - state, federal?

Mr WHEELER - It is all state funding.

Ms OGILVIE - And run through Treasury?

Mr WHEELER - Yes.

Ms OGILVIE - Have contracts been let yet?

Mr WHEELER - Construction contracts? No.

Ms OGILVIE - So you are at the beginning of that process?

Mr WHEELER - Yes. We can't do that until we have this approval.

CHAIR - For the knowledge of members, there can be a tender let subject to Public Works approval but that would be more the exception than the rule. I believe there were three projects in the last four years where that happened, so traditionally they may have prepared the tender documents but they will not be released until the Public Works Committee approves it or otherwise.

Mrs TAYLOR - Did the previous committee approve a tender, or is that not necessary for the design?

CHAIR - The Public Works Committee is for the project itself, for the $21 million. The design work would already be provided outside the limit of the Public Works Committee, which is $5 million, so that is funded separately. But the whole project, if it were to proceed or not, requires approval of the committee. If the Public Works Committee approved that project, then it would normally be up to the department to manage it. However, from a political point of view, the money will already be allocated under the Budget for this project. This is the last stage before it goes to tender.

Mrs TAYLOR - I have been associated with this project for a number of years. His Excellency's message said $13 million.

Mr WHEELER - Yes. That was to do with the construction breakdown cost within the overall cost.

Mrs TAYLOR - So that does not include land purchase and all those things.

CHAIR - Also contingency payments.

Mrs TAYLOR - Are you talking about escalation cost? It is $360 000. It includes all of that. I wondered how you arrived at the $21 million.

When this project was first promised by a previous government five years ago, the amount then was $21 million. That included purchasing, destruction and reconstruction, building into that entire central council area. It is cheaper and less constricting to put it on a separate site; that is not a bad idea. The Health department part of the project was about $14 million or $15 million. The rest was the associated cost having to with those kinds of things. You do not have that cost now. Why is it still $21 million?

Mr WHEELER - Our estimation is that it will still cost us $21 million by the time we have completed it. There have been cost escalation issues since when that estimate was made. We also have the Clarence ICC and we have worked on a square metre rate of that. Even though our construction cost is $12 million, our escalation cost is at $360 000. These budget allocations do flow a little bit; you have to massage within these numbers; that is standard within a construction project. Our last budget estimate is that these costs will still be the same.

Mrs TAYLOR - So these are expected; they are not actual costs because you have not gone out to tender.

Mr WHEELER - The construction one we have not, but we have some built-in contingency in there.

Mrs TAYLOR - I was hoping you were going to say, 'We are actually going to do more things than we were going to do'.

Mr WHEELER - We are doing that, to be honest. The scope has expanded from its original scale and we are packing as many services as we can into that building.

CHAIR - Can you explain what they are?

Mr HOWARD - It was always proposed to do a range of things, depending on the floor space. In the original proposal, we were looking at maybe two chairs for oral health rather than six. The ACC would have been a lot smaller than what we are building now. We did not have the minor injuries clinic on the agenda at that time. We were not looking at putting in a chronic disease gym.

CHAIR - Was that demand-driven or because you had the money and you wanted to spend it all?

Mr WHEELER - No, it was always demand-driven.

Mr HOWARD - As a bit of background, the whole concept of integrated care centres was flagged in the Health plan in 2007, but Glenorchy was not one of them.

Mrs TAYLOR - Correct. Glenorchy missed out on that.

Mr HOWARD - Yes. Then we had a consultant come in and do a review. Carla Cranny and Associates came in and did a review in 2009, from memory. It highlighted the severe need for more services to go into the northern corridor. This northern corridor is the most densely populated area in the state. It has some of the worst health outcomes for one reason or another and low socioeconomic levels are one clear reason.

Mrs TAYLOR - And the greatest number of people who use the Royal.

Mr HOWARD - Yes, exactly right. When the consultants started looking at the data coming out of the Royal, the highest number and the most complex cases were coming from the northern suburbs. It made logical sense to build something which was a bit more than a standard community health centre.

Mrs TAYLOR - It is an interesting background in that it was not considered as an ICC because that was Federal, wasn't it, the ICCs?

Mr HOWARD - No.

Mrs TAYLOR - Or the superclinics?

Mr HOWARD - The superclinic was the Federal component.

Mrs TAYLOR - The basis on which the decisions were made was about future demand and they did not take into account current demand. It was the council that jumped up and down and said, 'Excuse me, but have you looked at us because it is not future demand, but we need it', and to give the DHHS credit, they recognised that and responded accordingly.

Mr WHEELER - The other change is now that it has turned into an ICC, it is more of a regional -

Mrs TAYLOR - It has and I am happy to have it.

Mr WHEELER - It has more of a regional base; that creates more demand as well because it has that regional focus. How did it happen?

Mrs TAYLOR - Yes, why did it change?

Mr HOWARD - The health plan defined what the levels were for different health facilities. Glenorchy health centre was level 1-2 and was probably going to be redeveloped to level 2. Carla Cranny's report came out and we started to have a look at the services required. The level of services required moves it up to the next level, which is level 3. Level 4 integrated care centres are where day surgery happens; we did not want to go that far but level 3 was probably right.

Mrs TAYLOR - People who go currently into the Royal for, say, cancer treatment, would they be dealt with there?

Mr HOWARD - Potentially. Some of the work that can happen out of the ACC, the acute care centre, is about that chemotherapy.

Mr FARRELL - About that level 3, what impact might the new centre have on a regional hospital like the one in New Norfolk? Are you offering similar services or -

Mr HOWARD - There are no beds in the complex at all.

Mr FARRELL - What level of care would be at New Norfolk in comparison?

Mr HOWARD - New Norfolk is classed as a sub-acute in-patient facility- or sub-acute/acute. You can have acute people there because medical coverage provided by the GPs is limited; it tends to be sub-acute, focused more on rehabilitation and in-bed care for respite time services. They have a range of services but they are limited in their scope. The Glenorchy ICC will be a hub for more specialist services so there is still an opportunity for people to travel from the Derwent Valley to the ICC but it also an opportunity for ICC services to move out to the community. Sometimes it is about critical mass and you have to go where the problems are.

Mrs RYLAH - Looking at the numbers here, you have the Art Site scheme at $80 000 as not being part of this and I do not know anything really works. Can you give me some insight into how that works and why is it at that number?

CHAIR - It is a legislative requirement of either 5 per cent of the project cost or 2 per cent of the project cost up to $80 000. I will put it on the record again: in my opinion, it is a complete waste of money, but pending some change in the legislation that I am not aware of, it is a requirement of any public project building construction to have that cost in there.

Mrs RYLAH - Could I ask another question?

CHAIR - Not all members agree on that and I have had that debate in previous committee hearings, too. I think it was the $80 000 on car park artwork for the last car park that I had a bit of an issue with, but anyway it is a legislative requirement; there is not much we can do about that.

Mrs RYLAH - What does 'Corumbene works' mean?

Mr HOWARD - As part of this project, when money was being allocated, there was an opportunity to provide additional beds at Corumbene Nursing Home, which is in the Derwent Valley. At the same time there was the closure of the Ouse centre and a transfer of beds from the Central Highlands to Corumbene. The state kicked in the money.

Mrs RYLAH - What has that got to do with that?

CHAIR - We may need to seek some advice on whether that is allowable.

As to landscaping costs, I know there is a little bit of landscaping, and from previous Public Works hearings there is normally an astronomical amount allocated to that. There is no line item for landscaping?

Mr GRIMSDALE - It is included in that building budget. It is in that $12.8 million of construction costs. That includes the landscaping component. The existing plane trees are being retained. There is a landscape easement on that side of the site.

CHAIR - As to the professional fees and associated costs, can you give us a breakdown on those?

Mr WHEELER - A detailed breakdown? I would have to come back to you with that information.

CHAIR - I know there are industry standards and expectations.

Mr WHEELER - The architectural fees are a certain percentage of the costs. I'm sorry, but I can't give you that detail, but I can come back to the committee if that is helpful.

CHAIR - The furniture and equipment, obviously that won't pay for the complete fit-out - dentist chairs, et cetera. What does that include and what doesn't it include?

Mr HOWARD - It includes most things, but doesn't pick up on the Oral Health Services costs. They have a separate capital dollar, again funded by the Commonwealth.

CHAIR - Is that similar to the dialysis?

Mr HOWARD - There is not a great deal of cost with dialysis, believe it or not.

Mrs TAYLOR - You already have the chairs and would be transferring them from St John's Park, would you?

Mr HOWARD - No, we would be buying new chairs, but they are not very expensive.

CHAIR - Are you comfortable with the amount allocated for the equipment purchases?

Mr WHEELER - We could always use more, of course.

CHAIR - You are not going to get any more.

Mrs TAYLOR - Are we going to get a blowout?

Mr WHEELER - The professional fees and associated costs line, for example, is one of those things where there is a good chance, should there be spare money in that at the end of the day, it will probably go into something such as furniture and equipment if the demand is there for that.

Mr HOWARD - The allied health equipment that is already in 2 Terry Street will come out and be moved to the new facility - podiatry chairs, plinths for physio and their equipment - which is a significant amount of money. That will not be replaced; it will be transferred across.

CHAIR - When you provide the committee the detailed information on the professional and associated costs, could you also provide the full-cost breakdown of the project? Obviously you have a more detailed breakdown.

Mr GRIMSDALE - The quantity surveyor has prepared an estimate.

CHAIR - Do you believe $21 million for this project is an appropriate use of taxpayers' money?

Mr HOWARD - Yes.

CHAIR - Is it warranted?

Mr HOWARD - The demand is definitely there for this service. The long-term savings and benefits to the community are without question.

CHAIR - The amount allocated will provide sufficient infrastructure and services to manage that demand?

Mr HOWARD - Probably for the next 20 years, yes.

CHAIR - You would be comfortable that it's an appropriate use of taxpayers' funds for this project?

Mr HOWARD - Yes.

Mrs TAYLOR - In terms of land purchase and site works, that includes the demolition of the current building and the site works because the skate park has a hole in the ground; does that also include the cost of relocating the skate park?

Mr GRIMSDALE - Yes. Included in that is the grant that we have provided to the council to help them with the skate park.

Mrs TAYLOR - So that is taken care of?

Mr GRIMSDALE - Yes.

CHAIR - We have done costs.

Ms OGILVIE - Can I ask about the building design in regard to energy consumption?

Mr GRIMSDALE - We have gone through an exercise to find out about it. We have a mechanical system that we are going to use in the building that limits the use of energy. We have natural gas running past, through the Main Road, which we will be utilising as much as we can, for hot water and things along those lines.

Ms OGILVIE - No solar?

Mr GRIMSDALE - At the moment the engineers are looking at it but we do not believe it is a worthwhile thing to do. All the light fittings, obviously we do not have a choice and they are now meeting 'no energy' requirements.

We have in place, and we are looking at a whole lot of other things, like bike racks and bike storage, to meet the green council requirements and the community requirements.

We have two mechanical systems that we need to run in the building because places like the MIC and the ACC need a more air-conditioned style of space, whereas some of the other areas can be what is almost natural, but is not. In those areas we will have a heating and cooling system. The other areas have different requirements.

We have to provide some backup generation for some of the areas because we have drug fridges. There is a generator room and that will keep things like the drug fridges going and also the renal chairs. The last thing we want is for those to breakdown halfway through. We have that covered.

We have tried to maximise natural light but limit solar gain. It is a series of punctured facades rather than lots of areas of glass. Where we do have lots of areas of glass, it is in areas which have good shading.

Mrs TAYLOR - Double-glazing?

Mr GRIMSDALE - At the moment we have priced it in. In many respects - the double-glazing is okay - you can get almost the same thermal efficiency if you use laminated glass.

Mrs TAYLOR - I was thinking about noise.

Mr GRIMSDALE - Yes. They are using laminated glass just about everywhere, as you do now. It should be right for the noise. The major glass areas are onto the public open

spaces. The clinical areas usually have a single window into them which would be double-glazed or a fairly thick laminated glass.

Mr WHEELER - We have focused quite strongly on things we think will make the most effective material difference rather than what might be visually -

Mr GRIMSDALE - As an insulated building, we have to meet certain regulation requirements. What we usually do here is slightly above that, particularly in ceiling and roof insulation. The walls, being a brick building, will be insulated. You will get good insulation from the facade construction. Under-slab insulation will meet with the requirements.

Mrs TAYLOR - Is it timber frame with brick veneer?

Mr GRIMSDALE - At the moment it is probably not going to be timber. It will be steel or maybe plantation pine. We are looking at that at the moment for the cost.

Mrs TAYLOR - Is it brick veneer?

Mr GRIMSDALE - It is basically brick veneer.

Mrs TAYLOR - Is it plaster on the inside?

Mr GRIMSDALE - Yes. It will be plaster. Certain areas need better functioning wall finishes than plaster. We will run vinyl up those walls, particularly in some of the clinical spaces. A lot of the plasters we use now are not normal plasterboard; they are called impact-resistant plasterboard. They have a higher cement content in them so they can take bangs and dings and all those things because there are going to be trolleys going around everywhere.

Mrs TAYLOR - Are your internal walls insulated?

Mr GRIMSDALE - Where they need to be. Around the perimeter they will be, and between rooms where we need sound isolation. You do not want to be hearing people in adjacent rooms. We will meet the standards to do that. There are various regulations you can use. You can stagger studs and put double layers of plasterboard and acoustic insulation.

Mr WHEELER - At Clarence we had a problem with acoustics and we have constructed it to the level that we found eventually was acceptable.

Mrs TAYLOR - That is very important, particularly when you put it all in such close proximity between floors and rooms. This is a place where, very often, people are going to be in pain.

Mr GRIMSDALE - To stop the sound mass is needed in the walls, so quite often we put two layers of plasterboard on each side, coupled with acoustic insulation.

Mr WHEELER - All clinic-to-clinic walls are acoustically rated to that level and all clinic-to-public are the same.

Mrs TAYLOR - So within a clinic it is not necessary? Six dental chairs, for instance.

Mr HOWARD - You won't hear the screams next door!

Mrs TAYLOR - But that's what we are saying - you will.

Mr GRIMSDALE - That would be counted as clinic-to-clinic. It is an enclosed room. Having said that, sounds is like water. You can do anything you like with the walls but it goes straight through the door. You can put seals around the doors but you still have locks and interleaving things like that. You can only take it to a certain level without putting in double airlocks and those sorts of things.

Mrs TAYLOR - I understand that, but you want to minimise it as much you can.

Mr GRIMSDALE - Where it is an enclosed room it will be insulated.

Mrs TAYLOR - If you have gone to the standard that you have found works at Clarence, that is probably -

Mr GRIMSDALE - Clarence had the benefit of an acoustic engineer designing that wall, so we have followed a similar situation.

Mrs TAYLOR - Is it the second wall or the first wall?

Mr GRIMSDALE - The second wall.

Ms OGILVIE - Will the building be data cabled and NBN ready?

Mr GRIMSDALE - Yes.

Mr FARRELL - The site is on a flood plain - is that correct?

Mr WHEELER - Yes.

Mr FARRELL - Has that created any additional concerns?

Mr WHEELER - We have done two things as a result of that. First, when Glenorchy made us aware of that early in the piece, we made sure nothing was built below ground level. At Clarence we have some underground car parking and some plant. That was one of our constraints so we made sure nothing was underneath that level, even though technically we could. The floor level has been raised slightly above ground level to the point that council has said we need to get them to approve that.

Mr GRIMSDALE - Some of the landscape designs also take that into consideration, through mounds and berms to channel water if it comes down the rivulet and through there. It will be picked up out on the site rather than through the building.

Mrs TAYLOR - It is not normal flood plain; it is only catastrophic events.

Mrs RYLAH - To go back to the hot water situation, I see it is listed as solar hot water and you are saying you are now moving to gas.

Mr GRIMSDALE - They are investigating whether it is worthwhile having solar. We have gone through a planning process to say it is solar, simply because we have to. If there are solar panels on the roof, we have to have a planning permit for those, but we are looking to see whether it is cost efficient to do it. The initial response now, after this report was written, is they are not going to gain that much by using solar because of the gas in the street.

Mrs TAYLOR - But that is on current prices and we know the predictions for the future.

Mrs RYLAH - Why aren't we just using our hydro power? Surely that is the most energy efficient?

Mrs TAYLOR - It isn't. Electricity to heat is not the most efficient. It is not as efficient as gas.

Mr GRIMSDALE - There are cost benefits from using gas.

Mrs RYLAH - There are, including the capital cost?

Mr GRIMSDALE - There is always a capital cost up-front. In this instance, it is not that bad because it is a new building. Retrofitting is usually hard because it is a fairly big cost, but on a new building we use it anyway. It is the best way to go at the moment. The majority will be hydro power, but you can limit those costs by sometimes using solar. Clarence has solar because there is no gas over there, so we put solar panels on there for hot water only. We are looking at the same here, whether it is solar or gas.

CHAIR - Where does the ambulance go again - on that yellow bit at the back?

Mr GRIMSDALE - Yes, that is right.

Mrs TAYLOR - Where does it come in - you said a circular route?

Mr GRIMSDALE - You can come in and then come back in and around.

Mrs TAYLOR - They can do that and it is not circular?

Mr GRIMSDALE - No. The ambulance comes in and backs up into there. They will back the ambulance into there and then they will come out with the stretcher.

CHAIR - I know there are some constraints around trying to fit allocated spaces on to a tight area and not have people park there. I see some disabled spots here in car spaces 41 and 42. They may block access to the ambulance. Is there no other alternative?

Mr WHEELER - It has been rigorously tested. It is done to all the appropriate standards.

Mr GRIMSDALE - The traffic engineers have modelled that car parking model, as well as all the approaches and so on. It has been modelled to suit things like ambulances and

rubbish pick up. It has been modelled to make sure that that all occurs. The car park sizes all meet Australian standards.

CHAIR - Have you consulted with clinicians and other people around the building design?

Mr HOWARD - Ad nauseum.

CHAIR - I understand the King Island Hospital was a challenge in consulting to death and then still not getting real agreement. Certainly, they will be the ones working in here daily.

Mr HOWARD - We found exactly the same with Clarence. We consulted to death and when the thing was finished, the people who moved in said, 'This is not what I expected'. I think we have done even more consulting this time around, actually taking people to similar spaces. We can pick them up and say we will take them to Clarence and show them what the space will actually look like. As far as clinical space goes, if there is a concern, they say, 'Oh, yes'. A lot of people do not visualise what a space is when they see it as a flat piece of paper; I can fully appreciate that. Certainly, we have tested the clinical spaces and the patient flow through the building because these are important things. I do not think we have got that right at Clarence but we have had the benefit of actually building Clarence -

CHAIR - I think everyone has a degree in hindsight, haven't they?

Mr HOWARD - Yes, that is right.

Mr WHEELER - We had a very structured consultative process, too. Once we knew roughly how it would probably turn out, we first of all started with consultation groups for the whole building. Then we broke them down into floors - so we talked to them about the whole floor. This had the added benefit of starting to break down those organisational silos. Then we talked to the individual users. So as we went further into detail, we got smaller and smaller groups. I am not aware that we have done that before quite to that process.

Mr HOWARD - And we are still consulting and giving people the opportunity at each stage to have their say.

CHAIR - The people who may or may not be working there have seen the plan and are part of the consultation. Obviously, you cannot pick everyone, but the people whom you have consulted have provided feedback?

Mr HOWARD - Most definitely.

Mr GRIMSDALE - The plans they have looked at have been advanced a little bit from that. So we can do things like blowing up the room. We show the full furniture fit-out there complete with a chair. Then we do an elevation of each internal wall. So they have had the opportunity to say that that wall is going to have treatment beds banging up against it, or chairs banging up against it, so we have run vinyl up the wall. All of those have been picked up on and they have signed off on all of those drawings now.

CHAIR - Probably something I have learnt previously in Public Works hearings is - and hospitals are a classic example - that for the doctors and nurses who have to work there and get the cleaning gear out of the broom cupboard to wipe up people's accidents, it has to be practical. Are you satisfied that has been taken into account and people have had the opportunity to have their say on the practical workings of this facility?

Mr HOWARD - Most definitely. I came back to the ICC project halfway through the build of the Clarence project and I have been the one who had to field all the ongoing issues for the building. It has taken a lot of my attention to make sure that we consult with every man and his dog to make sure - and getting signed off because I do not think that was done well with Clarence either, where they said, 'Oh yes, I am happy with that', verbally, and it was not signed off. Then they came back six months later saying, 'I am not happy'.

We have been testing and testing and consulting and consulting the whole time just so it makes my life easier.

CHAIR - I understand that.

I have been given some examples previously on works that have been through the Public Works Committee that I have sat on, and one was the Port Sorell School, a very good building and very good outcome. However, one of the colour schemes used for the varnish on the doors was not a locally available, Australian product. It was designed by the architect to be a specific colour and they had to freight it in from Germany at the cost of $1 800 just so that the door frames were the colour as specified. Have you taken into consideration in your design what is locally available, where possible, and also the ability to keep the costs of that down?

Mr GRIMSDALE - Yes. At the moment we are going through an exhaustive process about sourcing bricks because, as you know, the major brick company down south here no longer makes bricks. Quite interestingly, we found a company up north that makes a significant number of different types of bricks which we were unaware of until we started this process.

We pride ourselves in what we do in the buildings. We try to use local materials as much as we can. Sometimes you can't avoid it. I can't tell you that the main mechanical plant won't be German, it probably will be. You can't avoid that sometimes; light fittings is another difficult area to get Australian made.

CHAIR - Someone told me that they were told to get that stain, whilst there were many suitable alternatives. But it was the specific stain to do with that. I have also been given another example where the flooring in a public building had a specification requirement. The detail around that was that it was a US product. There was a suitable local resource available that met the same specification that would have saved $35 000 but it was not approved by the appropriate government agency because that was not what was written. It was a specific product, not the specifications around it.

Something we see, as a committee, is an opportunity to raise that with the departments. It is something I feel should be considered at least and would pass on to the architects that, if we can, work within that, that would be beneficial. Is that the same attitude?

Mr WHEELER - Most definitely. Speaking personally, I also do some project management. I am a project manager officer and I always have that conversation with builders. We have a three-way dialogue with the architect, the builder and the project manager. The idea is that they are supposed to be coming to us and have an open dialogue about things that are documented, not just about local content but also about efficiencies and improvement, and they are assessed and we have a conversation. It is a team process and local sourcing of products is one of those conversations because it adds a cost benefit.

CHAIR - That flows into the recent Treasurer's Instruction to include a local benefits test in all government tenders, and that will be applicable for this.

Mr WHEELER - We try to do it culturally as well.

Mr GRIMSDALE - There is nothing we are proposing to specify that is out of the norm here. At the moment we keep saying it is like a brick veneer building. That is not denigrating the building; it is saying that it is a fairly traditional type of building. We are trying to maximise what we can do with structural elements to get the interest in the design, but there is nothing untoward or unusual about them.

CHAIR - The opportunity to disaggregate contracts where possible, so instead of having a $20 million project that many smaller businesses would not qualify for - the plumbing might be, say, $500 000, $400 000 or $1 million - would open up that opportunity to many more local contractors and something that could be considered.

Mr WHEELER - It is fair to say we are planning to try to not disaggregate this into a series of building contracts. There are a number of local building contractors who can do up to $12 million and then they would use local subcontractors. My experience, having worked in government for 10 years, is that projects of this size are, by and large, always local builders and local subcontractors. It is very rare to get something even of this scale which is not.

Mrs RYLAH - I may have misheard, but did you say you are not going to disaggregate this?

Mr WHEELER - I can't say we are not going to; we are going to apply for it not to be disaggregated.

CHAIR - You will comply with government instructions.

Mr WHEELER - That's right. There is a process for that and we will comply with it.

CHAIR - I have been banging on for four years about local contracts and buying local, and I will continue to do it on this committee.

Mr WHEELER - I am confident, even if it were not disaggregated. I would be very surprised if it wasn't locally -

CHAIR - And that is not to exclude anyone else applying because we have our free trade agreement obligations.

Mr GRIMSDALE - The head contractors have to comply with Treasury to be able to do it. There is no head contractor in Tasmania who encompasses all the trades that would be working on this building. Most of them are like a project manager with their own carpenters, et cetera. They will subcontract quotes for plumbers, ceiling work, painting; all of those will be subcontracted works.

CHAIR - There are some challenges with some operators able to do that, where they buy the tender as cheaply as possible and then squeeze the subcontractors out. That has happened on several government projects previously, and I have no doubt it may be attempted again. We need to be wary of that and make sure they meet the standard as much as possible.

Mr WHEELER - Cost is obviously one of the things we need to assess, but we are also very interested in the qualitative criteria in the submissions.

CHAIR - Do you disagree?

Mr GRIMSDALE - No, I am smiling because I have been involved where a couple of builders have gone broke because they have done exactly that, and it is nasty. It is not good for anybody.

CHAIR - Normally I get the department telling me it does not happen, but it is important we get it on the record.

Mrs TAYLOR - Going back to heating and cooling, is there going to be a central heating system?

Mr GRIMSDALE - It is centralised on level 3. There are major plant room and sub-plant rooms on each floor, so it is reticulated down. There is a big condenser unit on that level which is used to condition the air as it comes through. That is reticulated through the ceilings in all the levels. Some of it will be just heating or cooling air.

Mrs TAYLOR - So it will all be operated by that central plant, which will be gas fired?

Mr GRIMSDALE - Pretty well. It will be using gas in some things but the majority of that is going to be electrical. The hot water will be using the gas. At the moment I believe they do not propose fire up those boilers. There is a gas boiler but the main condenser unit will be electrically driven.

CHAIR - That does allow it to be safer because you can set the temperature of the hot water if I am correct. Is that part of the reason you are continuing that?

Mr GRIMSDALE - You can set the level of hot water. The hot water is a bit complicated and I am not sure I can explain it as well as an engineer would. They get some of the waste heat off the mechanical system and push that back through the hot water system to use as much reclaimed heat as possible. You are talking about the primary source. Hot water at the moment is going to be gas if the solar does not prove to be as they are telling me, but the major mechanical will be electrically driven.

Mrs TAYLOR - You need to take into account that we have been told that gas is going to double in price over the next couple of years, so regardless of what the cost is now it is a known fact, or pretty much known.

Mr GRIMSDALE - Most of them do not usually rely on one or another. If it is electrical you can modify it to do something else. Electrical is usually the primary source of most of the running and even when it is gas you will find it has backup. If a gas line breaks and it takes a week to fix it, you do not have a centre without hot water; you would always have a backup for it.

Mrs TAYLOR - I think solar hot water should be considered.

Mr GRIMSDALE - Clarence put solar panels on the roof for that and it was raining hot water over there.

Mrs TAYLOR - In terms of the design, and I mentioned it to you on site, in the original concept around the council chambers block part of the reason that the whole design worked well was because there was a fair amount of other community stuff happening there. There were cafes, some retail and part of that was to make it easy for people to go from one to the other. You are not having that here, obviously because the site is away and I understand that, but that is why my question is about, and I questioned you earlier, how does this get to be family friendly? If a single parent comes in with an injury or some other medical condition and has, because of the socioeconomic area - I know this happens - sometimes one or more children in tow because there is no capacity to leave them with somebody or in childcare. I am not exactly saying family friendly spaces. How are you going to manage to take care of that in this design?

Mr HOWARD - They are family friendly spaces. We have had experience with the Wellington Centre clinics and putting clinics into Clarence was another learning for us. As much as we can do to make it family friendly we will do, but we cannot cover every contingency.

Mrs TAYLOR - Will there be anybody there? Is there anybody in this design who will take care of that if it is a crisis situation?

Mr HOWARD - More than likely. Social workers in the building will have administrative staff who are available to look after whatever happens and this is what we find. It is not so much the actual setup of the building - it is having staff who can respond to situations. The calibre of your staff is the crucial factor - the sharing and caring staff we believe we have in health.

Mrs TAYLOR - Yes, but it depends on their role.

Mr HOWARD - Of course.

Mrs TAYLOR - If you have people with PD descriptions that say that?

Mr HOWARD - We have very broad PD descriptions and we do not go into specifics about what people should and should not do; there is broad guidance regarding those types of things. With any of these buildings, health facilities, we have a series of procedures and

guidelines which cover virtually every contingency. The staff were orientated in those and reminded of those ongoing procedures in guidelines.

Mrs TAYLOR - So when you have family friendly spaces if, say, a neighbour came in with another woman and you had to deal with the second woman - but they had children between them - then it is okay for them to be in that space. They do not necessarily have to be patients - they do not have to go through triage or to say, 'I am sorry, you are not the patient' or 'You are not here for the service'.

Mr HOWARD - I think when you look at the waiting spaces throughout the building, they are fairly generous. Again, learning from Clarence, very often in oral health, for example, they turn up for the one child but they will have another one in a pram and two or three in tow. You have to have that space to be able to accommodate them.

Mrs TAYLOR - That is exactly right. I notice you have baby change rooms and toilets in that central area, which is good. But is there any capacity for, say, a cafe, or coffee? Are you planning to have machines for them? With a bunch of children you are going to need things like a drink.

Mr HOWARD - We tend to put vending machines in. We do not want to be in the business of running cafes and those types of things. They can get in the way of what we are trying to do, as far as the health side of things.

Mrs TAYLOR - I disagree with you entirely. I think a cafe could actually do the opposite thing; you can actually offer decent food in a cafe. You do not have to run it yourself, after all, with the space you could lease out. You do not have to be restaurateurs to have a cafe in the building.

Mr WHEELER - Pragmatically, we had a real issue with car parking and maximising our car parking on site and therefore that started to determine the maximum envelope of our building. If we put those services in, we had to take one of the health services out. We really maximised there. So it was really about making a value judgment about what we were there for and what we really needed to achieve for the community of Glenorchy. I can appreciate what you are saying from a social space point of view. But the bottom line is that in Glenorchy there were other cafes; there were other spaces and that if we could provide drinks -

Mrs TAYLOR - There were in the original site but in the site you are at now there is very little.

Mr WHEELER - Yes, I understand, but if we had stayed at the original site, it was even tighter than this one so there would have been even fewer services.

Mrs TAYLOR - I understand that it would not have needed to be provided because that whole original plan had other things. The adjacent buildings had cafes and that kind of thing with public spaces built in but you now do not have that in this new location.

Mr WHEELER - No, that is a fair point.

Mrs TAYLOR - And it is absolutely about health and the design of this building to maximise the health benefits for people. It has to be a building that people want to come to and are comfortable in and can manage their social situation in, or they will not come; they will still go to the Royal.

Mr WHEELER - Yes, that is right and we are doing what we can. We have made it very clear all the way through that the feel of the building has to be right. We have created extra sub-waiting rooms over and above what we did at Clarence. So we have created those spaces for opportunities to occur and we are also allowing that in the future we may need to design little - for want of a better term - gated areas. You might have some more child zones even within those spaces. Those spaces are designed for that, should it need to happen. That is what our contingencies allow for in the first year of its operation. If we need to make little adjustments, we can.

Mrs TAYLOR - Another question about traffic management - the front door is there on the corner, isn't it?

Mr GRIMSDALE - That is back up Cadell Street a little bit.

Mrs TAYLOR - It is. When we were on site there, we were looking at people crossing the road as we crossed the road - probably not at the traffic lights -

CHAIR - We crossed at Cadell Street near Mill Lane.

Mrs TAYLOR - Is that the front door in the middle?

Mr GRIMSDALE - Yes.

Mrs TAYLOR - What is that on the main road side - that is not a door?

Mr GRIMSDALE - That is just an office.

Mrs TAYLOR - When you look at it on the drawings, it is hard to tell because it is all glass on that side.

Mr GRIMSDALE - It is just an indent on the wall.

Mrs TAYLOR - Okay, at the front on the main road?

Mr GRIMSDALE - It is staggered and moving along the main road; it creates an area to interface with.

Mrs TAYLOR - This is what I am looking at; you have glass all the way there, so the door is actually here. I just wondered why the traffic management people had not recommended putting a central line on there for people to cross?

Mr WHEELER - What happens in terms of the road itself is the responsibility of council. It could in their recommendations have asked us to do something of that nature. My understanding is they are still thinking broadly about their traffic, so they have not asked us to do it as part of the conditions of our planning approval or to pay anything towards

it. They may, with the money they are getting out of this project, decide to do some updating or they may be looking at a more integrated plan for that area generally. I am not sure. In principle, they don't want to encourage people crossing at this point, closer to it, as we did, but to cross at the lights.

Mrs TAYLOR - It is the nature of people being what it is because if you park your car across the road, generally speaking, if you didn't have to, people wouldn't walk to the corner and cross at the lights. That is what they ought to be doing.

Mrs RYLAH - If somebody gets dropped by taxi to health services, and there is a lot of taxi use in that area, where are they going to go if there is no parking there?

Mrs TAYLOR - There is no parking lane.

Mr WHEELER - They will drop off in the car park.

Mrs TAYLOR - There is 'no standing' all along that side.

Mr WHEELER - We originally looked at doing all that but the traffic management report said it was too risky.

Mrs TAYLOR - Can I talk about pathology and X-ray and double up or not double up because further along Main Road, next-door to each other, is X-ray and pathology. Is that not Pathology South?

Mr HOWARD - No. That is a private operator.

Mrs TAYLOR - They bulk-bill.

Mr HOWARD - Do they bulk-bill for everyone?

Mrs TAYLOR - If they bulk-bill for me they probably bulk-bill for everybody.

Mr FARRELL - A lot of them are starting to change though. Up the valley way they have gone to a charge system.

Mrs TAYLOR - If a person comes along to the healthcare centre, the ICC, with a suspected broken arm or leg, or an arm that hurts, then they are seen by MIC and they might say, 'I think your arm is broken, off you go down the road to the X-ray clinic'.

Mr HOWARD - They may do that or they may refer them straight to the Royal Hobart Hospital.

Mrs TAYLOR - For an X-ray?

Mr HOWARD - Even if they have the X-ray done and there is a confirmed facture, they will probably need to go to the splinting clinic at the Royal Hobart Hospital anyway.

Mrs TAYLOR - They might refer them straight to the Royal Hobart Hospital?

Mr HOWARD - Yes.

Mrs TAYLOR - In terms of pathology, why double up on the pathology services if you are not doubling up on the X-ray services?

Mr HOWARD - Pathology is a stand-alone. Pathology goes via a script. You take your form along to the pathologist who takes the required blood and does the testing. The script is provided by your GP.

Mrs TAYLOR - As they are for an X-ray very often, depending on what it is.

Mr HOWARD - True.

Mr WHEELER - My understanding is the ACC and the MIC are more likely to be asking for blood and urine samples - is that correct? It is more likely the pathology services are required by people visiting this building as part of their diagnostics.

Mrs TAYLOR - I find it a bit difficult to understand why you would do that. It seems to me the two are much of a muchness. Have you looked at the effect you are going to have on the businesses by doing those things?

Mr HOWARD - Pathology is booming everywhere and I don't think any business can keep up with demand. In Clarence we have Pathology South and we have Hobart Pathology.

Mrs TAYLOR - That is what it is in Glenorchy, Hobart Pathology.

Mr HOWARD - Both are extremely busy. You will double the size of any given practice, which people do not want to do.

Mrs TAYLOR - Do they have X-ray at ICC Clarence?

Mr HOWARD - No.

Mrs TAYLOR - But you do have pathology?

Mr HOWARD - Yes.

CHAIR - Is it possible for you to provide the traffic management report to the committee? Do we need to provide that in writing?

Mr HOWARD - Yes.

CHAIR - The committee will discuss that and send you a letter formally requesting it.

I notice in the security services, the isolation between wings is appropriate - locked areas, I would presume - and this is not to stereotype or say anything other than you have different people going to different areas that you may want to keep in that area. You are providing a vast array of services - mental health services, drug support services - and are you comfortable with the security arrangements for those facilities?

Mr HOWARD - Yes, most definitely.

CHAIR - And the design has taken that into account?

Mr HOWARD - Yes.

CHAIR - Are there adequate security controls in place?

Mr HOWARD - Yes. One of the things we are doing with this development is looking at a swipe card system throughout the building rather than a key. What we have found at Clarence is that people lose keys and then if they are identified they could allow access into the building. At least with a swipe card we can cancel the card and there will be no security issues.

CHAIR - You believe it should proceed?

Mr WHEELER - Most definitely.

CHAIR - Do you believe it is an adequate use of taxpayers' money and will fit the demand?

Mr HOWARD - Yes.

CHAIR - Is there adequate demand for a facility such as this in that area?

Mr HOWARD - Yes.

CHAIR - Do you believe it meets the stated purpose?

Mr HOWARD - Yes.

CHAIR - And it would provide value for the public?

Mr HOWARD - Yes.

CHAIR - As I said at the commencement of your evidence today, it is protected by parliamentary privilege. Once you leave the table you need to be aware that the privilege is not attached to comments you may make to anyone, including the media, even if you are just repeating what you said to us. Thank you for your time, gentlemen.

THE WITNESSES WITHDREW.