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**THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN, THE CRADLE COAST AUTHORITY CONFERENCE ROOM, BURNIE ON MONDAY 11 MAY 2026.**

## **NORTH WEST REGIONAL HOSPITAL UPGRADE - EMERGENCY DEPT AND AMBULANCE DROP-OFF REDEVELOPMENT**

**The committee met at 2.00 p.m.**

**CHAIR** (Ms Butler) - Welcome, everyone. Before we commence the hearing, I'll introduce the members of the committee. To my left, I have Helen Burnet, to my right, Tania Rattray and Mark Shelton, we have Karen on Hansard, we have Scott Hennessy and Georgia, who are looking after our secretarial duties today. It's my understanding there are no apologies for the hearing today.

Secretary, would you please read out the message from Her Excellency the Governor and Council referring the project to the Committee for Inquiry?

**SECRETARY -**

Pursuant to section 16(2) of the *Public Works Committee Act 1914*, the Governor refers the under mentioned proposed public work to the Parliamentary Standing Committee on Public Works to consider and report thereon: North West Regional Hospital Upgrade Emergency Department and Ambulance Drop-off Redevelopment. Pursuant to section 16(3) of the act the estimated cost of such work when completed is \$14.5 million.

**CHAIR** - The committee is in receipt of one submission from the Department of Health. Could I ask a member to move that this submission be received, taken into evidence and published? Moved by Mr Shelton.

**Submission received.**

**CHAIR** - The witnesses giving evidence to the committee today are appearing on behalf of the proponent, the Department of Health. Could I ask each of you to state your name, your position and organisation and then make the statutory declaration?

**Ms PAULA HYLAND**, CHIEF EXECUTIVE, HOSPITALS NORTH WEST; **Mr CASEY STARK-ALLEN**, DIRECTOR, REGIONAL OPERATIONS NORTH WEST, AMBULANCE TASMANIA; **Mr SIMON DUNNE**, DIRECTOR PROGRAMMING AND DELIVERY, INFRASTRUCTURE SERVICES; **MR ANDREW GOELST**, PROJECT MANAGER, INFRASTRUCTURE SERVICES, PROGRAMMING AND DELIVERY; DEPARTMENT OF HEALTH WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

**CHAIR** - Thank you for appearing before the committee. The committee is pleased to hear your evidence today. Just before you begin giving your evidence, I would like to inform you of some important aspects of the 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

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committee to speak with complete freedom without the fear of being sued or questioned in any court or place out of parliament. It applies to ensure that parliament receives the very best information when conducting its inquiries. It is important to be aware that this protection is not 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. Members of the public and journalists may be present and this means your evidence may be reported. Do you understand?

**WITNESSES** - Yes.

**CHAIR** - I'm not sure who would like to lead here. Ms Hyland, would you or one of your colleagues like to make an opening statement?

**Mr DUNNE** - Chair and members of the committee, thank you for the opportunity to appear before the Standing Committee on Public Works today to present the North West Regional Hospital Upgrade Emergency Department and Ambulance Drop-off for redevelopment on behalf of the Department of Health.

The North West Regional Hospital is a critical component of Tasmania's health system and provides emergency care to a large and geographically diverse population across the north-west coast. Its emergency department plays a vital role in delivering urgent and complex care and has been operating under consistently high demand for a number of years. This redevelopment responds directly to the demand and to identified shortcomings in the existing physical environment that impact safety, efficiency and access to care. The overarching purpose of the project is to significantly improve the safety and security of all users of the emergency department, including staff, patients, carers, visitors and paramedics. The redevelopment will address physical constraints and environmental risks within the existing department, improve lines of sight, separation of clinical and public spaces, and provide safer and more functional environments for emergency care delivery.

In parallel, the project seeks to improve the overall physical environment to the emergency department. Modernising and reconfiguring the space will create a more supportive and efficient working environment for clinical and operational staff, while also providing patients with a facility that is better suited to the delivery of contemporary emergency health care. Improving the quality, functionality and condition of the built environment is central to supporting workforce wellbeing, retention and the delivery of high-quality patient care.

The redevelopment also responds directly to the outcomes of the independent review of Tasmania's major hospital emergency departments. The project will improve patient flow within the emergency department, address congestion and bottlenecks and support more effective triage processes, including for mental health consumers. Importantly, it will also enable better care for patients with low acuity needs who arrive by ambulance, ensuring they are received in a safe, dignified and appropriate manner without compromising care for higher acuity patients.

A key focus of the project is inclusivity and accessibility. The redesigned emergency department will be better equipped to meet the needs of patients who are neurodiverse, experiencing a mental health condition, living with disability or have experienced sexual assault. Design decisions have been informed by the need to support privacy, reduce sensory

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stress, improve safety and provide trauma-informed care environments that recognise the diverse needs of the community served by the hospital.

Scope of the works includes the extension and remodelling of the ambulance drop-off bay to improve safety and functionality for Ambulance Tasmania crew and patients. This will enhance patient transfer, reduce operational risk and support smoother handover into the emergency department. A new pedestrian pathway along Hospital Street will also provide safer and more accessible entry to the emergency department, improving separation between vehicles and pedestrian traffic.

Stakeholder engagement has been integral to shaping the project. During the concept design in September 2025, the department undertook consultation with emergency department staff, Ambulance Tasmania, Tasmania Police and consumer advocates. Feedback was received on layout, functionality and safety considerations, and key themes included the location of the sexual assault medical services room, security and privacy of staff areas, mental health patient safety, ambulance drop-off design, neurodiverse patient needs and the safety and security requirements for Tasmania Police. These insights have been carefully incorporated into the schematic design to ensure the redevelopment is practical, responsive and fit for purpose. Consultation on the schematic design phase was undertaken in February 2026, which influenced the outcome of the detailed design and the subsequent tender documents.

Finally, Chair and members, this redevelopment forms an important part of the broader body of work required to achieve the strategic objectives for the North West Regional Hospital. As articulated in the North West hospital's master plan, it represents a targeted and necessary investment to ensure the hospital's emergency facilities are safe, inclusive and capable of meeting current and future demand.

The department welcomes the community's consideration of this project and is pleased to assist with any questions.

**CHAIR** - Thank you. For the Public Works Committee hearings, we usually move through our submission in a chronological order, page by page. A lot of the information within this submission is repeated information. What we may do is try not to jump too much, but I believe each member has a variety of questions, so if we do jump, we don't mean to. It's just that there is a lot of repeated information within the report. I think this may be a more time-efficient and more coherent manner for us to proceed through this.

I might kick off with asking: on page 4 it says the project budget is for \$14.5 million. It's fully funded by the Tasmanian state government. How does this fit into the North West hospital's master plan, and do you think the \$14.5 million for the refit and refurb is achievable?

**Mr GOELST** - As part of stage 1 of the master plan, there are other projects that are part of that which I understand the committee has already reviewed in the North West Mental Health Precinct that will be on top of the hill, the link bridge, the new inpatient unit, the moving of renal from Parkside up to the hospital and also a transit lounge is part of that. Those projects will fully close out stage 1. This upgrade to the emergency department is an integral part of delivering stage 1 of the master plan, noting that stage 7 will deliver the larger upgrade for full futureproofing off into the future.

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We have rigorously worked with the design team and an independent quantity surveyor to check our budget. We have had three checks on the cost of the project under the budget and we continue to have an appropriate contingency available to us to address market factors that have also been taken into account by the quantity surveyor, such as the Iran war and the like, and then local contractor pressures. We believe that we understand the north-west contracting market and that we have very strong tender interest to ensure that we get a competitive tender. For those reasons, I believe the budget is appropriate and adequate.

**CHAIR** - Thank you very much as well for the tour that you provided to our committee this morning and our secretaries. We appreciated the time and the effort, especially in an area which is completely functional at the moment whilst we were standing in the middle of it. We do appreciate your generosity, your time within that process.

In a perfect world when you are not constricted to the \$14.5 million, because we understand it is very expensive to undertake these kind of refit-outs in hospital or emergency areas, do you feel that what you are putting in front of us today is the best that you could do with that amount of money? In an ideal world, could you have done a lot more if you had another \$5 million, for example? I know I am asking you to look into a crystal ball, but is this enough to really make a difference for this area?

**Mr GOELST** - My response to that would be that stage 7 of the master plan makes the dramatic difference to the area. For stage 7 to become possible, the helipad needs to be moved. The location of the helipad really does constrain what is possible within the footprint of the emergency department. For \$14.5 million, you could not completely move the emergency department or incorporate the relocation of the helipad, but that is really mapped out very clearly and strongly within the master plan. For myself, as a project professional with 30 years of experience of delivering government infrastructure, I see this as very good value for money for what it is going to achieve and the outcomes for the stated project aims that it is going to cover. I think we are covering a lot of square metres within what would normally be an expensive hospital environment and so I do believe, even though I have not come with facts and figures for it, my professional judgment is that we are getting very good value for money for the impact that we are delivering.

**CHAIR** - Can you explain why the helipad is an inhibitor, and in that strategy of all the different stages of this redevelopment could that have been configured differently or reallocated differently to make sure that you got the best bang for our buck out of this emergency department?

**Mr GOELST** - What we would have liked to have achieved, Casey, you might be able to support me in this, is a different way for ambulances to access and egress from the site. It would have been nicer to achieve a drive-in/drive-out for the ambulances in a more refined way. We need to realign what is called Hospital Street out there, which is the main road that traverses the site. That street cannot be appropriately realigned until the helipad is moved in accordance with the master plan. It is very much the three-dimensional nature of the site. The sheer level change and level differences that we have to incorporate means that you need space to overcome level and dimensional changes. The helipad puts an incredibly solid bookend with its large concrete columns, its bridge and just the structure itself to be able to give any cost-effective flexibility to address that.

**CHAIR** - Just one last question on that: what stage is the helipad movement?

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**Mr GOELST** - I may have to take that on notice. I didn't memorise that for today, even though I should have. I think it's stage 3 or 5 - stage 5. Thanks, Rachel.

**CHAIR** - And this is stage?

**Mr GOELST** - One.

**CHAIR** - One. Okay.

**Ms RATTRAY** - I note in - and I've moved to page 7, so I'm not helpful at all, Chair - it talks about further cost savings being addressed through design development and tender costs are expected to be below the \$14.5 million budget. I know that at our site visit, I asked a question around the design and construction contingency and was advised that design has already come in on budget. That means that the current contingency is the construction contingency only. I'm just interested whether that has any bearing on that \$14.5 million because, again, during the site visit, which was very much appreciated, as the Chair has already mentioned - does that mean that you'll be able to get those extra additional upgrades done in the current budget? I know it's an expectation, but given what's been said here is, is that almost a definite?

**Mr GOELST** - I believe that we have a very good chance. What we mean by the tender costs below \$14.5 million is that the tender costs will come in to not put pressure on having to exceed the \$14.5 million budget and that we will be able to defend what is an appropriate construction contingency for the complexity of the project and the need to keep everything operating 24/7 including: the helipad, including AT, including the entire emergency department and the surrounding areas, medical imaging and the like.

Whilst the design phase is now complete and that third check from the quantity surveyor is complete - it was completed in the time from when this was submitted to today - I'm just able to give the committee the very latest information. A lot of hard work went into that and we certainly have looked for cost savings where possible.

Some of the other items that have been alluded to today that will be addressed in future stages, many millions of dollars' worth of investment is required for that and so certainly exceed any potential to touch in this project due to one or two orders of magnitude above where we are right now, in any savings we could deliver.

**Ms RATTRAY** - You just talked about the helipad - the removal or relocation of that piece of infrastructure. Would it have been more prudent to have done that first and then come to this? I don't want to scare anyone who's obviously put a lot of work into this, but is there some synergy around that or is it just not practical to wait for that?

**Mr GOELST** - My reading of the master plan is that the move of the helipad is best done when construction and decantings are occurring in the area as to where the helipad will go. So, it's really until those steps are taken. I think there is an inherent logic to the way that the master plan has been laid out. Whilst I've described it as a challenge for this project, because we just don't have any room to move, I think that the master plan is very sound in the logic of its flow on how the site is renewed for the future.

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**Ms RATTRAY** - Right. So, there's virtually another five stages to come before you would get to stage 7 of the relocation of the helipad?

**Mr GOELST** - My understanding of the logic for that, Paula, is a lot of decanting has to occur to free up spaces so you can move spaces around.

**Ms RATTRAY** - And there's not a huge budget for decanting in this particular?

**Mr GOELST** - No. That's correct.

**Ms RATTRAY** - It's only \$500,000 for decanting?

**Mr GOELST** - Yes. That's correct.

**Ms RATTRAY** - Which is a reasonably small amount in the big picture.

**Mr GOELST** - It is a small amount.

**Ms RATTRAY** - And that's going to cover that?

**Mr GOELST** - Adequate with the combined contingencies for the project.

**Ms BURNET** - Fourteen-and-a-half million sounds like an extraordinarily small amount when you compare how much we've just okayed for the Tyndall project, which was \$40 million. So, getting this much out of \$14.5 million seems like an extraordinary good spend of public funds.

I'm curious to know, with the impacts of the war in the Persian Gulf and supply of materials in particular, how does that impact this budget?

**Mr GOELST** - The material types that we're using in this project have probably had the least cost escalation versus other infrastructure projects that are out there. We have very minimal roadworks, so a very small amount of bulk earthworks or the like that are moved by heavy machinery and trucks. We're doing very little sort of under the ground where all sorts of different types of pipes have had ridiculous amounts of cost escalation in a short period of time. Then we're not using very much steelwork or that much concrete either.

It's very much we are refurbishing internal spaces, which is paint, floor coverings, plaster, stud walls, those sorts of things, which have had probably the lowest amounts of cost escalation in this season. So, a fortunate project to be delivering when there's a major Middle East crisis.

**Ms BURNET** - That's good. I think you alluded to, and Ms Rattray asked the question, about the plant, so the plant stays pretty much as is - doesn't need much of an upgrade?

**Mr GOELST** - No, very, very small amount. I think the mechanical drawings are four drawings, whereas a project of this size might usually have 20 to 25 mechanical drawings. That's an indication of the relatively small amount of money that we're spending above the ceiling tiles or above the hard ceilings.

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I alluded to - we got lucky. That's probably a terrible thing to put on *Hansard*. We had some helpful outcomes as we investigated the intricacies of the site with the specialist sub-consulting engineers and some things cost less than we expected them to when it came to mechanical engineering in particular.

**Ms BURNET** - That's all that I have on the project costs. Thank you.

**CHAIR** - Do you want to move to page 8, or did you have a question prior to that?

**Mr SHELTON** - I'll move on. It's to do with the general aspect of the renovations.

You mentioned - and thank you very much for the look-through this morning. What it highlights to me, and presumably the rest of the committee, is how much of a rabbit warren back in the 1960s - how hospitals were designed. When you come to the need for not only security of staff, but the patient care, when you're wondering as a staff member what's going on around the corner. That must be really difficult. So, it's a question around the future and opening it up and making it more glassware and seeing through for security reasons.

The future coming our way really quickly is AI. A question about the design and how it might fit with what could come up in the future as far as artificial intelligence and how that might be placed into an ED in the future, and that this design doesn't detract from what might come I assume anyway?

**Ms HYLAND** - Would you like me to take that question, thank you?

In terms of that, we haven't specifically designed for that because the AI that we might be looking at in the future for us would be computer-based at the desktop. We already have all of those spaces and terminals and computers already available.

Where AI's being used outside of the public system is generally note-taking during assessments and things like that and transcribing. At the moment it's more desktop-based, so nothing would change from our perspective in that.

That's not to say that for the next stage, when the stage 7 large redevelopment, that we wouldn't be taking that into consideration.

**Mr GOELST** - The only AI comment I have as project manager is I have been informed that it's likely that AI will be able to assist in the monitoring of the security feed from security cameras. And, again, we've incorporated that because, again, that's really only computer-and-cable focused, so we can cope with that technology as it becomes available in, I imagine, the next few years.

**CHAIR** - Brave new world. Just before we go on to page 8, your submission on page 6 alludes to a 2023 security incident on the site, in that particular site. Without providing too much detailed information, for the record, could you give us a broader understanding of that particular incident and how the new design of this proposed project or refurb would mean that incidents as such could be lessened?

**Ms HYLAND** - In 2023, a contracted staff member of the North West Regional Hospital was unfortunately stabbed outside of the doors of the emergency department just directly in

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front of those where I think you walked this morning. That led to quite a significant review for the whole of the Department of Health, but specifically the North West Regional Hospital and led to things like standby security now 24 hours a day, seven days a week at the emergency department and that is still in place while these things are happening.

The design here has really indicated, and I think you referred to it as the rabbit warren in the back there, that staff areas were actually not secured. One of the key changes is that those staff areas - and we've even changed office layouts and moved doors so that they will all open into the staff area, with swipe card access, so that patients and visitors can't inadvertently walk through that space. We've changed the flow as well. There is now only one in and out, whereas we actually have two or three in and outs, that will make that easier to monitor. All the visitors and patients in reception in the waiting area will only go in and out through one door, rather than in and out multiple doors. There's more ability. The new security office is located with doors to go straight into the waiting area and straight back into the ED for additional security. We also have our patient safety officers that were employed after that time that also circulate within the emergency department and the waiting room to support safety.

**CHAIR** - Thank you. Did anyone have any questions up to page 8 that they'd like to ask?

**Ms BURNET** - Again, thank you for the tour. It's really good to have clinical staff there as well. It's not very iterative getting from the car park. In fact, we saw examples of pedestrian crossings which were in car parks, in the actual car park. You are either having a car parking on that pedestrian crossing - certainly very difficult to safely get around. I understand those might be issues for management as well. Can you just describe how, for patients arriving by car - and then, Casey, it would be really good to hear how it might change from an ambulance perspective as well. Can we hear for the record how people would arrive and how that is more iterative?

**Ms HYLAND** - We've gone from - we have one drop-off zone for patients and families who might be dropping off so there's less walking distance. That will go to two drop-off zones in this change, and -

**Ms BURNET** - Sorry to interrupt, but most people would walk from the car park, would they not?

**Ms HYLAND** - No, if someone's coming to the emergency department who actually has either injured themselves or needs assistance with a wheelchair, they will go to the drop-off zone, which is right adjacent to the walkway where you would have been this morning. The walkway move is a big change for the North West Regional Hospital. Human beings go from the quickest point from A to B. They don't cross roads and then cross roads back again, which is unfortunately the current design, so this is a major change for us to have the walkway on the same side as the hospital, which will prevent - and we would have staff and patients and visitors walking on the road every day at the current point in time.

**Mr SHELTON** - Yes, we witnessed that.

**Mr GOELST** - Look, I really think that is an important change. We did see that onsite. We saw at least close to a dozen people walking up the road today. The footpath being part of this project really is a critical safety improvement and a critical improvement to assist access

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and egress and then certainly for carers to come as well, go grab a coffee safely. Those sorts of things. Very important outcomes.

**Ms BURNET** - We didn't look at parking from the other aspects. Say if somebody were parking, we were talking, around where the helipad was or is, is it easier and more accessible if you're using a wheelchair from the other end of the campus?

**Mr GOELST** - A lot of the disability access points are under the antenatal clinic, and then also further along - sorry, I didn't point out the antenatal. The antenatal clinic's just on the other side of the main hospital entrance. It is flatter, more level access. That's the flatter section of the site as you move east.

**Ms BURNET** - You said that the acceptable level, the gradient is too steep to reach access standards.

**Mr GOELST** - That's correct. For the footpath.

**Ms BURNET** - Going down to Brickport Street, is that right?

**Mr GOELST** - Going down to Brickport Road and going down to the private hospital as well.

**Ms BURNET** - In some ways, if I can finish there, there may be some guidance as well for people who need a flatter access.

**Mr GOELST** - There will be increased investment in wayfinding and signage to support all individuals that will interact with the site.

**Ms BURNET** - Good. Can we hear from Casey, Chair, in relation to the ambulance experience?

**Mr STARK-ALLEN** - In comparison from what occurs now to the future design, besides the entrance moving, I don't think there's any real change to the flow. There's greater capacity within the transfer holding bay, which allows us to maintain clinical care while experiencing transfer care delays or provide care to acute patients while being triaged through the ED system. I don't think there's a huge amount of change besides the egress and exit. I don't think there's going to be a huge amount of difference for the flow of our patients between what occurs now and the future design. Effectively, the entrance is just relocated slightly and then the transfer and hold area is increased.

**Ms BURNET** - Where does the journey for paramedics end? Do you go into the emergency area? What happens?

**Mr STARK-ALLEN** - The end of the journey is a bit fluid depending on the clinical presentation and the collegial care that continues with the patients. Effectively when transfer of care occurs is when a handover has been provided to a member of the ED staff, whether a nurse or doctor, and the ED takes over care. The paramedics will then go and finish their patient care record and ready their vehicle for either returning to station to stand by or to respond to another case in the community.

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**CHAIR** - Are we ready to move on to page 8?

**Ms BURNET** - Just one more question. The ambulance bay will have a glass door that will open automatically and then close automatically. Does that improve safety or the patient experience, if you like?

**Mr STARK-ALLEN** - Absolutely. We will get a rapid roller door, very similar to what the Launceston General Hospital has in their ambulance bay, which will increase privacy for patients, which is a big concern for patient care and also safety for our paramedics so that we don't get members of the public just wandering in and looking for the entrance to the ED department while clinical care is being provided in the transition. It is also a better working environment. Within the new ED design, we're looking at creating a write-up space for paramedics. Currently they do that in the triage bay, which makes it a very noisy and busy environment. This will allow them to have their own space, which is away from the elements.

**Ms BURNET** - Great, thank you.

**CHAIR** - On that, it's my understanding that part of this refurb is the creation of additional space for ambulances to transfer patients before they can then be actually placed into the hospital or admitted into the hospital. Is a part of this refurb part of that policy to address the ban on ramping, which is how it was referred to?

**Ms HYLAND** - I'll take that question if you like. The North West Regional Hospital has an extremely good relationship with Ambulance Tasmania and has very, very good transfer-of-care times. Patients do not sit on a bed generally in that holding area. While the area itself might be slightly larger, it's still not intended for beds to stay there for any length of time. Our model of care will remain the same - for quick transfers. It's more for ease of flow and access around if someone does happen to be in a bed there. It is not an intention to change our flow; we will continue to have rapid offloads.

**CHAIR** - When we were on our tour this morning, Casey, you were referring to the Infection Prevention and Control (IPC). Could you run us through the IPC requirements of that ambulance area and how were you complying with the IPC requirements?

**Mr STARK-ALLEN** - I think there are a number of things. Having the rapid roller door will make it a little bit more concealed from the environment. Additionally, we noted this morning that there were a lot of bins that are stored there that are being relocated as part of this reason.

**Ms RATTRAY** - Quite colourful actually.

**CHAIR** - It does not look right though does it, having bins?

**Ms RATTRAY** - Where people are being dropped off in an emergency.

**Mr STARK-ALLEN** - The removal of the waste bins will aid towards IPC standards. Additionally, a new storeroom and write-up area will allow for better ventilation and better storage of some of our critical equipment, allowing our crews to remain response capable.

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We still maintain the same Personal Protective Equipment (PPE) on-ing and offing area as well as decontamination sinks and equipment to decontaminate the ambulance. Additionally, there is a dedicated decontamination shower for patients or crew that end up going to an incident that requires them to decontaminate before onward journey.

**CHAIR** - There is additional write-up and support areas, is that right, for ambulance?

**Mr STARK-ALLEN** - Correct. Once the patient has been transferred to the care of the ED department, or during that process, one of the paramedics will either continue or start writing up their clinical notes for the case. Having a dedicated write-up area allows them to do that without encroaching on the ED staff space, which, as you could see this morning, is quite confined by the footprint.

Additionally, after a critical incident, a lot of crews, given that North West Regional Hospital is the major catchment for high-acuity cases in the region, they will facilitate a debrief, and at the moment that occurs ad hoc, either in the garage if the environment is correct or sometimes occurring in the triage bay, which creates more ambient noise. Having their own dedicated space to facilitate this is excellent.

**CHAIR** - Thank you. Any other questions on page 8? Page 9?

I would like to ask you a question around the dedicated sexual assault service area, and if you can compare what the experience is now with the current care arrangements compared to what this project will be able to provide to patients.

**Ms HYLAND** - Thank you. Currently, victim/survivors who might come into the ED for an examination will remain within the waiting area; they might be directed to a slightly quieter spot, but there is no separate waiting area. The new design provides for a flexible room that can be used as a waiting area for that person that is actually out of sight of the rest of the ED. As you can imagine, it is a small place and everyone tends to know everyone and so having that privacy is really essential.

We already have an existing SAMS room, but this is actually an upgrade essentially for what we will have and with the addition of the waiting area. It is in a quiet space; we think that it will be well accepted. We have talked to the Arch Centre for sexual harm and support, and we will be taking over the same colours as they use at Arch so that we can have the exact same sort of process, so that if victim/survivors are using both services, which we strongly encourage, they will have a seamless transition between services.

**Ms RATTRAY** - They will have an ensuite as well?

**Ms HYLAND** - Yes.

**Ms RATTRAY** - So that will be a much more appropriate?

**Ms HYLAND** - Yes.

**CHAIR** - Is there a risk that that area being separate, being devil's advocate here, that visibility and safety could actually be a concern to that person whilst they are waiting in that section? Is there some form of monitoring or an ability to still be able to keep an eye on.

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**Ms HYLAND** - While it is a quiet area, it is certainly not outside of the ED and so it is a through-traffic, and there are doors there that go in and out that staff would use. There would be regular flow; they would just have a private space within that. So, I don't think that it would pose difficulty from that perspective.

**CHAIR** - Okay. Just quickly, if you can talk us through people with mental ill health that are presenting in the emergency section, what that journey would look like for them? Are there any separate areas for them or would they have a different entry point as well.

**Ms HYLAND** - Currently, you may still enter through the emergency department or you may be brought in by police, or you may be brought in by ambulance. You would enter the department. We have one existing, what we're now calling low stimulation or mental health space, which has low ligature areas and no equipment that can be used to hurt themselves or others, which is monitored - which is quite up near the doors. The issue we have is that we were going to have a second space, but we're recognising that it's not just for people with mental ill health issues and we do think it's necessary for our neurodivergent population to have a quieter place to be.

It does depend on clinical need. So if you do still require quite high level of clinical support, you will be in the main area and you may even be in a resus bay, which is quite difficult. But where we can support it, we will have access now to two low-stimulation rooms to support many different types of our population to have a better experience. The design of the second low-simulation room came out of an anti-discrimination case that we worked with a complainant on and included them in the consultation for this.

**CHAIR** - Just for the record, there isn't a separate entry point for people who are feeling mentally unwell at that time?

**Ms HYLAND** - No. The model of care is that they need to be clinically assessed to ensure that there isn't something clinically that's impacting them into ill health, whether that might be sepsis or other types of infection or some other issue. When the new mental health precinct comes on board on the hill, there is the intent that that could be the second entry point for those clearly not with a clinical issue.

**Ms BURNET** - Can you describe the makeup of who accesses the emergency department and can you describe how that is likely to change? What's envisaged though the next five to 10 years?

**Ms HYLAND** - In terms of categories? Like the types of patients?

**Ms BURNET** - Yes.

**Ms HYLAND** - North West Regional Hospital Emergency Department has on average 30,000 presentations in total per year. Just in the last 10 months alone, we've had 23,725, so we're on track to hit the 30,000 by the end of June.

The second largest makeup is the category 4 and 5s. They are patients who potentially could have been seen in either an urgent care centre or a GP practice. That was 8915 in the last 10 months.

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Category 3s are our biggest, so 10,732. That's that mid-range, and many of those would go on to be admitted. Category 2s are 3845 and cat 1s are 233.

**Ms BURNET** - And what's cat 1 versus cat 2?

**Ms HYLAND** - In terms of the more serious nature?

**Ms BURNET** - Yes.

**Ms HYLAND** -Category 1: they're very serious, either traumas, things that need emergency - they need to be seen almost within 0 minutes and they're taken into resus bays and treated in that way. Category 2s will get into the ED very quickly; they're urgent, but not needing a full team to see them immediately. They can be triaged within a certain period of time.

You asked the second part to that question, I'm sorry?

**Ms BURNET** - Yes. The second part was how do you envisage that makeup? We haven't had a breakdown of paediatric versus people with mental health issues, et cetera. It's a complex question, but I just want to get an idea of what kind of patients are rolling through.

**Ms HYLAND** - So the majority of our patients would actually come in and go within the same admission. There's not that many who actually go on to further admission within the hospital.

I think what we've done, even though we focus mainly on security in the design, is that we have actually managed to change or enlarge the footprint of the ambulatory care area, which is where most of our category 3s, 4s and 5s would be treated initially.

We have added for futureproofing - we only currently have one triage room; we will now have access to three. Two will be fully compliant assessment rooms, and one will be a procedure/assessment room and they lead directly back out to the waiting area so that people would come in, access treatment and go back to the waiting area as needed. That's a huge change for us and should help the flow of our ambulatory care patients to get treated quickly and go again.

**Ms BURNET** - And 'ambulatory care' means that they're -

**Ms HYLAND** - They're walking.

**Ms BURNET** - They're walking or they're with somebody?

**Ms HYLAND** - Yes.

**Ms BURNET** - In relation to modelling as to best practice and what's practised elsewhere, what have you borrowed from or where have you borrowed from for getting the layout and so forth? Obviously, it's got its own unique challenges, but where is emergency done well?

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**Ms HYLAND** - We've looked internally because there have been some other redevelopments or planned redevelopments in this state. We also accessed information. We've looked at Nepean Hospital in New South Wales. That has a very large number of presentations with a very small waiting area process, with triage rooms that line up directly in and out into the waiting area. That's where we borrowed that, essentially, from. The procedure room was also - one of our consultants has worked extensively in other states and he had brought that information about the procedure room, so we borrowed that as well. I can't tell you specifically which hospital that was, but the need for that type of room for us to have that to be able to do things and then for people to leave if that's where they're going.

**Ms BURNET** - Presumably the model of care over the years that this was first built, I don't remember seeing when it was first built, but how much has that changed over time?

**Ms HYLAND** - We have fast-track now - so if we can get you in and out to the ambulatory care area and you can leave, we have that in train. We wouldn't have had the emergency medical unit, which attaches to the ED for 24-hour stays to 48 hours. We also had the acute medical unit, which actually sits adjacent to the ED as well. I'm not sure if you saw that when you -

**A witness** - Didn't go through.

**Ms HYLAND** - No - which is another, again, 48-to-72-hour stay for patients who are predicted to not require clinical care longer than that three-day period. So, we wouldn't have had those models.

**Ms BURNET** - Just to follow up - one more. The age - are you most of your patients older? We identified that there's clearly paediatric areas and an upgrade to the paediatric areas. What is the age breakdown?

**Ms HYLAND** - I apologise, I don't have the exact age breakdown, but the majority of our presentations would be between about 30 and 90. We have a small percentage of paediatrics - I can get that information if it's required.

**Ms BURNET** - That would be useful. Thank you.

**CHAIR** - It would be great if we could get that on notice - just clarify that we've got the wording right on that.

**Ms BURNET** - Particularly geriatric clients as well.

**CHAIR** - We might move on to page 11.

**Ms RATTRAY** - On page 11, it indicates the architectural responses and talks about recognising the complexity of construction within a fully operational emergency department. I'm interested in having some understanding of how you see that working in the practical sense - should this project proceed to that - because it's going to be quite disruptive to an already really busy, high-traffic area and there'll be lots of contractors, or potentially lots of contractors, around and there's not much parking. Actually, there's very little parking, but that's unique to all hospitals, I think; just some indication of how that is going to be managed, and particularly that interface between construction and clinical environments.

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**Ms HYLAND** - Andrew can talk about the staging. We've got significant staging within the project in order to do that. The biggest impact will be to the waiting area at different times, but we would have that zoned off and we have the capacity to move things in order to zone in order to actually undertake that. We had extensive conversation about access and entry to the ED and we've managed to stage that so that while we'll change the access and entry, we'll maintain it at the ED instead of having to go through another part of the hospital.

We've explored all sorts of different options in order to make that less intrusive. Again, if it is an area that's going to be disrupted, they're quite used to that type of approach. It's not their first redevelopment either, and so they're quite keen in order for the project to go ahead to get the outcomes that they're looking for. They understand that it'll be a short-term-pain-for-long-term-gain kind of approach.

**CHAIR** - Any further questions on page 11? I just had a question about the duress systems. Can you give us a run-through of what the current duress systems are in that area, including the ambulance station area as well, because you're very exposed, and how the duress systems may be improved in this refurb?

**Mr GOELST** - I might lead off on that one. I'd suggest that right now it's not uniform and is a little bit ad hoc and would require a fair bit of knowledge of the area to really respond to that. The project will make the duress and security responses uniform. The same type of buttons, same-coloured buttons, same throughout the entire department. Access through doors and the like will be made uniform as well.

We are also putting them in places that will make them far more accessible and within arm's length in critical areas or within a few steps. That has been done in very close consultation with frontline staff. Then also I've put aside what's called a provisional sum within the contract because you can't expect frontline staff to fully assess the limited 2D plans and 3D things that we've shown them. We also have some finance put aside to respond to the frontline staff. They go, 'Gee, we wish you'd thought about putting it there', and there'll be money to put that extra additional in. We've really tried to cover that off from all angles because that really is a critical thing of what we've done by going and doing the consultation we've done to date, setting up with the AT staff in the superstation. They came up with, 'We need a duress button here.' That's something that came from detailed staff consultation. We believe we've done a lot to capture good outcomes there.

**Ms HYLAND** - We did have a security review of the design. That's included.

**Mr GOELST** - Appendix C of the report, that specialist security consultant with international experience, has been part of every step of the way. They have been checking every iteration of the plans and will also support us through construction.

**CHAIR** - Anything to add to that, Casey, from the ambulance point of view with the bay?

**Mr STARK-ALLEN** - The only thing is this upgrade will enhance the security duress features within the ambulance bay, which I don't believe there are any currently. Our paramedics wear a radio with a duress button on it. It's not linked to the hospital system. It's

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linked to our comms cen from the statewide operations centre who liaise with Tas Pol, so this will be a welcome addition to the ambulance bay.

**Mr SHELTON** - The second diagram on the bottom of page 12 looks at the ambulance bay. You mentioned in our walk around that access to the ambulance bay will be now on the lower side of the pillar that goes - that diagram there makes it look pretty good. However, there is about a metre rise that needs to be incorporated in the design, and while the closer you get to the hospital, the flatter it will be, but I can imagine that third bay right on the outside actually has to be - and I'm sure the ambulance drivers are quite capable of overcoming it, but that diagram doesn't really indicate the difficulty of driving around an embankment that slopes away from here as well as backing into that outside bay. You'd agree with that? It all looks good, but the diagram doesn't really indicate just the difficulty in the engineering.

**CHAIR** - Flattens it out.

**Mr SHELTON** - If the road stays on the same alignment, which you mentioned it will be, then it has to be incorporated in that ambulance apron area. I don't know whether you need to make comment on that, but it's just something, looking at the diagram.

**Mr GOELST** - It is difficult in these 3D artistic renders to get all the shadows absolutely right, to really show what is a complex geometry there. We've endeavoured to make sure, and we've had engineers check, that we're not doing anything steeper than anywhere else that's currently in use in Tasmania. Also, we've had our civil engineers essentially look at it millimetre-perfect for how that space will be formed. Going into the fourth bay shouldn't be any worse than what it is currently or any different from Royal Hobart or LGH in that regard as well.

**Mr SHELTON** - I'm sure that the ambulance staff would be very pleased to have a door coming down and get in out of the weather and any other difficulties that were created because of that would fade into the background when it came around to debating the whole thing, so -

**Ms RATTRAY** - Less sweeping out of that big area, I'd expect. I noticed the broom was there this morning.

**CHAIR** - Moving on to page 14. Any questions on page 14? I did have a quick question about the new footpath that would be linking the private hospital and the proposed development from today, and understand that there's a coffee outlet, which a lot of pedestrians are going up and down that site for; hence the new footpath. That could be quite difficult for people who are wheelchair-bound, to be able to go up -

**Mr GOELST** - Or even come down.

**CHAIR** - Or come down as well.

**Mr GOELST** - It's difficult. Yes, we're working with a specialist disability access consultant to ensure that we will have appropriate warnings and wayfinding signage in place. Then we'll need to really reinforce the pathways with lifts to navigate that significant level change internally through the hospital as well. We're going to have to improve wayfinding there, and the project team will work with the hospital to achieve that outcome.

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**CHAIR** - It'll still be safer than the current arrangement, I understand.

**Mr GOELST** - An awful lot safer, that's correct.

**CHAIR** - However, if it's a dedicated footpath and pedestrian access area, then it's taking on that whole new reality.

**Mr GOELST** - That's correct. We intend to have multiple signage points and multiple communications to ensure that, if someone does choose to use that, they're well aware that it doesn't meet modern disability access gradients and standards. We will still have a pause point; so there will still be some elements where we're making it as safe as absolutely possible.

**CHAIR** - I suppose you probably would have looked at every alternative possible but, in an ideal world, if you could engineer a solution, what would that look like?

**Ms RATTRAY** - It would be a greenfield site.

**CHAIR** - Or maybe elongate it, kind of sloping -

**Mr GOELST** - A multiple switch-back ramp, that we just physically don't have the space to put that in. Also we have some very expensive infrastructure underneath the ground there, including the main high-voltage cable.

**Ms RATTRAY** - Make sure you don't dig that up when you dig up that part of the road.

**Mr GOELST** - No, that's been marked and remarked, and checked and rechecked.

**CHAIR** - Moving on to page 15 - I think we've covered a fair bit of the information here already. Page 16 - I think we've covered the geotechnical service engineering.

**Ms BURNET** - I suppose it was quite clear from the current layout that there are a lot of blind spots, so very difficult to see around corners to really surveil the waiting area and access is easy for any member of the public to go to areas which are staff areas. Can you just describe how you've addressed some of those issues?

**Mr GOELST** - I think the moving of the triage area is absolutely critical to that. As you would have seen on the walk, the triage area probably has 120-degree view currently, and then over a fairly short distance into some solid walls. What we're opening up is an almost 360-degree view where they can see externally, because at the moment they really cannot see externally, so they can see externally, they can more easily see the ambulance bay, then they can see through the entire area. We also form a single line of security where only a tiny section of floor is not visible to the triage area, so in the moving of the public toilets and the reglazing, so every solid wall in that space is demolished and returned with glazing. Then we have in the entire area tripled the number of security cameras as well.

We've got backup on backup in that regard, so the change in sight distances is considerable.

**Ms BURNET** - Was there consideration of a physically separated area for paediatric patients?

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**Mr GOELST** - We have the fully physically separated waiting space there beside the red-wait mental health space, so that can be fully enclosed and acoustically sealed off and also has incorporated a television with a different feed on it for children's programs to be on that television. That is the appropriate response Australia-wide for emergency departments at this time, so we're certainly having current standards met through that space.

**CHAIR** - Thank you. Page 16, any more questions?

We'll move on to page 17, which I think we've covered.

Just to double-check, I know that disability and vision impairment advocates have been consulted, we've already stated that, domestic and sexual violence support reps including Laurel House and for emergency department staff and paramedics with the lived operational experience, can you talk us through mental health advocacy groups and some of the feedback that they've provided to your group and some of the advice that you took from them within this design?

**Mr GOELST** - The design has been heavily influenced by both internal departmental staff and external advocates who we've spoken with.

The improvements to the high-dependency room: to increase the size of that room; for that room to have a dedicated mental health space as well. We have also dramatically improved, say, odour control in that space as well, which is a which is a really good outcome.

Bays 11 and 12 are nominated to have glazing on the front of them and are in a quieter part of the department, so they have been communicated to be spaces that would be prioritised for neurodiverse patients to be able to be placed into, for them to be lower-stimulus spaces.

The creation of the second, equivalent room to the high-dependency room, but not quite as hardened as what it is, mainly around doors, but that space is in a quieter corner of the department. It also has a dedicated ensuite associated with that as well.

The use of the multiple assessment rooms assists with departmental staff having options for patients and then the nomination of the red-wait area, when there isn't an infectious patient in there, to also be used for patients who need lower stimulus as well.

It could be argued that from two touch points, we've got over half a dozen touch points in that space. Then the floor plans, the wall layouts, the colours will still also be informed by those groups as well.

The current feedback from those groups is that they are really impressed with the amount of codesign that's occurred in that space and the listening that the design team has done to get some dramatically improved outcomes.

**Ms RATTRAY** - I did note that further on the report it talks about feedback survey summary and it says that, 'the consultation was generally positive'. Then it goes on to say 'while most feedback received was positive'.

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So were there some matters that were raised through the feedback and the consultation that haven't been able to be addressed in this particular proposed redevelopment and upgrade?

**Mr GOELST** - I can talk to that problem. One of the ones was there was a small amount of doctors who really wanted to maximise the floor metres, the square metres inside the emergency department and see the forensic sexual assault space moved to another location. We did genuinely explore that and examine that possibility. It's also not something that is impossible for the future; it's just not possible at the moment. That would be probably the main item that was raised.

I think, elsewhere, on a sort of lesser priority, is obviously we would love to significantly increase the size of the staff spaces as well and perhaps provide - some staff from different streams of staffing would have liked a separate area for them, whereas they really want to try to keep the staff together and to explore a holistic team. Issues like that were raised. What we've done is ensured that we've communicated back to the whys and why-nots, but the listening we've done - it's overwhelmingly positive because they really have stretched the design team. There were three things that were raised. Paula's already raised one with the procedure assessment room, where I just thought would be impossible to achieve, but they kept asking for it, we kept on looking and we got a great outcome. Paula also had some input that allowed us to get the third assessment room in place. We've achieved some really great outcomes in the codesign process.

**Ms RATTRAY** - But there are some reasonable upgrades for staffing areas, as well. It certainly wasn't completely dismissed out of hand. It was addressed in some way, not perhaps all the way?

**Ms HYLAND** - We can't always do everything that everyone asks for. I think we've had a good balance of actually meeting most needs and taking on board that there might be some changes in the future, but the sexual assault medical service room has to remain where it is. I think the staff has acknowledged that with the meeting room and the family room and where the waiting area is that's now separate, that that will actually be a better change.

**Ms BURNET** - What is the retention and recruitment of staff like for this department?

**Ms HYLAND** - From a medical workforce point of view, we have actually just achieved our accreditation with ACEM up to a level 2. We were level 3 and we've actually gone up to a level 2, which means we can have registrars trained for two years instead of one, which is a great recruitment and retention activity. A lot of work's gone into that by that department.

We do have a reliance on locum staff, but that team has also been instrumental in working on a model where we can actually have staff on contracts that can actually fly in and fly out so that they're not actually locums; they're actually employed by us. We have actually offered, I think, two contracts so far to people who want to be long-term with us, but still want to maintain whatever their life is somewhere else. That's a model that we're certainly looking at because it's advantageous for us. We get recurrent people who are well known.

Nursing-wise, we do reasonably well. We have had some agency staffing in that area, I can't tell you the degree right at this current time, but we are attempting to maintain our benchmarks so that we stay properly staffed.

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**Ms BURNET** - Perhaps if I could have that taken on notice as well. It would be good to know that. We've just talked a little bit about the improvements in staff facilities. Can you just also describe what other things are - I mean, clearly the layout, the safety issues, any sort of breakout spaces for staff and the training facilities?

**Ms HYLAND** - Within the design, the staff currently has a lunch room that's actually cut off in half, so they have two spaces they can access if there's too many. This now means that they can have one full space so that they can access as a larger group, but they've also still provided enough space for a staff training area that's a breakout for them. They have regular senior staff meetings that will be used for that as well. There's additional office space that they don't currently have. All of that will be within the swipe card access area so that there won't be walk-ins or accidental walk-ins by other visitors or patients.

**Ms BURNET** - Okay, so a lot of that will be more back of house rather than a walkthrough?

**Ms HYLAND** - Yes.

**Ms BURNET** - We didn't touch on allied health. Allied health staff are very important. What's the recruitment like in allied health?

**Ms HYLAND** - Allied health has very good recruitment at the moment and is nearly fully staffed across the board.

**Ms BURNET** - In emergency?

**Ms HYLAND** - We don't have allied health who are dedicated to the emergency department. The departments sit outside that area and staff see patients, but not after hours.

**Ms BURNET** - Thank you. One other question and then we will go up to the other end. Storage space, obviously, storage in a facility is problematic. How have you addressed some of those issues?

**Mr GOELST** - I can talk to that. We put a storeroom into the ambulance bay extension without compromising, I believe, the other needs of that extension. In moving the public toilets to a far better place for better outcomes, we are turning the existing toilets into a new store for the emergency department, improved linen storage as well. Then in the removal of the plaster room we have provided appropriate storage to replace that and turn the plaster room into a trolley to get better use of spaces. We have included a dedicated cleaner space within the department; otherwise that is on trolleys in corridors as well. That decongests that space and provides improved toileting for patients. We have looked for opportunities for better joinery and the like within refurbished spaces as well, which would help to decongest items. We have negotiated with other parts of the hospital to move some items that are currently stored within the emergency department, particularly what we're converting into the low-stimulus room, to be stored there and then being brought on the infrequent ad hoc basis that those items are needed down to the ED. We have worked very hard to maximise the storage that is there.

**CHAIR** - Subsequent to Ms Burnet's question, is there a capacity, as part of the overall master plan of the entire site, to build some dedicated storage areas because it is really not very workable that area. I think this design that you put in front of us today shows a lot of people

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trying to find as much space as they can. A lot of the equipment is pretty bulky, especially a lot of your mobility equipment, your wheelchairs and so forth. Then on top of that, you also have to carry so much stock as well. Is there an opportunity for there to be dedicated storage areas because it is a lot to keep asking to provide such a high level of care for patients and workable spaces for staff, yet really ad hoc solutions to storage constraints. Is that something that really should be taken seriously in the overall master plan?

**Ms HYLAND** - Can I start with that?

**CHAIR** - Have I touched a button there?

**Ms HYLAND** - No. Storage is one of my favourite things to talk about. We have done a lot of work with statewide supply. We do carry too much stock and it's a leftover from COVID. We became COVID-hoarders during that period of time because there was very much a fear that people wouldn't have access to things. We have done a huge amount of work to have - statewide supply now does runs every day for us to provide stock. There is nothing really should be that urgent and we do not need to keep massive amounts. We have very much gone to min-max levels in all of the areas, so that we can reduce what we are keeping. The big supply area is in Launceston, the massive big shed with all the supply there. We have done a lot of work in that space.

We have done a lot of work internally. There have been some great designs with minor works - not in the capital sense, but we have actually taken up space that we need to. We found gaps in walls that had enough space to create storage rooms, which are just outside the ED actually, to minimise those things. We have done a lot of work about making sure we can keep beds out of corridors and all of those things. In general, the whole hospital is doing very well in terms of where it stores things, how it stores them, and not doing it in corridors. We always include it - and you guys can talk about design - but as soon as you build it, you'll end up - and I saw it in the Royal Adelaide Hospital when I went to visit that when it was new and it was all touted with all these massive amounts of storage and there was still equipment in the corridors and things like that. It's a perennial problem, but we have done a lot of work internally around improving that while we wait for things like the master plan.

**Ms RATTRAY** - Sounds like a garage sale might be coming up. I love a good garage sale.

**CHAIR** - Shall we move on to page 20. I'm noticing that we're eating into our time. I have a question on page 20 about the timeline. You've got design and contract documentation complete in April 2026, so that's complete. Construction contractor appointment, which will be in about another two months from now, but your construction commencement is August 2026 with a practical completion by December 2027. It seems like quite a long duration for that, because it is really, in essence - and I know there's a lot in it - it's a renovation of sorts, isn't it?

**Mr GOELST** - The reason for the duration is the need to keep everything operating 24/7. Rather than being able to do large areas all at once, this is a bite size. That's the reason for the length of time that is going to be needed. I actually believe that the proposed duration at the moment is actually going to be incredibly tight. The contractor is going to work very hard to achieve that.

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**CHAIR** - Will you be decanting one area into another area?

**Mr GOELST** - That's largely what we're doing. We're building the ambulance extension first, so that we have areas to decant to, to move the Tetris pieces around to make it all happen. For example, you saw today where the public toilets will eventually be; that'll have to be a red wait room for a time and those sorts of things. To keep it 24/7, we've had to go very slowly through the space.

**CHAIR** - Ms Rattray was asking a question this morning about the traffic and the roads.

**Ms RATTRAY** - Yes. But, to follow on from your question, I wrote down this morning with the staging, when we talked about that at the site visit, the ambulance bay area that Casey's very much interested in will be finished by December 2026.

**Mr GOELST** - That is correct. The extension and readiness to fit the panel lift door should be by the end of this year.

**Ms RATTRAY** - Right. Okay, so that's actually been missed out of your project timeline really, hasn't it?

**Mr GOELST** - I absolutely take on board that I could have put that in there.

**Ms RATTRAY** - That's alright. We know about it now, but it would have been a good one to have and done early. I did ask, thank you Chair, about some of those challenges that will be with contractors onsite. That's part of the staging process and you've got that well in hand, Andrew?

**Mr GOELST** - Absolutely. Very detailed consultations occurred on the construction staging. We've had well north of a dozen meetings on that, spent many hours with the infection prevention control clinical nurse consultant in getting all that signed off as well. We've got some recent learnings from very difficult projects that have been delivered at Launceston General Hospital to make sure we've got the very best air quality control in behind the hoardings and the spaces as we're working in some very difficult areas. We make sure that the hoardings are also hardened so that it's safe for both the contractors and the staff. We've talked about locking down tools so they can't be gotten to and stolen. We have turned it upside down, looked at in a lot of different ways with a lot of different individuals, including the key frontline staff, doctors and nurses, orderlies, clerks, cleaners. We have 12 major stages plus, the roadworks is a 13th stage. All those stages have multiple sub-stages and we have gone over it with a fine-tooth comb.

**Ms RATTRAY** - You also talked about the fact that maybe it's one-lane-only access -

**Mr GOELST** - Correct.

**Ms RATTRAY** - in and then you'll use the top exit at the site. What's it called?

**Ms HYLAND** - Uplands Place.

**Mr GOELST** - Yes. The idea for the roadworks is that there will be a time when we're building the footpath that we will have to have Hospital Street down to one lane and that will

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be a west to easterly direction. Using traffic lights for two-way there would be a nightmare because of all the intersections that are there and private hospital car parking and the like. The commitment we're making will still allow fast entry for ambulance and police, and the contractor will work with ambulance and police if they do need to head out west under lights and sirens. We will facilitate that and enable that to occur. But we'll certainly be putting out public communications closer to construction to ask the public to be patient with us as all traffic is directed out Uplands Place for a period of time.

**Ms RATTRAY** - And no negative impact on the helipad?

**Mr GOELST** - We have worked very hard to absolutely minimise any impact on aero-medical operations and we believe the project can be delivered with zero impact on the helipad, because we have around 30 minutes' notice. So, the contractor just needs to work with that timeframe of notice of an incoming helicopter, and usually it's a little bit more.

**Ms RATTRAY** - I recall we had some information for the previous reference that the committee looked at around the mental health facility - that there was quite a lot of actual movements by the helipad at the site. I can't recall what it exactly was, but it was more than I had thought. It's certainly a well-used facility and much needed. Comment only, Chair, not a question.

**CHAIR** - Page 22. That ties in with Ms Rattray's construction, traffic and parking. With parking, it is the largest issue that we seem to hear about the site. Will any part of the greater master plan incorporate new car spots at the site - stage 3 or 4?

**Mr DUNNE** - I can't really refer to the which stage that will be, but there's a total of, I think, 630 in total over the 20-year program. There is to date 43 car spaces that have been created in addition to that 630.

**CHAIR** - Thanks. Any questions on page 23? Page 24.

**Ms RATTRAY** - I jumped ahead on that one, Chair.

**CHAIR** - No, that's fine. Page 25. We've run through a lot of this information already. Just checking the planning approval - it was written at the start of this submission that a planning approval had been put in. In your timeline it does state that it has come back. I just wanted to -

**Mr GOELST** - That's true. I could have added an extra sentence there. We have that in place and it has utterly minimal conditions because this has no real interface with Burnie City Council infrastructure. It's our land, so, yes, good to go.

**Ms HYLAND** - As is the road.

**Mr GOELST** - As is the road, yes.

**Ms RATTRAY** - I didn't ask earlier about the art scheme, but I did ask during the site visit about what was proposed for that. I was given a response that there would be some cabinets that we're going to be part of that.

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**Mr GOELST** - Not funded by that, but to display potential artwork that may be created under the art scheme.

**Ms RATTRAY** - But not part of the \$80,000?

**Mr GOELST** - The cabinets would be built under the project budget and what goes in the cabinets and perhaps what's placed on walls would be funded - would fund the artists to create the artwork to go in the cabinets and what might be placed on walls.

**Ms RATTRAY** - Right. There's no real idea about what that might look like as yet, then?

**Mr GOELST** - No, only just emerging. We've got -

**Ms RATTRAY** - How does that unfold, if you like? Is there a small committee -

**Mr GOELST** - Yes, that's correct.

**Ms RATTRAY** - made up of the likes of Paula, yourself, Casey and, perhaps Anna and Maxine? How does that actually work?

**Mr GOELST** - That's typically how we work it across all our infrastructure projects: we create a small working group with Arts Tasmania and their project officer, and then Arts Tasmania runs the consultation with Tasmanian artists and runs the tenders on their side, but we have a small consultative committee here for the final outcomes.

**Ms RATTRAY** - Okay, because I note in the heritage part it says 'not identified any registered Aboriginal relics or apparent risk to impacting registered Aboriginal relics' yet you talked this morning about having some Aboriginal-focused, if you like -

**Mr GOELST** - That's an idea that's currently on the table that's been submitted to Arts Tasmania to work that through, working closely with the Aboriginal Health Liaison Officer to use the arts funding to make the space as welcoming as possible for individuals who identify with Aboriginal heritage.

**Ms RATTRAY** - Because you won't actually get any sea views from any of the upgrade?

**Mr GOELST** - No.

**Ms RATTRAY** - So you can't use that beautiful view out of the facility?

**Mr GOELST** - That's correct.

**Ms RATTRAY** - So you'll need to put something on the wall.

I noticed in one of the -

**Mr GOELST** - One of the arts shows - an idea for that Robert Carroll & Associates have put forward.

## PUBLIC

**Ms RATTRAY** - In that waiting room area, there was quite a nice big picture looking big on the wall.

**Mr GOELST** - That's correct. That's one idea that we're exploring at this point in time.

**Ms RATTRAY** - Alright, but it'll definitely be a whole-of-community - not whole-of-community, whole-of-the-people who work there?

**Mr GOELST** - It will be highly consultative in how we do that, for sure. That's what I've done on all other health projects.

**Ms BURNET** - Andrew, I think this morning you intimated that part of the reason with the thinking was around the number of Aboriginal people who use the facility. Can you just describe for the record the data of that, please?

**Mr GOELST** - So I'm quoting what I received from the Aboriginal Health Liaison Officer. Paula might be able to check me on this, but I understand they represent around 3 per cent of the population, but representations there are almost 20 per cent of the representations.

**Ms HYLAND** - That's correct. In some of our areas and our catchment, because it goes right through to Smithton, that's 8 per cent. So it's quite high in the north-west.

**Ms BURNET** - But that's a high - that's an overrepresentation, if you like, of the general population.

**Ms HYLAND** - Yes

**Ms BURNET** - And it would be beneficial to everybody who uses the facility to have that interaction with that art as well.

**Ms HYLAND** - Yes.

**Ms RATTRAY** - There's a wonderful community called the Circular Head Aboriginal community.

**Ms HYLAND** - Yes, we work with them.

**Ms RATTRAY** - Met some of those people on my journey.

**CHAIR** - Any further questions? Alright.

**Ms RATTRAY** - Lucky I got that last question in.

**CHAIR** - You did.

Thank you very much for coming in today and providing us with the evidence that you have and once again for allowing us to have access to the site this morning. We appreciate the time and the information that you provided to us as a committee.

## PUBLIC

Before you leave the table, as I advised you at the commencement of your evidence, what you have said to us here today is protected by parliamentary privilege. Once you leave the table, you need to be aware that privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you have said to us.

Do you understand that?

**WITNESSES** -Yes.

**CHAIR** - I have some questions, as well, that you if you can answer 'yes' or 'no' to before we move into our deliberations this afternoon.

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

**WITNESSES** -Yes.

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

**WITNESSES** -Yes.

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

**WITNESSES** -Yes.

**CHAIR** - Do the proposed works provide value for money?

**WITNESSES** -Yes.

**CHAIR** - And are the proposed works a good use of public funds?

**WITNESSES** -Yes.

**CHAIR** - Thanks very much.

**Ms RATTRAY** - Chair, before we close, before we close the *Hansard*, can I just acknowledge the previous member of the committee, the honourable Dean Harriss, who won't be returning, and thank him for his service?

He was great on the P50/P90 stuff and I'm going to miss that, but I want to acknowledge his time on the committee.

**CHAIR** - Definitely, I think that is well and truly worthy and we want to make sure that is on the record, because some of the questions that Mr Harriss would ask, he wouldn't say that, but when he did ask you a question it was a curly one and they were the best questions. We will miss him greatly. Thank you for joining us.

**Ms RATTRAY** - Thank you, Chair.

**The witnesses withdrew.**

**PUBLIC**

**The committee adjourned at 3.30 p.m.**