PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON MONDAY 9 MAY 2022

MENTAL HEALTH SERVICE ST JOHN'S PARK FACILITY, 16 ST JOHN'S AVENUE, NEW TOWN, TASMANIA

CHAIR (Mr Valentine) - This is the Parliamentary Standing Committee on Public Works and the reference today is the Mental Health Service at the St John's Park Facility.

We have an apology from the honourable John Tucker. Tania Rattray is not able to sit with us today because she is not officially a member of the committee until she gets sworn in. She has been a member of this committee for some time. That won't take too long to happen. She has been re-elected.

On this side of the table, Rob Valentine, the Chair; Felix Ellis and Jen Butler on the screen, who are members of the committee today; Scott Hennessy; and Rosemary Johnson who is with Hansard.

The secretary will now read the message from Her Excellency the Governor-in-Council referring the project to the committee for inquiry.

Mr DALE WEBSTER, DEPUTY SECRETARY, COMMUNITY MENTAL HEALTH AND WELLBEING, **Mr GEORGE CLARKE**, MENTAL HEALTH, ALCOHOL AND DRUG DIRECTORATE, **Mr ANDREW HARGRAVE**, DIRECTOR, PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES, **Mr MARK LEIS**, PROJECT MANAGER, DEPARTMENT OF HEALTH, AND **Mr PETER SCOTT**, DIRECTOR, XSQUARED ARCHITECTS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Before you begin giving evidence, I need to inform you of some of the important aspects of committee proceedings. A committee hearing is a 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 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 may be watching and we welcome them today, and journalists for that matter

Do you understand? I need a yes from each of you?

Messrs LEIS, SCOTT, CLARKE, WEBSTER and HARGRAVE - Yes.

CHAIR - Thank you all for attending today. For us to do our job we need as much information as we can get. We thank you for the submission that has been made. A lot of work that has gone into that. Would you like to make an opening statement?

Mr WEBSTER - The Department of Health is establishing serious strategic frameworks to aid planning for services. They include: My Healthcare Future; Health Workforce 2040; Rethink Mental Health plan; and the Digital Health Strategy. Informing planning specific to mental health services have been the Mental Health Reform Task Force Report, the Child, Adolescent Mental Health Services review and report, the Roy Fagan Centre review and report, the Prisoner Mental Health Taskforce report and the Forensic Mental Health review.

This planning and these series of review have informed us in a number of ways, including helping us to decide on our infrastructure needs.

The first of those needs has been addressed with the new southern acute inpatient unit of the Royal Hobart Hospital in September 2020; the mental health short stay unit at the Royal Hobart Hospital in February 2021. Work is currently underway in Hobart and Launceston to better locate our community mental health teams, including the first of 27 beds being 12 beds at the Peacock Centre, to open in November this year.

The reforms also identified the need for safe havens or spaces for people to go, particularly after hours, just to be around others. One-stop shop, or integration hubs, where state and community sector services can be delivered or entered upon as one, sub-acute mental health beds and an eating disorder service.

Peacock, I just referred to, and now St Johns Park, are designed to meet these specific needs in the south, with some statewide operations. The building we are submitting to the committee today will deliver safe haven, an integration hub, sub-acute beds, eating disorders residential service, and a southern eating disorder's day centre. The model of care for these services has been developed in conjunction with our community. In particular, our consumers through Flourish, their supporters through Mental Health Families and Friends, and drawing on external expertise such as the input from the Butterfly Foundation.

The design of the buildings and the model of care takes in the concepts of mindfulness, by creating moments of pause using the outlook as well as the internal and external built environment to create a residential scale of building within a landscaped open environment.

The building is not on the scale of a busy hospital. In particular, the eating disorders unit will house up to 12 people. Importantly, the bedrooms can be reconfigured to accommodate single or shared rooms, or to increase the number of therapeutic treatment rooms depending on the need. Six to eight will be typical numbers in that unit.

The safe haven will allow for drop-in and will replace the emergency department waiting room for a lot of clients, particularly those with suicidal ideation not requiring non-psychiatric medical treatment. It will allow for you to grab a coffee or a snack, or have a chat, or just stop and feel less vulnerable with your own thoughts.

The integration hub will mean that we don't need referrals that move you around buildings across the city. The services will be together on site at St Johns Park.

Sub-acute beds will continue to take pressure off our acute wards, but also provide the necessary slightly longer place for consumers to be hospitalised in a more conducive environment to their stage of ill health.

Thank you, Chair.

CHAIR - Thank you. The committee is familiar with some of the terminology used here. It has examined the Peacock Centre Project, which is not unlike the project before us, except I don't think it had the eating disorders component?

Mr WEBSTER - That's correct, Chair.

CHAIR - Normally we work our way through the report page by page to make sure nothing is missed and to give the members an opportunity to ask questions.

I suggest we start at chapter 2 on page 6 because the executive summary will be covered through the rest of the document. Is that fine? Jen, are you happy with that?

Ms BUTLER - That's fine, Rob.

CHAIR - Okay. Perhaps I can lead off. Partway down on page 6, it says:

> This development proposal is consistent with the most current DHHS Strategic Asset Management Plan by creating efficient assets that support effective services that are responsive to change, developing buildings in key locations, and creating a management and service structure which responds to local needs while maximising professional interation and economies of scale.

Now, they are easy words that can flow in a description. Can you give us how that statement is demonstrated in this particular development, if I can put it that way? It is an interesting descriptor.

Mr WEBSTER - Yes, Chair. So, if we take St John's Park, the first example of that is the fact we've co-located the Tasmanian Eating Disorder Service and the eating disorder beds with the southern sub-acute beds so that we have that multi-purpose. That allows us to share services and get an economy of scale in that building, which has saved considerable money.

The second thing is the flexibility of spaces, and as I've already said, while we can house up to 12 patients in the TEDS wing, ideally, it's six to eight, but the rooms are configured so that they can be changed to shared rooms, or indeed converted to therapeutic rooms so that people can retreat to them for therapy. So, those sorts of things. Reusing land that we already have within our suite is another example of us of using assets strategically rather than going out to look for new land and those sorts of things.

The other thing within the envelope that we're putting out there is we're looking beyond 'let's have our sub-acute beds here and let's have our integration hub here and our safe haven here'. We've said, 'no, no, let's bring these services together,' because they work together, but secondly, it means that we've got a number of staff always on site that can actually intersect and overlap with each other, including staff from the community sector, which is important to

recognise that more so than other parts of health, the mental health sector very much needs to integrate with its community sector. So, whilst we have that sort of primary care versus acute care split for the main parts of health, parts of the primary care of mental health sits with us, some with the community sector, and vice versa, so we need to make sure that we're more fully integrated.

All of those are examples, as I said. The actual environment we've created out there - or will create out there - so it makes use of the site so that you can have a therapeutic environment that has an outlook, and those sorts of things. It is too easy to say, 'we can build a big building and get economy of scales', it's actually getting a small building that's got that economy of scale as well, and I think we've achieved that in this design.

CHAIR - When we were out on-site this morning, you were describing how this looks in a statewide model. For the record could you describe where this facility fits in that model, and how it might differ - in a sense - to what the Peacock Centre in North Hobart achieved?

Mr WEBSTER - In one sense, it's another version of the Peacock Centre, as you said, but more broadly than that, we've got other features out there, and the main one is the eating disorders. When we looked at the Eating Disorders Service, what our planning told us is that the number of people coming in will vary between that six to 12, and up to 12, but it'll be about that six to eight people at one time. To create a therapeutic environment for that group, if we built three centres across the state - or four centres as we have with our hospitals - you'd only have one or two patients in each centre, and that doesn't build a therapeutic community.

So, the decision is that we'll have a statewide residential hub for eating disorders and that will be part of St John's Park. But then we need to create an environment where people go back to their own community. With the Eating Disorders, at St John's Park will be the southern day centre service attached to the residential service but we'll replicate that in both the north and north-west so that when people leave the residential component of their therapy they've got ongoing therapy in their local community and their local environment so that's connecting our statewide service to our regional services.

The safe haven will be localised. We will replicate that in other centres so there's one at the Peacock Centre and we will have another one in other centres as well, so they'll be replicated. The sub-acute beds, in the main, will be state-based beds because the tertiary hospital and the largest of our inpatient units is here in Hobart. It is regular that we have people transferring from other parts of the state for more specialist treatment at the Royal Hobart Hospital so we'll treat the sub-acute beds in that way. However, having said that, we have an acute ward in Launceston and our planning is - and we are going through this process - we build a mental health precinct in Launceston. We will take into account - 'okay, we have acute beds, what's the next step? Do we need sub-acute beds within our mental health precinct? Do we need to bring together our integration hubs and those sorts of things?', and the same in the north-west?

The other major thing is that we need to integrate with the Commonwealth reforms so-called Head to Health. They are providing kids' Head to Health and adult Head to Health so we won't be replicating the integration hub in the north because the Commonwealth is funding a Head to Heath centre. A Head to Health centre is almost the same as an integration hub with a few variations on a theme. It's actually looking at our planning on a statewide basis and saying 'what do we need, where?' across the state.

CHAIR - Thanks for that. Jen, you wanted to ask a question?

Ms BUTLER - I have so many questions, I'm not quite sure where to start. I am more interested as a starting off point in the practical application of the Tasmanian Eating Disorder Service. Currently, in the south and in the north, people who suffer from disordered eating enter into the hospital system. That's often for acute assistance to full weight restoration and to get their weight up to a healthy level and then, after that period of time, the Mental Health support starts. Can you explain to me how this will work with the current practices? Where the people who do have disordered eating begin and are they then transitioned over to the St John's facility? How is it going to work on a practical level?

Mr WEBSTER - On the practical level there will still be a few cases that will go to acute hospitals because they may be at a level of condition which we would see as 'non-psychiatric medical' so that would still be done in the acute hospital setting. However, it's more typical that people aren't at that acute non-psychiatric medical level; they are more at the psychiatric medical level so they currently go to our acute facilities across the north-west, Launceston General Hospital or at Hobart, and then they transition to community.

This will replace the acute in-patient for the psychiatric medical side of it so you'll still have, as you said, some people get to the point where they need that help to get their weight back up. That would be seen as 'non-psychiatric medical'. In some cases, that will still happen at an acute hospital but the vast majority of people won't go to the acute hospitals, they'll go to this facility or residential facility first. This is incredibly important and means that the mental health inputs start alongside the medical inputs at the centre. The third element of this is the non-residential component, or the day centre component, which is the normalising component. This is generally the longer part of the therapy. We'd want an acute intervention within the residential setting, followed by a very long therapeutic environment close to their community.

Ms BUTLER - I think the studies show that a full recovery from having a disordered eating illness is about seven years. I'm interested in where the data was developed from for how many beds this facility would require. There is a huge need out there in the community at the moment. I found some figures in here, but I think they were from 2018 to 2020. How were those numbers developed?

Mr WEBSTER - The first thing we did was we involved in our planning the Butterfly Foundation, which runs the eating disorders programs across Queensland mainly, but they do run in other states. It's drawing on their experience.

Second, we mapped the inpatient and mental health intersections with people with eating disorders. Typically we think it'll be six to eight, but we've allowed for flexibility in allowing for 12, because it could be up to that number at any one time. That's not how many clients we would have in this service at any one time; that's the number in the residential facility. The number across our day services will be considerably higher than that. I can't bring the number to mind, but we're assuming with looking at the data, for the north-west, around 20, slightly bigger in the north, and in the south about the same. The spread isn't equal across the state. We recognise there is an issue in the north-west that's particular to the north-west.

Ms BUTLER - It's very hard once a person with disordered eating has, for instance, some cardiac issues which have been resolved, the psychological assistance has to proceed.

Currently what happens is they leave the hospital and they might go into the care of family if they're lucky, but a dietician and the proper psychological services just aren't there at the moment. There's a really long wait, sometimes up to three months, and by that time they've probably gone backwards, then they're back in hospital again. What measures do you have in place to make sure that you're going to be able to staff this facility with the dieticians and the proper psychological assistance and the GP services, and also the pathology services? Do you have a plan and a strategy for that? The last thing you want is to build this beautiful facility and have the same problems we have at the moment with people still not being able to access.

Mr WEBSTER - Through you, Chair, that's an incredibly important question. Upfront I mentioned that part of our planning is Health Workforce 2040. We're developing a number of immediate strategies in how we employ people, a number of medium-term and a number of long-term. If I start with the immediate term, it is advertising, particularly internationally and in the larger states to try to attract people here. We have staff whose specific role is interstate and international recruitment.

The second part is making ourselves more attractive. We are working with University of Tasmania to change the courses they offer. We haven't had a Chair of Psychiatry at UTAS for the past few years since the retirement of Professor Ken Kirkby. We are hopeful that within the next few months that Chair of Psychiatry will be reappointed. We think it is really important that if we are going to attract registrars to train in Tasmania that our university has a Chair of Psychiatry that has good standing. A good example of that is attracting Professor Brett McDermott into our CAMHS area. His reputation is already having some benefits for us in terms of recruitment of psychiatrists to the state. Most recently, in attracting one we managed to attract their partner. We get two for the price of one in that child and adolescent space.

Our medium term is to improve our reputation, through things like UTAS. The long term is the course mix at UTAS, particularly across allied health. From next year the university is offering post-graduate courses in physiotherapy, occupational therapy, and I have forgotten the third one. It is the first time they have done that in quite some time. We think that is important because those people will then do their placements within our system. That gives us the chance to attract them further.

It is not actually in this mental health space but we have a graduate program running at oral health this year for the first time in 10 years. Those are the sorts of programs that are rolling across Health as part of Health Workforce 2040, to bring people down and then hopefully keep them here because they find us an attractive place to be.

Ms BUTLER - One more question on that. Is there a plan strategically to work with Victoria in relation to the TEDS area? I know Victoria has been very well funded and they are miles ahead of most of the states in Australia, in this area. Are we going to be working in conjunction with them in this area too?

Mr WEBSTER - Not specifically with Victoria. Through our contract with the Commonwealth we are obliged to intersect with Butterfly, which is the major provider in Queensland; in fact, they are a leading provider in this space. We are open to working with any state or territory that has programs we can benefit from.

We are calling this the Eating Disorder Service. While we are building a building, we are actually creating a service to match it. The federal funding is around the building, the state input is to fund a service that matches with that building. The day services will be in place, particularly in the north and north-west in advance of the building of the southern facility.

Ms BUTLER - Thank you.

Mr CLARKE - Chair, we can add to that. We currently have the service manager for the Tasmania Eating Disorder Service which has been advertised, and is open to the public until 17 May 2022. Ms Butler touched on that workforce is the key aspect, and getting that manager in early helps integrate our service. As we develop the model, we have that lead on board to work with us. It has attracted a lot of interest.

CHAIR - You can have the best facility in the world but if you cannot staff it it is not going to perform well. That sounds very positive, a clear plan, which I think is important.

Do we have any other questions on that page?

Mr ELLIS - This one might be best to you, Mr Webster. Can you give the committee a sense of what our breakdown is in the comparison between the number of people with eating disorders that we might expect to see at this facility and the number of people with eating disorders we might expect to see at our day services, particularly statewide?

Mr WEBSTER - Thanks, Mr Ellis. Typically six to eight at any one time, but as Ms Butler said the recovery time for eating disorders, particularly when they become chronic and severe, is incredibly long. At any one time, within the service, we're probably looking at having around 80 to 100 people getting direct services. That probably means we've got multiple hundreds in various stages of recovery and they may be referred to the occasional contact from our continuing care team, or they may have been referred back to general practice or primary care providers. Because of the nature of this particular disorder, and the length of time it takes to fully recover, it's a really difficult cohort to pinpoint to a number, but we would say that at any one time we're probably in that 80 to 100 more direct service deliveries.

Mr ELLIS - It is potentially a long tail in terms of the number of people and time with which they're interacting with the day service?

Mr WEBSTER - That is right, a particularly long tail. But the important thing is that the goal is to get back into community. With that comes the old-fashioned term of 'normalisation', but it's important in this space, so that's why the residential service has to start looking at you preparing your own meals and those sorts of things. The day service has to reinforce going out and purchasing meals instead of skipping meals. All of those sorts of things take a long time to retrain the mind to think that way about food, if you have an eating disorder. The number of relapses that will occur within this particular disorder is large, so it is quite a tail and, as I said, services may extend for anything up to - as Ms Butler said - the typical is seven years, but it could be a lot longer than that for some people, so a very long tail on this group.

Mr ELLIS - In terms of maybe shifting focus to people coming into our mental health service there, could you give the committee a sense of what happens when someone who's presenting at home with quite acute mental illness and their family might take them to an

emergency department or something like that, how do they go from that situation to finding their way to one of these services?

Mr WEBSTER - Typically in the mental health space, or the mental health illness space more specifically, there are pointers and we spend a lot of time educating people on what those pointers are. Beyond Blue does a fantastic job around depression and anxiety. So, we try to get the pointers so that you can get intervention earlier. So that's the first entry point: to try to get people to our integration hub or services around the state at an early point before we get to an acute illness.

The second level - if you like - is they're starting to show signs of acute illness. We then try to come in with hospital avoidance programs, and we have strictly a hospital avoidance program, it's called, but there are also things like the PACER program that we're trialling in the south - PACER stands for Police Ambulance Clinical Emergency Response - so you ring up triple zero, they do a triage about is this a genuine 'let's send out lights and sirens and get you to the ED,' or is this an emergency where some input from a paramedic and a clinician going out with the safety of a police officer can intervene and keep you away from a hospital and keep you out there. They will typically then refer you to other services, so again, that's another entry point to services.

Then you have those who become acute. They generally come through the service through the ED, or if they've already had input through PACER, through our hospital avoidance. Through our hospital in the home, we are working on a process where they would direct admission to an inpatient facility, so we're skipping the ED step if they don't have non-psychiatric medical. I emphasise that ED is the right spot for a medical emergency, but if they can skip that step, we will try to do that.

Ideally, the stay in the acute inpatient unit should be as short as possible. The goal of being in an inpatient unit is to be discharged almost as soon as you are there, because it is about stabilisation and reducing your illness to a level where it can be managed in a more conducive environment. Acute inpatient units are not conducive to long-term therapy; they're conducive to short-term stabilisation, if I can put it that way. That is because of the through-put of people, the level of acuity of the people arriving on a daily basis. Having sub-acute beds allows you to then move people out of the acute ward into a sub-acute setting such as the one we're going to have at the Peacock Centre, and this one we're talking about here, where they can spend a longer period of time, again with the goal of getting reading for the community.

At the moment, with the lack of sub-acute beds in the south, we are using our inpatient acute beds as acute beds followed by a period where you're sub-acute and we're trying to prepare you for the community -

Mr ELLIS - But you're effectively in the same bed?

Mr WEBSTER - Exactly, so we need to have that to happen there. Then we have what's called 'step-down beds' which are longer-term beds. We use Mistral Place for that here in the south. In the north, that is in the community sector, and then, of course, there's back into the community.

Alongside that we also have long-term rehabilitation beds. They are for people who are not going to recover in a hospital-type of environment. They need long-term input from allied

health - from psychiatrists, but in a controlled environment too. In the south that is Millbrook Rise. Beyond that we also have to have things like secure forensic mental health and secure civil mental health which we've got at the Wilfred Lopes Centre and again at Millbrook Rise. So there's a whole serviced system that wraps around and you can enter it at a number of different points and you exit as quickly or as slowly as you need.

Then, unfortunately, we have those with chronic mental health issues that just don't resolve throughout their lifetime. You see them typically through a number of beds, highly supported these days through the National Disability Insurance Scheme (NDIS). They are typically in our Older Person's Mental Health beds at the Roy Fagan Centre.

CHAIR - Thank you. Some feedback - I came across somebody who'd experienced that PACER system with their family and they said it was absolutely terrific. They said they couldn't have asked for a better attention to the issue that was at hand. It certainly seemed to assist them in their circumstance at the time.

To be able to clarify as well something was said during the site visit - we talked about mother/baby units. This is not intended to perform that sort of role for a mother who might be experiencing severe postnatal depression, or whatever the technical term is?

Mr WEBSTER - That's right, Chair. Our mother/baby beds we purchase through St Helen's Hospital here in the south. Typically, we don't have a large number in this cohort which is fortunate, but if we do we use the private beds for that. However, as I said up-front, we're doing all of this planning. If we need these beds in our acute facilities into the future they will be accommodated through swing units and things like that. What we find is that if we had a specific unit, it wouldn't be occupied very often because of the nature of this particular illness.

CHAIR - Thank you. Do we have any other questions, page 6, page 7?

Ms BUTLER - I may have missed it, but I wanted to double check on the paediatric psychiatrist, or the psychiatric area. Where will those young people be going that require those services at the moment? Will they be able to access it through these new facilities? That's another area where we're really lacking for young people.

Mr WEBSTER - Through you, Chair. So, the Child, Adolescent Mental Health Service review and reforms, which are being led by Brett McDermont, will inform where we need those inpatient beds. At the Royal Hobart Hospital in K Block as part of the paediatric unit we have some mental-health-standard beds within that unit that can be used for this particular cohort. We've done the same at 4K in Launceston. We're designing a service system, particularly with children and adolescents, which is about early intervention.

As I was saying in response to Mr Ellis, we're getting in early so we avoid the acute admission. We're developing that system particularly around the more vulnerable children and adolescents. Another part of our planning - I know it's not in this building - if you're going to replace Spencer Clinic, which is 20 beds, with 20 beds in the north-west, you'd make them far more flexible in that it would look like five lots of four, so that you could close off four to make an adolescent unit if the need is there, close off if there's the need for mother-baby.

Our asset management planning involves much more flexible spaces. The St John's Park facility is not specifically designed for children and adolescents. Having said that, it's important to acknowledge that eating disorders don't start in adulthood; they start quite young. The residential facility will accommodate them. Part of the model of care and part of the building is to make sure that we can have that level of separation as required for that particular cohort.

Ms BUTLER - I'm sorry if my question wasn't very clear. I was referring to where we have a situation where a 14-, 15-, 16-year old may have an overnight visit, maybe after self-harming, at the LGH or the Royal, but then they're discharged the next day after they're stabilised or maybe two days after, but those wraparound services aren't there for them. They're left to parents while they're trying to find - if they're lucky enough to have private health - a psychiatrist to assist them. That can sometimes take up to six months. Are we looking at building anything for those kids? By the time they get to be adults, if they do, they're very damaged from that process. There's that gap. They leave the hospital and they're stable to an extent, but then there's nothing until they're able to find that assistance. I was hoping there'd be something like that in this facility, where they can drop in, where they can have that service.

Mr WEBSTER - Elements of the facility like the safe haven and integration hubs are designed for any level. Importantly the CAMHS review and reforms -

Ms BUTLER - Is the safe haven area for young people or just for adults?

Mr WEBSTER - It generally for older adolescents rather than younger kids. With the CAMHS reforms which are rolling out at the moment we're concentrating on a youth intervention program for the north-west, multi-systemic treatment around trauma, particularly in out-of-home care and those sorts of things. Those sorts of services are the services that create the circumstance where you have an acute event and then you're waiting for something else. We're filling the gap with those services at the state level. It's important that a lot of the planning and a lot of the models of care for that are happening. We're starting to recruit. We need to increase our child and adolescent mental health service workforce, and that's what is underway.

The second part is Head to Health, which is a Commonwealth program that integrates with what we are doing here. It's Headspace but it is broader than Headspace in that it goes to a younger cohort as well. In the bilateral agreement recently announced between the Commonwealth and state, there is additional funding for kids' Head to Health. We are looking at integrating it into our early childhood programs through our child and family learning centres. We will have kids' Head to Health attached to those, so very early in the cycle of issues occurring there. We need to avoid, with children and younger adolescents, time in institutions. I would include sub-acute beds in that and should be avoided as much as possible.

You are right, we must have the services that are beyond the hospital. That is what the CAMHS reforms are for.

CHAIR - Thank you, you've given a very good overview and probably answered a lot of other questions that are through the rest of the report.

Page 8: do we have any further questions there? No.

At the bottom of page 8 it says, 'A new Tasmanian eating disorder service will address gaps in the current eating disorder service system'. Clearly you see this as something that has not been available before?

Mr WEBSTER - It has been available in scattered forms.

CHAIR - But not in the one space?

Mr WEBSTER - That's right. A bit of it is in CAMHS, a bit of it is in the acute hospitals, as Ms Butler described. We need to make it a service so it's holistic.

CHAIR - Yes. You describe the physical environment as, 'The development will be familiar, comfortable and residential style'. It is not exactly like a home, is it? Can you describe that?

Mr WEBSTER - No, it's not a home. It is still a hospital or therapeutic environment. I will probably throw to Mr Scott about his design. The idea is that in the building you don't feel like you're in the typical hospital environment.

CHAIR - A more domestic feel about it.

Mr WEBSTER - Exactly. Which is why we are not building on a massive scale with a 200-bed hospital. We are building it as two 12- to 15-bed hospital wings, but then you build into that environment. There are a few photos in there that Peter has included. It is really down to the skill of the architect.

Mr SCOTT - Chair, perhaps another way of looking at that is that we are targeting a non-institutional aesthetic. The term 'residential' is used to draw a comparison with an institutional environment. The focus is on using domestic- and residential-style design cues to make people feel at home, even though it is clearly not a domestic setting.

CHAIR - Which helps with their normalisation.

Mr SCOTT - Absolutely.

CHAIR - Over to page 9.

Mr ELLIS - Chair, going back to the Peacock Centre. You are saying there are similar levels in terms of their purpose and the clientele they serve, but one is specifically for the south and the other is statewide. How do we differentiate who goes to which? What is the decision-making process?

Mr WEBSTER - Eating disorders are definitely statewide. Wherever you are in the state, if you need residential that will be the service. If you've come through Royal Hobart Hospital you will be going through this sub-acute, whereas if you have come through the Launceston General Hospital you will have that service more in the north, so it's tied to the hospital you've come through, in that sense.

The difference between Peacock and St John's is in the south we need 27 sub-acute beds. We were tied to the Peacock site by the bequest that we got, we can't use it for any other purpose

other than as a mental health facility. We took the choice of saying, 'we can't build 27 beds on the Peacock site, it's not big enough and we would have had heritage issues, et cetera, but we need 27, so let's split the unit into two'. South-of-Hobart patients will probably have Peacock, and the north of Creek Road will be the St John's Park.

Mr ELLIS - Right, so when we're saying 'south', we're talking about south of Hobart, and then north is the northern part of Hobart.

Mr WEBSTER - No, I meant it generally as the statewide when I said it earlier, but that's how we're splitting it in the south. But also, because St John's Park is bigger, if there are Launceston or north-west patients who we can't accommodate, they'll go to St John's Park, because that's the bigger of the two, until we've got similar facilities elsewhere. It's an artificial barrier between the two. I think it won't exactly work like that way, but in terms of the integration hubs, we'll try to direct people that way, because it's easier for Kingston people to get to Peacock than St John's Park.

Mr ELLIS - Effectively, you could go to either?

Mr WEBSTER - Exactly.

Unknown - Other than the eating disorder suites, yes? The eating disorders facility, which doesn't exist at the Peacock Centre.

Mr WEBSTER - Yes, that's a one off.

CHAIR - Okay, page 9. A small question, about three paragraphs down - or four, 'the combined purpose-built facility is to meet each business unit's MOC,' what is MOC?

Mr WEBSTER - Model of care.

CHAIR - Model of care, thank you. I'm thinking, what does this mean?

Mr WEBSTER - We must have not defined that one. Sorry about that, Chair.

CHAIR - That is okay. We learn as we go. It's not a problem.

Mr WEBSTER - I do say, Chair, we don't usually shorten that to MOC.

CHAIR - I took the time to look up the recovery-oriented practice guidelines, and found it quite fascinating to read that. Maybe we'll get to this a little later, before I start asking about how some of the principles are being implemented in the design. We'll do that a little bit later. Okay, any questions on this page, page 9? No? Page 10?

Ms BUTLER - I have one on page 10, Chair. I was wondering whether the committee might be able to talk me through the section on the National Disability Insurance Scheme? It sounds a bit ambiguous. Can you explain to me how the NDIS will fit into the Mental Health Integration Hubs (MHIH)? It just says: 'Will include a dedicated presence from the NDIA.' What does that presence look like? Would that be someone who's there on site, or will it be a meeting room? What does that actually mean?

Mr WEBSTER - Through you, Chair, what that means is that once you get a package through NDIS, the agency then funds a number of services. As you move in and out of particularly the sub-acute areas of mental health, you will have mental health practitioners involved in your care to deal with the particular issue, but you'll still have your support network that's funded in your package. So we have to accommodate that there are two sets of practitioners involved, and making sure that we integrate between the two of them. When we say the 'presence is there', it may be that through your package you are funded for an overnight sitter to be around, to deal with anything that's happening overnight. It may be that that person then is part of a service delivery in the sub-acute unit. I'm just trying to work that out.

The important thing here is that what we're finding with this is that when we look at our longer-term rehabilitation clients, they are typically the clients who are transitioning to NDIS. They're not having an episode and recovering. They are longer-term clients of a mental health service. A handful of them will probably even go back to the Royal Derwent Hospital days but with the establishment of NDIS and the establishment of the criteria, they are now eligible for a package. We're seeing some of them move for the first time out of one of our longer-term - and let's face it, they are institutions - into the community for the first time in their adult lives for some of them.

We need to take account of that going forward because there will be people who are slow in recovery and, therefore, qualify for NDIS. We need to make sure we're building a facility that integrates that new style of delivery of service that's been around a few years now and is still a developing service, particularly in the mental health space.

Ms BUTLER - I suppose that goes to my next question. How will we, as government members, ensure that the level of service for the people who are within our facility receive from the NDIS and their workers who are coming to feed them or assist them is at our standard? We know that at the moment there are problems with adequate training, adequate quality, number of people, to meet those clients' needs? Is there a mechanism? Is there a tool that we use to be able to ensure it is at that right standard, at that right level?

I did a home visit last week for a person on the NDIS and it was obvious that the assistance they were receiving wasn't appropriate and wasn't working, but it hadn't been checked by anyone for a long time. What levels do we have in the place? I know that can happen. People are human, systems are systems, and it's all very new. Will there be checks and balances in place within our facility to make sure that we have some control over that?

Mr WEBSTER - When it's occurring in our facility, we have control over it. It's done under our accreditation and we're responsible for the quality and safety of the people within our institution. You're right - outside of our direct sphere, we don't have any control of that. It is through the Quality Commission that's attached to the NDIS which has the role of monitoring that.

As we are going in this transition phase, because not all clients have transitioned to NDIS or NDIA yet, we are working very closely to make sure the packages that are put in place are appropriate for the client before they leave our facility to move into another facility. It's a balancing act because, of course, we've already handed over the funding so we're no longer funded to give the service, but we make sure that, in handing over, we're not diminishing and, generally speaking, the packages are fit for purpose for a particular client but there are occasions where we're advocating for our client.

CHAIR - On this page, you talk about the 'safe haven'. I am interested to know in the design of these spaces, do they take into account things like hanging points and furniture that can't be utilised for those sorts of difficult circumstances?

Mr WEBSTER - Yes, they do. The design standards for these types of facilities require we don't have ligature points, or things like door handles take into account that they can break away if they're in - particularly in the residential rooms - so you can't use them. Importantly, in the Safe Haven, generally they're used because you need to be around others. The important worker here is, in fact, the peer worker, the lived experience worker, who is interacting, just making sure that people are getting what they need, which might be just a quiet corner, or it may be a chat, or it may be just a coffee or a meal. The idea of the Safe Haven is - I think I said earlier - that person who doesn't feel safe enough to be at home, doesn't feel safe enough to be away from, and so generally these days they'll attend the ED, and they'll be in the waiting room at the ED -

CHAIR - That is not a great place for them to be.

Mr WEBSTER - which is not a great place, but they just want to be around someone. Indeed, it's not a great place, and it's so busy, et cetera, it's probably adding to the anxiety and the stress levels, et cetera. We want to get them out of that space into this much quieter space, and provide them literally with a safe haven so that they can do what they need to in that period where they feel they need that support.

CHAIR - I was just interested in the design aspects. Is that throughout the whole building anyway, or is it only in certain locations where people with suicidal tendencies or whatever might be?

Mr WEBSTER - No, the design standards apply throughout a health facility, and we get accredited against them, so we monitor that.

CHAIR - So it's a general application in the site? Okay.

Mr WEBSTER - It is a general thing.

CHAIR - Obviously the various aspects of multipurpose spaces, quiet spaces, family spaces, et cetera, are self-explanatory. Any other questions on that page?

Mr ELLIS - I might just ask about the recovery college. Can you give us a sense for what the reasoning is behind it, any academic literature on the - without going into too much detail - but in terms of why we think this model is an effective model of care, versus what they're saying there of a more therapeutic model?

Mr WEBSTER - Sometimes, particularly with medium/long-term mental illness, you start to lose the skills to live, literally, so the skill to actually learn how to schedule your time, in some cases the skill to cook, and those sorts of things. The idea of a recovery college is to say that through the issues you're having with your mental health illness, you may actually be deskilled in a whole lot of different areas. Rather than look at that as a therapy that you need to go through, looking at it as an education you need to go through.

The other thing is that learning about your condition can be incredibly empowering, so it's also that side of it. This is very much tied to the whole concept of people learning from lived experience and intersecting with lived experience, people who have similar lived experiences to learn. It's a skills approach. For some people, their ill health will continue for incredibly long times, or even their whole life. Having an approach to it that is a set of skills that help you cope with that lifelong illness is another reason you would take an education approach rather than a therapeutic approach.

It is being used quite widely in Australia these days, particularly in New South Wales. Our chief psychiatrist Dr Groves is particularly interested in the development of this in Tasmania as another one of the suite of approaches that we take, because the longer-term is part of what we need to focus on and make sure that they're not redeveloping acute illness.

CHAIR - Are there any other questions on this page? No. Page 11 - hours of operation and work patterns. It's obviously not going to be 24/7 by the sound of it. It's going to be driven by demand, is it? Is that basically it?

Mr WEBSTER - That's right. Different services will have different hours of operations. Obviously, TEDS - the residential component, is 24/7; the sub-acute is 24/7, but the Safe Haven Hub predictably tends to be late in the evening through the next morning type of thing or a bit longer than that.

I'll use PACER as the example. We run that 16 hours a day but they're the 16 hours a day where we'll have the biggest impact. So we'll design these and, of course, integration hubs where we're drawing on the community sector, they're not funded to run 24/7 so they're, obviously, more a Monday to Friday, 9 to 5-type of arrangement. It's a real mix in this centre.

CHAIR - I suppose as service provision evolves, you'll get a better feel for what that sort of employment needs to be.

Ms BUTLER - A quick question - those Safe Haven Hub operating hours, I suppose it's a bit too early, as we were saying before, to figure out exactly what would be required but, currently, with the situation where people will, say, attend the Launceston General Hospital because they feel like they're going to harm themselves or they've attempted to and so forth, will there be a capacity within those Safe Haven Hubs for those people to attend, and what happens if they do attend but they're not able to access it? Can you run through what that looks like at the moment? That seems to be a big part of the need?

Mr WEBSTER - Typically, the majority of those sort of presentations at our Emergency Department are, understandably, in the hours of darkness. If we look at the one that runs at the Royal Prince Alfred Hospital in New South Wales, they open as soon as it gets dark and they close about an hour after it gets light. They get the people through the darkness but you don't just send people out the door when it gets light, it is around 8 o'clock, et cetera. Services are opening up so you will refer them.

If someone has just come in because they feel they need to spend some time with other people then there's probably not much of a referral. But if they're really seriously suicidal then you're doing a hot referral to another service whether your assessment is that they're acute or whether they're already in contact with a case manager that you can put them in touch with. You are actually using the space to do those hot referrals as well.

Your hours of service match to what the need is. We will typically when we're opening the Safe Haven Hub, we'll have a look at what are the presentations at the ED, having said hours of darkness are critical periods. Christmas Day is also a day where you might want to open all day. You match your safe haven to the need that's in the community. As I said, the RPA one, which has been running now for a few years, the hours of darkness are their core hours.

Ms BUTLER - Do you imagine that the Safe Haven Hub capacity of this may require extra security or a police presence? How will you manage to keep that Safe Haven Hub safe? I know it's a very tricky question.

Mr WEBSTER - We certainly wouldn't want a police presence, but it would integrate with our PACER service. It would integrate with our other services as well. We will have security on site, either physical or dynamic security. We need to make sure it is safe for staff and others who are there.

It is important to say that you don't just go there and then you leave after 12 hours. During that time we try to intersect services. We're getting to know you. If you're already connected to services then the next morning we try to reconnect you. If during the night we need the PACER service, then we would get it. All those things have to be factored into this.

If we look at our ED, a lot of these presentations are in the window from about 8 p.m. until midnight, rather than past midnight. Your service needs are not going to finish at midnight. You'll need to have the space open and available to you through the night.

All of those things go with the model of care for a safe haven.

Ms BUTLER - The location of St John's is one of the main reasons I am asking because that close police presence isn't there, or is not as close as it is at some of the major hospitals. How far away could that assistance be if someone is in a really bad state?

Mr WEBSTER - One concept of the safe haven is that you can find any building and put it in. This is with other services. We have other clinicians on site through the night, so if you declare a Code Black there are people to respond and we are in easy reach of the PACER system.

CHAIR - An important aspect of this whole development is catering. Clearly there is a need for catering, you have a 24-7 on-site facility. How are you going to see that handled? I'm talking about the facilities you need for food storage and for preparing food. Will there be people to prepare food, or is it going to be up to the individuals themselves?

Mr WEBSTER - It's a mixture of both of those. On the TEDS side, we would be teaching people about food again. The kitchens there are quite vital in doing that. There will be a number of kitchens and spaces. We envisage we would run it as we do Roy Fagan, where breakfast is prepared by staff and clients on site. Typically lunch comes from our Cambridge facility. Dinner the same. Afternoon tea and snacks are then provided on site.

CHAIR - You bring a lot of that in?

Mr WEBSTER - Yes. You bring that service in for some of the main meals. Obviously TEDS is slightly different because that is also about learning the skills of preparation. It is part of the therapy.

CHAIR - Anything else on page 11? The zones are explained over the page, unless anyone has any questions on that? Pages 12 and 13?

Page 14, consultation and governance. Perhaps you can give us some comfort about the level of consultation that has been undertaken. I note that a number of the supporting community services like Flourish, Mental Health Families and Friends and Butterfly were involved. How significant was that involvement and did they have a lot of input into how this facility was going to be developed and the needs of their clients met?

Mr WEBSTER - All of those groups were directly involved, not just in consultation, but also in the oversight of consultation. Flourish and Butterfly in particular were directly involved and were part of the oversight committee for the model of care for eating disorders before it was signed off. We made sure they were comfortable with it.

The whole process designed by our infrastructure team when we do infrastructure is to have what I call steering committees, which tend to be departmental, but then we bring in project control groups, which is about joint or co-designing with our community and our consumers, depending on the facility. Our consumer community, our community sector organisation will be working in it, it's an integration hub, so we've worked with them on the model of the integration hub. Involved in this is probably a group of 50 or 60 people, having different inputs from all over the place.

CHAIR - It's Mark's bread and butter, is it?

Mr HARGRAVE - This is largely Mark's bread and butter, Chair. He's been very much involved in this.

Mr LEIS - There's been quite extensive consultation through the design process, where we've had those larger work groups pouring over the design. There have been more than a couple of goes across the last 18 months to get this right. We now have designs that all the stakeholders are happy with.

CHAIR - Were there many points of contention between the two types of development we're talking about? Obviously no show-stoppers, otherwise we wouldn't be dealing with it.

Mr LEIS - It would be fair to say that there's been a robust process, and they have been resolved through the process. Dale can elaborate more as he's overseeing it.

CHAIR - Seems like he might want to.

Mr WEBSTER - If I'm completely honest with the committee, there have been a couple of show stoppers that we've had to send back to rework. While it's a co-located building we are running two very different services, in fact a range of services.

CHAIR - Yes, that's why I asked the question.

Mr WEBSTER - There have been some. I love the way Mark put it, there's been some robust toing and froing to get this right. It's delayed us slightly, but I think it's a better product that everyone's quite comfortable with.

CHAIR - It has been resolved?

Mr WEBSTER - Yes.

CHAIR - They were show stoppers, they're no longer show stoppers?

Mr WEBSTER - It is a slightly different design now.

CHAIR - Okay. Any other questions on page 14? Page 15? Nice little diagram there to tell us how the project management hangs together. Any questions on that? Page 16, design approval?

Ms BUTLER - This was announced in 2018 and the project won't be operational until 2024. I think it was meant to have been completed by 2021. I want to make sure I got those dates right. What has caused the delay, that six-year gap, when it's such an acute area? Can I ask, has it been that some of the consultation was really lengthy, or what where some of the delays? We have asked but we haven't been able to get a straight answer.

Mr WEBSTER - The first thing I would say is, and I'm not going to doubt the dates, is that making sure we get the right facilities was the first thing. Initially we would have probably put this in one site, and then of course, we're faced with the Peacock issue so we then split into two sites. But then, for this particular one, is that the TEDS announcement came slightly later, in fact a number of years later. Because we had the opportunity, we thought this is a good opportunity to build a bigger facility and do something different around eating disorders. The fact that we have been able to get the day services and the buildings for day services on the agenda for the north and north-west is because of the savings we have been able to make in making this facility a joint facility with the two.

Then you throw in COVID-19 and all the issues we had with getting through design and consultation with that. Then you throw in the fact that we started at Peacock and we had a fire, all of these things have transpired to lengthen this time. Incredibly importantly for me as Deputy Secretary for Mental Health, is we will finally open a group of sub-acute beds, a safe haven and an integration hub at Peacock later this year. We had hoped to open in January 2022, but unfortunately we had the fire in December 2021, I think that's right, my years are getting mixed up at the moment -

CHAIR - It must have been a heartbreak to see Peacock destroyed -

Mr WEBSTER - It wasn't a good thing to wake up to on Christmas Day, put it that way. It's not an ideal time line. We have a combination of deeds, the issues with Peacock, followed by COVID-19. I think we have a better outcome because we waited for the eating disorders consultation to occur, and fed that into the same building. So, all of those things, whilst not ideal, have probably got us a better outcome overall.

Ideally, we would have had Peacock open by now, and the pressure off the system in the south occurring. What I do need to reassure you, along the way, and I mention this upfront, is

that we have been doing the reforms. The acute care team has been in place now for almost 12 months and will be fully operational in the south over the next few weeks. The continuing care team is in place. We've put PACER in place. So, we're doing the reforms, the non-building side of the reforms have been progressing through the period. It's just that we haven't had the buildings.

Ms BUTLER - We can only deal with what is in front of us in the report, but do you think it will be completed by 2024? It seems like it's been such a journey to even get it to a tendering position.

Mr WEBSTER - From my perspective I don't want to even think about not doing it by that stage, it is a realistic time line, a very realistic time frame. I do emphasise, I mentioned a few, but things like hospital in the home, hospital avoidance, all of these things have happened in the meantime. We have been addressing the needs that we identified, it's just the building works have not been at the same pace, and there are a number of reasons for that. All of the experts are saying that 2024 is a reasonable time frame, so, I'm hoping we can do that.

CHAIR - With regard to the national guidelines and standards, once you've arrived at everything, had you done that check against those guidelines and standards to make sure that you're on track? How did your interaction with those guidelines work, so that we've got confidence that we're not going to find that once this facility is built that someone says, 'oh, we didn't do that, we forgot about that'?

Mr WEBSTER - I guess there are two sets of guidelines that apply there.

Firstly, there is the standard for health buildings, of which mental health is a subset, so that's Peter's job to make sure that the building environment meets that standard in quite some detail and he will have gone through that. That national standard has been adopted by the Department of Health and if you want to vary from that in your design you have to flag it to what we call our Infrastructure Oversight Committee which is chaired by our Deputy Secretary of Infrastructure and has most of our health executive as members. So that committee has basically said 'you must meet the national standard'. If you want to vary from it, you have to come back to us and explain to us why you are varying it. That's the building side.

On the other side -

Mr ELLIS - Can I ask either you, Mr Webster or you, Mr Scott, are there particular things that we may want to vary from the national code? Are there things that pop up from time to time that we can name or are we pretty happy to stick with the standard?

Mr SCOTT - Through you, Chair. The standard we're talking about is the Australian Health Facility Guidelines. They're fairly prescriptive and they apply to very specific room types. Let's say it's a treatment room and there is a treatment room in this facility then it has to have a certain size, it has to have certain access and egress points, it has to have a certain minimum amount of furniture arranged in a certain minimum way.

If it's considered that a treatment room is required then, generally, we've designed it to the Australian Health Facility Guidelines, so that it is fully compliant. But, for example, if I can just refer to the Peacock Centre, the treatment room in the Peacock Centre is actually located within the existing heritage-listed building and the geometry of the building does not permit

for it to be easily accommodated in the footprint required so we sought a deviation in that instance from the guidelines from our steering committee so that we could provide an adequate facility which did not actually meet the national guidelines.

Equally, in this facility, one of the TEDS' AHFG-required spaces is a consult room and that has very specific sort of medical implications attached to it when this is a mental health facility. The importance of making spaces for consultation with users that puts them at ease is somewhat at odds with the medical requirements of a 'master and servant' relationship across a desk with a point for a laptop and that sort of thing. Occasionally, there are very sound reasons why we might seek an exemption from the national standard so that it provides the maximum degree of comfort and safety for the users of the facility.

Mr ELLIS - Thank you.

Mr WEBSTER - On the other side, the model of care or the standards that we have to meet for accreditation, we check our models of care against that accreditation standard and included in that are things like -

CHAIR - What is that called, can I ask?

Mr WEBSTER - The National Safety and Quality Standards Commission is the overarching body.

Mr ELLIS - What a memorable title.

Mr WEBSTER - Exactly. There is a set of standards we sign up to for accreditation and then we have what are called 'SNAPs' which are short notice assessment periods where they come down and have a quick look and they'll pick a standard. So, knowing that, as soon as we open this, it adds to the statewide Mental Health Services accreditation. We need to make sure as we're opening we're designing models of care that meet those quality and safety standards.

CHAIR - It's in our interest to get it right.

Mr WEBSTER - Exactly because we don't want to lose the accreditation.

CHAIR - What's the risk register look like for this project?

Mr CLARKE - I will have to defer to the project manager on that one if I could. Mark?

Mr LEIS - We have that listed each month with our project status report. It certainly has some length to it in dealing with these standards as well as the stakeholder requirements.

CHAIR - Do you know how many items you might have?

Mr LEIS - I should be able to remember. It's about 20.

CHAIR - Okay.

Mr LEIS - We have some of them grouped up; we haven't gone through the minutiae. They're all in the process of being treated.

CHAIR - You answer to a steering committee, as the diagram shows?

Mr LEIS - Yes, through to Dale, as well as Andrew each month.

Mr WEBSTER - Then the steering committee answers through to the infrastructure oversight committee.

CHAIR - All right. Page 17, design philosophy. Page 18, design approach. This is where I was indicating that there might be a question on design for our architects present.

Page 19, communication, personal space and density, choice and control considerations. Do you have any comment to make on how you've included all of these in your design approach?

Mr SCOTT - Later in the submission, Chair, we've done a step through of how a user would actually utilise the facility. That touches on these. For self-determination for users and short-term residents, the facility is a critical component and covers many of these things. I can expand on each of these, but in summary so that it doesn't take too long, the underlying principle behind the facility is one of an interaction between users and clinicians and staff. It's not again a hierarchical arrangement. Users are given a sense of self-empowerment, that they are equally sharing in the resolution of the issues they confront. Communication is key.

CHAIR - Control of their own destiny, so to speak.

Mr SCOTT - That is expressed from a design perspective by not having the staff overtly separated from the users. There is a concierge model of greeting, so you don't have receptionists at a reception point, but you actually have a floating concierge-style staff member who can draw users into them or take them to a place where they feel comfortable.

CHAIR - On the way through, and I don't want to ruin your flow, people can walk in off the street - mind you, it's a fair way out of the way - if they don't see a reception. How are they going to be dealt with? I am not talking about people who are coming there for a particular service, but they might be looking for somebody, or come there to do some work. How is that handled?

Mr SCOTT - I don't know.

Mr WEBSTER - The name badge is the big thing, 'Hello, my name is'.

CHAIR - It's as simple as that?

Mr WEBSTER - Yes. You don't want to have a situation where you have barriers between your client group. There are harder levels of security as you get back into the building, it, but at the front end, as Peter said, it's a concierge service, it's not a -

CHAIR - The name badge does it?

Mr WEBSTER - That's about all you'd want.

CHAIR - It's a simple thing, but it works.

Mr SCOTT - It's a layered approach. When you walk through the door, TEDS mental health facility, there will be someone there. They will be non-confrontational in their approach to you. They may be standing rather sitting, they may be located in the waiting space rather than behind a piece of joinery. If you don't want to talk to them that's okay, but in the layout of both facilities there's an intuitive wayfinding embedded in the design. If you look at the plans you see both have a long corridor down the middle. It's not a narrow institutional corridor, it's a broad, expansive social space. It draws you down through the facility to the point at which you need to interact with the services provided. That is true both on the day level and on the residential level.

The safe haven is located on the ground floor at the far end away from the entry, so you're drawn through. If you rock up at 8 p.m. and you want to use the facility, you will enter as a member of the public, unannounced. You'll meet a concierge because the facility will be staffed and they will direct you to the safe haven where you can be helped.

It is obvious where you are going to. There is a window so you can see daylight right at the end of the pathway. You have an intuitive wayfinding methodology embedded in the design to draw users to the point within the facility that they need to be.

CHAIR - By the time they get to the safe haven they will feel safe.

Mr SCOTT - Yes, they will feel great, hopefully.

Communication, personal space and destiny: the department has been generous enough to provide a budget to allow us to create lots and lots of diverse spaces for people to find a point of rest. If you do not feel comfortable in this space under the stairs, let's say, you can sit in this room over here. You can go to the safe haven over here, you can sit at the top of the stairs over there. You can sit outside in a heavily landscaped precinct. That way we are providing the maximum opportunity for people to feel comfortable and in control of their care.

Choice and control: probably similar. Again, giving people the opportunity to access the services in a variety of spacial media. There is not one consultation room type replicated. The consultation rooms are geometrically different and they are furnished differently. One might have a couch in it and one might have two easy chairs in it. You can navigate to a place where you feel the most comfortable.

Sensory considerations: we are very focused on the use of natural materials and high levels of landscaping. The form of the building is designed to maximise access to natural light and views out. It is not the most efficient footprint because that would be basically a cube. It is one that maximises the perimeter of the building. That is why it has two wings, so you have lots of access very close to you to natural daylight, the views outside and landscaping attached to the buildings. There are planter boxes and the like on the first floor.

Spatial clarity and organisation: there's an embedded intuitive wayfinding in its design, as I described before.

Decor choices: we have a focus on naturalistic and domestic-style finishes, so that people can feel it is a deinstitutionalised environment. I think that has been a key principle and one we have explored heavily at the Peacock Centre, which we are now applying here.

CHAIR - Are these high-maintenance or low-maintenance materials?

Mr SCOTT - Very good question. We aim to deliver for departmental projects a minimum maintenance life cycle of 25 years. This building is predominantly clad in masonry and metal on the upper level. They are basically non-corroding, non-deteriorating buildings with no maintenance regime at all.

CHAIR - No flammable panels?

Mr SCOTT - No, absolutely not. That is quite a complex area because the definition of flammable cladding is the entire construction of the exterior wall. It is not just what sits on the outside of that wall. We are quite conscious of the need for that, especially in a health facility. So no flammable cladding.

Positive distractions: embedded within the program for the facility is not just the design of the facility. We are facilitating views out to Mt Direction, Mt Wellington and across to the city. There is also a large focus on providing art within the facility, both as part of the funded program and part of the Art Site Scheme. That would be embedded both within the building and in the landscaping. These are things that take people away from their point of stress to a point of distraction, be it the artwork or the design or the view out of the window, or indeed the interaction with others in the safe haven.

Social interaction: probably the same. Lots of opportunities for and spaces embedded in the design for people to provide themselves with distractions via social interaction, or to get the support they need, in Safe Haven for example, or in a consultation environment. A strong focus on an environment that provides sense of safety. Again, de-institutionalising the design makes people feel more at home, which of itself provides a degree of psychological safety to those users.

CHAIR - On the safety side of it, obviously external gardens play a very important part in the health and wellbeing of people psychologically, having a space to 'hang out'. Are you in some way putting in a fence or whatever? I know that's not something that would be considered. How are you handling that side of it, if somebody is experiencing an episode of some sort, they want to get outside, they want to experience that open-air environment rather than being cloistered inside, and yet they're an at risk person?

Mr SCOTT - I am an architect and our job is to respond to a brief, but part of the method of managing people in stress is an operational one, not a design one. This is not a facility where people are secured against their will, and therefore if they choose to walk out the door they can. That is really managed from an operational perspective, not from a design perspective.

That said, there are spaces outside attached to the building that are secure, but the purpose of that is so that users can bring their family, so if they have young kids and they want them to be outside, they don't wander off into the bush. They have a secure and safe environment for those family members to be on-site. Equally for the TEDS facility, it's not fenced per se, but there are secure areas so that people can go out and have a sandwich without being overlooked.

The security is not to retain people within but to limit unwanted interaction from others. The question of fencing is not a simple one to answer, but I think it's not a 'secure facility', and fencing when it's provided is not for the purposes of retaining people within the facility, it's actually to aid them in providing security and safety.

CHAIR - You have answered the question well. I was really keen to understand how that interaction happened.

Ms BUTLER - I was going to add to that, Chair, I think that for a lot of people who are recovering from disordered eating, my understanding that it's a very personal journey for them and they require a lot of privacy within that recovery. Is that part of your design focus as well? Is ensuring that privacy through the design whilst also being part of the facility as well? It would be a hard one to balance, but I know a big part of recovery is that privacy, and that ability to have their own space and time to think.

Mr SCOTT - Through you, Chair, if I can answer that question. Responding to every single eating disorder trigger is virtually impossible.

Ms BUTLER - Yes, there's a lot of different triggers, and so many disorders too.

Mr SCOTT - Notwithstanding that, the TEDS facility includes spaces which are co-located with the places in which food is addressed or prepared, which are proximate to those zones of food preparation, and which are remote from those areas of food preparation to try to provide as many opportunities for people to find a place and at a moment in time where they are comfortable, in that facility. The design absolutely tries to address every one of those triggers, but I'd have to acknowledge there will be a situation where that has to be managed on an operational level and cannot be managed by the design, because triggers include smells. The smell of your hamburger might go down the corridor and that is something that is very difficult to completely mitigate.

Ms BUTLER - I think as well - just for the record - the use of the light and the sunshine is really important, and the gardens in this as well, it's fantastic. If this is what ends up being what's built and put in place, it should be fantastic.

Mr SCOTT - On that point I would add there is access to outside on the first floor of the TEDS facility, as well as on the ground floor. People in the residential wing who feel anxious about going through the day care area to the outside, can get access to daylight and outside from the first floor whilst maintaining a degree of separation and privacy.

We have tried to make it non-confrontational. Staff are generally embedded in the social spaces in the building, so that the interaction is not one of observation but one of a shared experience of those spaces.

CHAIR - Where do they go if they need some time out?

Mr SCOTT - There is a staff room, and they have a dedicated staff landscaped area, so they have an opportunity for retreat.

CHAIR - Outside as well as inside.

Mr SCOTT - Absolutely. It is a non-smoking site. You have to step on the road if you want a cigarette.

Regarding the functional layout, we have worked very closely with Dale and with Mark to make the design as efficient as it can be, and it is considerably more efficient than the starting points. I really appreciate the support of the department in achieving a design which maintains a high level of usability for the people who will come and use the facility.

That means inventing space which has no overt purpose other than to provide a point of rest for people within the facility at a moment in time when they are not actually in a room doing a meeting, or in a dining room having a meal, but they just want to sit somewhere, do a crossword or something. The design has been able to embed that in it as well.

CHAIR - Anyone else with questions on that page? Thank you. That was very useful.

Page 20: Implementation site, analysis site, constraints. Pretty well handled, I think, unless anyone has any specific questions with regard to that. You went through it this morning. I think it is described in here.

Mr SCOTT - Jen's point if I may, though, and about the program for the project. This is not the only site that was considered by the department for this facility within SJP. This is actually one of three sites. The first job we were asked to look at as part of this project was to do a site-analysis of those three, to pick the most advantageous one. That was not anticipated in the original program for the project, and that process took a month or two, maybe. It did involve us looking at, in quite a lot of detail, the heritage overlays that overlay the whole site -

CHAIR - Which aren't insignificant.

Mr SCOTT - Which are not insignificant. Not least, because this is the first site in Tasmania where historical heritage viewsheds were established as a guide to development. Two of the sites fall significantly within those heritage viewsheds. This one does not, although this one has a high possibility of archaeological disturbance. It was a very subtle balancing of those requirements to get to a point where we agreed this was the preferred site, and that those archaeological challenges could be adequately addressed.

CHAIR - Could you give us some indication of how that was progressed through Heritage Tasmania, and those sorts of departments.

Mr HARGRAVE - Between Peter and Mark, they would be best placed, Chair, to answer that question.

Mr SCOTT - There are two key heritage bodies. The Friends of the Orphan School, is the first. Dianne Snowden heads that organisation, and she is a former chair of the Tasmanian Heritage Council. She is a very significant player in the heritage space, and her group is very active on this site. The other is Heritage Tasmania (HT) acting for the THC. We have met with both Heritage Tasmania and with Hobart City Council's cultural heritage officers and planning officers, at least twice, with a group meeting of the Friends of the Orphan School to show them our anticipated approach and to canvas with them what they would like to see as a

corollary benefit of a development here for their desires for the broader heritage outcomes on the site.

For example, the Friends of the Orphan School wanted to maintain a reading of the burial grounds as a contiguous area, which is somewhat fragmented now both by the development that's occurred and by the landscaping that exists. That has contributed very strongly to our desire not to fence the site and for the landscaping to bleed off into the broader area. So the new building - even though it's a building within the burial ground - does not read as though it's a carved-off section and that the historical continuity of that burial ground can still be read by a user or passer-by. Aspects like that have been embedded in the design as it's progressed. We hope that we'll get strong support from each of those bodies with an interest in the heritage of the site as it progresses through statutory approval.

CHAIR - Development applications was supposed to be in March.

Mr SCOTT - It has been lodged for development application approval. We're in a process of responding to requests for further information, predominantly about site servicing. It's not obvious here, but the site servicing is extremely complicated. Fibre and a number of services traverse the site or approximate to the site. Quite rightly Hobart City Council and its officers are seeking to have a full understanding of the implications of this development on those services.

CHAIR - I can appreciate that.

Mr SCOTT - It is in the DA process.

CHAIR - Vegetation: you were talking this morning about a couple of gum trees that are very significant. One of them has to go, not only because it probably facilitates the development, but it's in a pretty bad state.

Mr SCOTT - We had an arborist assess the vegetation on site before the design had progressed. That arborist identified that one of the two significant gum trees on the site was at end of life and would need to be removed in the next five years, therefore it was our recommendation that it be removed now. A corollary benefit is that it frees up a bit more of the site for development. If it had not been the case we would have designed the facility differently to retain it.

CHAIR - There's nothing unresolved regarding heritage for this development that is likely to come up and bite you as matters progress?

Mr SCOTT - Not that I'm aware of.

Mr HARGRAVE - No, not that we have any knowledge of.

CHAIR - Okay, thank you. Page 21. Trees aren't listed, that was one of the questions this morning.

Mr SCOTT - It is a heritage-listed site, so if you do any works on the site -

CHAIR - That means vegetation could be as well.

Mr SCOTT - Only if it contributes to the heritage significance of the site, and they don't.

CHAIR - No, that's fine.

Mr SCOTT - In that sense, there's no restraint on removal.

CHAIR - Page 21, 22, any questions there? Yes, Jen.

Ms BUTLER - I want to ask about public transport access to the facility for members of the public who are visiting, or even people who are coming to the facility for the day. A lot of people don't drive as it's quite expensive. What are the public transport options for people around that facility?

CHAIR - I didn't talk to Jen about this, but I asked that question this morning. It's good you bring it up.

Mr WEBSTER - Through you, Chair, there are two significant bus routes. One is the Main Road bus service which is at the bottom of Ogilvie High, just below this building site. The second is the Creek Road route. The Creek Road route - I checked since this morning - is a bus service that comes into St John's Park. The bus stop is directly below this site, approximately 80 metres below, right next to Rosary Gardens residential aged care facility.

CHAIR - I was going to say, that services the aged care facility.

Mr WEBSTER - That is right. A bus service enters the site, as well as the two major public transport routes which go either side of the facility.

Ms BUTLER - The other question, is there a separate carpark for staff? I think there were 28 spaces, off the top of my head. Is there going to be enough parking for people using the site, people working at the site and people visiting the site?

Mr SCOTT - We have had a traffic consultant do an assessment of the required number of parking spaces. There are 30 spaces provided. They're not adequate for the full complement of the facility, but the site includes hundreds of carparking spaces that are not immediate to this site. The traffic engineer's analysis of current usage and of projected usage was that 30 spaces was more than adequate for the cohort and staff who would use this facility, since many of those users don't actually have a car or use a car in the way that we would. Therefore, the staff requirement could be adequately catered for by other parking within the greater St John's Park precinct.

Ms BUTLER - Thank you. I also wanted to ask about lighting for the facility at night? Will it be sensor lighting, outdoor lighting, solar?

Mr SCOTT - I would have to be honest and say we don't yet have a developed lighting strategy. This is a 24-hour, seven-day-a-week, 365-day-a-year facility, and lighting therefore as a minimum needs to provide safe access and egress every hour of every day from at least the carpark, or even the public domain, which is St John's Road, to all the entrances of the facility. That would be the mental health facility entrance, the TEDS entrance, the staff entrance, and the supply entrance which is approximate to the staff. I think you should be

confident that we'll provide lighting to allow adequate access and egress from and to the building, but equally that we don't wish to contribute to light pollution. All lighting would have no vertical component to it, and would not add light pollution across the St John's Park precinct from a heritage perspective.

Ms BUTLER - It seems there will be a significant amount of vegetation - which is beautiful - around the facility, so lighting can be a real problem for people, especially older people who may have issues with adequate visibility.

CHAIR - Can I suggest we have a comfort break for five minutes? I am aware that we've been here for a while. I'm not suggesting that we're going to go much longer, but I think it's important that people have the opportunity to go to the facilities. We'll just stop the broadcast for five minutes.

The Committee suspended from 3.59 p.m. to 4.02 p.m.

CHAIR - We are all back? We are on page 22.

Concept planning diagrams and designs and things. Quite clearly, disability access is something that you have to comply with through the building code. Were there any different sort of matters that needed to be considered in a development like this, that you would not normally consider for a general building, given the clientele?

Mr SCOTT - Not really. It is a relatively flat site and we comply with the requirements of legislation to get an accessible pathway to the public entrance from an accessible parking place within the carpark.

CHAIR - And lifts between floors. You can't not have them these days, can you?

Mr SCOTT - Lifts between floors. Absolutely. Beyond that, it is designed to ensure that every room is disability accessible, and every corridor is disability accessible.

It is too early in the design for it to have been detailed, but there will be a visual contrast embedded within the design also, for people with a sight impairment. It contributes to that overall intuitive wayfinding within the facility, and that will be embedded. You do not see it in these drawings because the design has not advanced that far.

CHAIR - Things like Braille plates, and all of those sorts of things?

Mr SCOTT - Well, even just colour contrast, in flooring and wall panels, and door and jambs, for example, are all important aspects of disability recognition.

CHAIR - Any other questions on page 22? Page 23? Double-loaded residential wings. That is an interesting one. What is that?

Mr SCOTT - Double-loaded means you have rooms on both sides of the corridor. It is designed to ensure that everyone has access to light and ventilation. Natural light and ventilation -

CHAIR - Okay, simple as that.

Mr SCOTT - It is designed to ensure that everyone has access to natural light and ventilation.

CHAIR - Okay. Anyone else on that page? No? Page 24? You have an up-and-back design, it keeps sunlight access, maximises sunlight access to the internal component of the building?

Mr SCOTT - Do you mean in terms of separating into two wings?

CHAIR - It says the setting back of the upper levels of the opposite wings opens the internal courtyard.

Mr SCOTT - Yes, the separation between the wings allows daylight across the top of one into the other.

CHAIR - That's good.

Ms BUTLER - Can you provide me with a layman's explanation of the heating and cooling systems that you'll be using in the facility?

Mr SCOTT - Yes, although I don't think we've made a final selection, but I can tell you what I anticipate the heating and cooling systems to be. Because this is a residential facility used 24 hours a day, seven days a week, 365 days of the year, the most efficient and comfortable heating system would be a radiant floor mounted heating system, which is what we're embedding in the new components of the Peacock Centre. That would involve a hydronic heating coil laid into a screed over a concrete slab to provide a low level of radiant heating. That would be hooked up to a reverse-cycle heat-pump system, which is highly energy efficient, provides between 3 and 4:1 output-to-input ratio in terms of energy-efficiency.

Then at the Peacock Centre, if that's a good model - which I believe it is - there's then supplementary heating and cooling, because a radiant heating system is on a long-lag, low-cycle type. So, if you turn it on, basically it sits about 15 degrees, and if you want to be a bit warmer, you want some more instantaneous heating, there's additional heating and cooling to provide both ventilation and the capacity for user control of the finer points of their thermal comfort. Again, that's a reverse-cycle heat-pump-powered system, so it provides the maximum energy efficiency to the heating and cooling systems within the building.

The reason we chose the radiant model for the Peacock Centre was because of the embedment of the World Building Standard ambitions within that project, and we're seeking to fold over a lot of those World Building Standard ambitions into this project, where they're cost effective to do so. The World Building Standard is a standard that sets out benchmarks for the achievement of a world-class-standard working and living environments through environmental and social considerations, such as heating, cooling and lighting, but also beauty, outlook and access to external areas.

Ms BUTLER - Recovery can be really different - as you would know from your research - for different people, whether it be recovering from disordered eating or another mental health issue. Is there capacity to individualise those systems within the complex?

Mr SCOTT - Yes, I would say that the World Building Standard has a very high threshold for individual user control of access to heating, cooling, ventilation, access and egress, and those ambitions are embedded within the ambitions for this project, so that users can control specifically the temperature and the ventilation to their residential facility. Also, they have access to some degree of control of some of the common areas, i.e. by opening the door to outside or by going outside, or by leaving that space and going to another on the shady side of the building, for example.

There is an ambition to achieve a high level of user-control, and that comes down to the philosophical desire for users to be in control of their destiny and their care, and that includes having control over their environment.

Ms BUTLER - Thank you.

CHAIR - Any further questions on page 24? Page 25? Pages 26 and 27?

Arriving at the design, was there visitation to other facilities that might have informed the design for this. Obviously you have a fair bit of experience in some of these facilities.

Mr SCOTT - Visitation, not so much, but we did look at a number of the Butterfly Foundation facilities around the country and have drawn inspiration from some of those. We also looked at some of the cancer care clinics in the United Kingdom. There is a foundation, the name which escapes me temporarily, which has been a good benchmark modifier for employing naturalistic elements and access to aspects of the natural environment into this project, and to the Peacock Centre before it.

CHAIR - Fair enough. Pages 28 and 29?

Ms BUTLER - I want to ask about the ongoing costs for the maintenance of this beautiful outdoor area? Are you expecting that will be quite expensive? I know it is very important, but I gather it will be expensive. Would that be part of the ongoing budget for this facility?

CHAIR - In terms of maintaining it?

Ms BUTLER - Yes.

Mr WEBSTER - Yes, it is part of the department's ongoing budget that we would have to maintain it. Hopefully Peter's designing something which is low maintenance, reducing our costs ongoing. It is part of the operating budget.

CHAIR - Lots of native plants.

Ms BUTLER - It looks beautiful.

CHAIR - It does. It looks great.

Okay, Page 30? Page 31? Page 32? The second storey outdoor spaces that you spoke of earlier obviously require some safety features. How are you handling that?

Mr SCOTT - Safety features for maintenance or for users and staff?

CHAIR - Users.

Mr SCOTT - For example, where there is a terrace it has a balustrade around, so that it is a safe and secure place to be outside.

CHAIR - What sort of height are we talking about for spaces that overlook an open area?

Mr SCOTT - A metre-high balustrade. Again, it is that balance between a user-friendly space that is safe and makes people feel comfortable, as opposed to one which gives an impression of enclosure or entrapment. We could put a 1.5 metre glass balustrade in but it would leave users thinking that they are basically in prison. That is not the intention.

CHAIR - That is not the intention of the whole exercise.

Mr SCOTT - There is a subtle distinction to be drawn between comfort and safety and a feeling of institutionalisation. Wherever we have had that conundrum to resolve we steered towards user comfort and away from the institutionalisation of safety. People can still walk out the front door.

CHAIR - When it comes to design of fixtures and fittings and we are talking about hanging points and the capacity for someone to injure themselves by jumping from a height, it is a difficult balance.

Mr WEBSTER - You need to also take into account dynamic safety. It is really important that the staff are on the floor, the staff are intersecting, the staff are monitoring the level the patient is at. Calling them a patient in that sense.

CHAIR - So that is modified accordingly in terms of staff presence?

Mr WEBSTER - That's right. An incredibly settled person might be out on the balcony by themselves. Someone who's quite aroused might need a staff member out there at the same time. You get that dynamic safety from the staffing.

CHAIR - Thanks, it is good to ask these things. Pages 33, 34, 35, 36? Page 37, what's WELL Building Standard?

Mr SCOTT - The WELL Building Standard is what I was referring to earlier. It is an internationally recognised standard of benchmarks against 12 criteria - I believe - which contributes to world-class living and working environments.

CHAIR - That is all right. I didn't know what the acronym was on page 37. Pages 38 and 39? The budget, time lines, any questions on that page?

Ms BUTLER - Are there any penalties that apply if the build isn't completed in a particular time, or would that all be part of the tendering process which you are about to enter into?

Mr WEBSTER - That is part of tendering and contracting.

Ms BUTLER - I can see here you've got a contingency of 12.5 per cent. That is quite significant. Is that the going rate at the moment for contingencies? Or has that been developed based on this project?

Mr SCOTT - Jen, I would say you need a 50 per cent contingency right now. That's probably a sensible allocation given market conditions. I don't know that we'll need it from a design perspective, but I think the project will probably need it from a market conditions perspective.

Ms BUTLER - Are some of the materials that I can see in the beautiful pictures going to be hard to acquire? Demand is really difficult, especially for timber products at the moment. Is that part of that contingency? Could there potentially be a change in design based on what materials you are able to access?

Mr SCOTT - That's a tough question.

Ms BUTLER - There's a lot in that.

Mr SCOTT - If I draw on the experience of the Peacock Centre project, which is obviously going through procurement of materials right now, the builder's been very proactive in identifying areas where we have supply chain issues. Generally, it's been a cost issue as much as it's been unavailability of product. That beautiful timber floor we have in the image on page 38 is actually a vinyl floor. It has a timber ambience to it to provide a non-institutional feel, but it needs to satisfy the requirements of infection control, and a timber floor probably won't do that.

Our experience with the Peacock Centre process probably has helped us to identify the areas where there may be logistic or availability challenges. I will suggest there are likely to be in areas of loose furniture as much as there are in anything else. We have also narrowed down the selection of materials for the Peacock Centre from Australian suppliers. I mentioned the treatment room earlier. There are thousands of treatment room medical light suppliers, but we've specified a unit from Queensland. We know there is a higher degree of ability to control supply chain than if it's made in Austria or Germany or China. I think we're aware of the challenges, and we'd work through the process of specification and selection to minimise the potential impacts on the project of the selections we make. That would mean that you should be confident there would be the minimum number of substitutions through the process of seeing this project to completion.

Ms BUTLER - Thank you.

CHAIR - Just looking at the project budget and reading the supporting the statements, one thing I didn't see in there - which we see quite a lot - is a thing called 'escalation' which is slightly different to 'contingency'. Or is it the same in your book?

A contingency is for things that maybe unforeseen that occur and you just need that extra dollar to do a particular component but escalation as you were really pointing out earlier - in today's day and age - some of them have 20 per cent. I am just wondering if 12-and-a-half for contingency is one thing, but escalation may well be a significant thing going forward.

Mr WEBSTER - Generally, escalation is built into longer-term projects when the build is over a longer period than this one. Certainly larger projects.

CHAIR - Okay.

Mr WEBSTER - It is something we will need to manage in the current environment. That's a big issue for us because there is some uncertainty in building tenders and then building tender processes. We haven't built it in here because of the short length of the project compared to a project like the one last year which was the building of the prison which was over a five- or six-year period and $200 million. We built in escalation there because you're certainly going to be hit with inflation over that time.

CHAIR - So could it ever get to the point where you don't have the funds to complete the project as stated here? Are there components you could pare back if you needed to? It wouldn't be a case of not going ahead maybe? Just a matter of not doing it to the fullest extent?

Mr WEBSTER - It could. I wouldn't like it to, but it could, and of course we are contractually obliged to provide the Eating Disorder Service building with the Commonwealth so obviously that is a priority within there. We believe within this envelope - as at today - we can do it. Yes, there are occasions when we have to withdraw and rethink, but given the time frame of this and the amount of time we've spent getting to this point, we've got as much confidence that we could have in the current environment.

CHAIR - Thank you. Any other questions on the budget?

Pages 39, 40?

Ms BUTLER - No. I am good thanks, Chair.

CHAIR - I think we've gone right through and then there's all of the drawings. Any questions with respect to the figures that are here that anyone wants to raise? It is all pretty clear.

Ms BUTLER - I'm good. I've asked a lot of questions.

CHAIR - We've asked lots of questions there. Is there anything you want to say in your summing up?

Mr WEBSTER - No, I don't think I do. We've covered some big ground today.

CHAIR - Well, we have covered some big ground and, of course, it is important to do that. We have a number of questions which we always ask at these hearings so that we cover the provisions of the Public Works Committee Act. I need a definite answer one way or the other on these:

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

Mr WEBSTER - It certainly does and it fits with the long-term planning of the department.

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

Mr WEBSTER - We certainly believe that it does. Yes.

CHAIR - Are the proposed works fit-for-purpose?

Mr WEBSTER - Yes.

CHAIR - Do the proposed works provide value for money?

Mr WEBSTER - I believe they do and in fact, because of the way we have designed this we've actually built-in additional value for money.

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

Mr WEBSTER - I believe so.

CHAIR - Thank you for that.

Before we wrap up today, I will remind you of that statement that I made at the beginning of the evidence. What you've said to us here is protected by parliamentary privilege and once you leave the table you need to be aware that privilege does not attach to comments you make or may make to anyone including the media even if you are just repeating what you said to us. Do you understand that?

Messrs LEIS, SCOTT, CLARKE, WEBSTER and HARGRAVE - Yes.

CHAIR - Thank you and thank you for coming and presenting to us today. It is very important work.

THE WITNESSES WITHDREW.