THE PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS MET IN THE CRADLE COAST AUTHORITY CONFERENCE ROOM, BURNIE ON WEDNESDAY 11 MARCH 2026.

NORTH WEST REGIONAL HOSPITAL MENTAL HEALTH PRECINCT

The Committee met at 2.00 p.m.

CHAIR - Welcome everyone. Before we commence the hearing, I will introduce the members of the Committee. To my left, I have Tania Rattray; Dean Harriss, who is also our Deputy Chair; myself, Jen Butler, I'm the Chair; and we have Helen Burnet; on Hansard we have Karen; and our Secretary, Scott Hennessy; and Georgia. Mr Shelton is an apology for today's hearing. Secretary, would you please read out the message from Her Excellency, the Governor-in-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 undermentioned proposed public work to the Parliamentary Standing Committee on Public Works to consider and report thereon:
>
> North West Regional Hospital Mental Health Precinct.
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> Pursuant to section 16(3) of the Act, the estimated cost of such work when completed is $40 million.

CHAIR - The Committee is in receipt of one submission from the Department of Health. Could I ask a member to move that the submission be received, taken into evidence and published: moved by Ms Burnet.

Ms BURNET - So moved, Chair.

CHAIR - All those in favour say 'aye', against 'no'. I think the 'ayes' have it.

The witnesses appearing before the Committee today are representing 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.

Mr JARROD BANNON, GROUP DIRECTOR, MENTAL HEALTH SERVICES NORTH/NORTH WEST, TASMANIAN HEALTH SERVICE; **Ms RACHAEL DOBSON**, SENIOR PROJECT MANAGER, INFRASTRUCTURE SERVICES, **Mr SIMON DUNNE**, DIRECTOR PROGRAMMING AND DELIVERY; **Ms CATHERINE SCHOFIELD**, EXECUTIVE DIRECTOR OF NURSING (DIRECTOR OF SERVICES), TASMANIAN HEALTH SERVICE, **Ms DEE-ANN SIMMONS**, PROJECT MANAGER, INFRASTRUCTURE SERVICES, DEPARTMENT OF HEALTH; AND **Mr CAMERON BURBRIDGE**, ARCHITECT, LEAD DESIGN CONSULTANT, ARTAS; 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's 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 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 - Ms Simmons, would you or one of your colleagues like to make an opening statement?

Ms SIMMONS - Yes. Simon will be doing that.

Mr DUNNE - Thank you, Chair and the members of the Committee, for the opportunity to present the North West Mental Health Precinct project. The Department of Health is progressing this important development to deliver a modern, purpose-built mental health facility on the North West Regional Hospital campus in Burnie. This is a state-funded investment and a major component of Stage 1 of the North West Regional Hospital Masterplan.

This project responds directly to longstanding community need and statewide mental health reform. It replaces the ageing Spencer Clinic with a contemporary, 22-bed inpatient facility that meets modern standards, supports recovery-orientated care and provides the capacity and the flexibility required for the region's growing population. The precinct has been carefully designed to provide a safe, therapeutic and dignified environment for consumers and high-quality workspace for staff. It includes single bedrooms with private ensuites, sensory modulation spaces and multiple therapeutic outdoor areas that support calm, privacy and healing.

The building integrates biophilic design principles, draws inspiration from the north west coast landscape and avoids an institutional feel, ensuring that the facility is welcoming to patients, families and the wider community. The design also delivers strong operational functionality. It separates public, clinical and service flows; enhances staff visibility and safety; offers flexible clinical zones; and incorporates sustainability features, such as LED lighting, double glazing and a light-coloured roof to reduce heat gain. The facility will connect into existing hospital infrastructure, and this is designed with universal access and inclusive wayfinding throughout.

The project has undergone two substantial rounds of stakeholder and community consultation, first in March 2025 and, again, following design refinement, in October and November 2025. Feedback has been consistently supportive of the project's intent with constructive input on building access, parking, visual amenity and service capacity. This feedback directly informed the final design.

The department has pursued a robust risk-management approach, including geotechnical investigations, acoustic modelling and careful planning to address landslip overlays and the proximity to the hospital helipad. Construction impacts, community expectations and workforce considerations have all been proactively managed through early engagement and detailed design.

We intend to procure a head contractor through an open tender process to drive competitiveness and value for money. Planning approval was submitted in November 2025, with the construction scheduled to commence in September 2026 and operational readiness expected in early 2028. This project represents a critical investment in the mental health infrastructure of north west Tasmania. It will significantly enhance access to care, improve patient outcomes, support staff attraction and retention, and deliver a modern facility aligned with contemporary models of care. We look forward to working with the community to ensure strong oversight and successful delivery of this essential project for the Tasmanian community. Thank you.

CHAIR - Thank you. I'd like to start by thanking the people who took us through for the tour this morning, and especially the staff who we met with at the existing facility. I state on the record what an amazing job that workforce is doing in that very confined space. I thank them for the amazing job they are doing to help people.

Regarding the decision to have 22 beds in the facility, it's our understanding from this morning's evidence that a 27-bed facility was initially discussed. Why was the 22-bed facility mark landed on?

Ms SIMMONS - Originally there was the five-bed, short-stay included in the design. Ultimately, it came down to available funding; we had to design within the funding envelope. The 22 beds of acute inpatient was what's needed. The five beds for short-stay, it's probably worth noting as well, it wouldn't just be an additional five beds for short-stays, it's a different model of care, so it would require a whole different, essentially, facility added onto the current 22 beds. So, it would have its own additional admin facilities, its own reception and it would be a whole different look and feel as well. Patients can come and go from short-stays, so it would have to have its own entry. It's not just an additional five beds; it would have been a whole additional unit, essentially, that would have been added. It came down to we needed to deliver the project, and 22 beds is what we could deliver within the funding.

CHAIR - Can I ask, what the difference between short-stay assistance - or short-stay opposed to a longer stay is, insofar as patient care?

Ms SIMMONS - I will probably hand that one over.

CHAIR - Yes, I know that's probably a very big question.

Mr BANNON - Yes, quite a complex question, but, I think to put it quite simply: the short-stay unit really is intended for people who are experiencing a time-limited episode of distress. Often, they are attached to a sister service, such as a safe haven, so a consumer would present in either situational or suicidal distress. It would be deemed that they're not safe to return back into the community for the evening. We would seek an admission to a short-stay unit for a time-limited period to put a safety plan in place for that individual before transferring

them back out into the community, as opposed to a typical acute inpatient admission where the average length of stay is around 12 to 14 days which would not be clinically indicated for the cohort of consumers who would require a short-stay admission.

CHAIR - Do we know hypothetically what the additional funding requirements or cost requirements would have been for the five short-stay or that section - on top of the cost?

Ms SIMMONS - We had a design done up including the short-stay and associated services to support that. That came in at around $83 million -

CHAIR - On top of the original cost or overall?

Ms SIMMONS - Overall.

CHAIR - I was thinking that's -

Ms RATTRAY - Gold plated, I think. Just following on from the Chair's question around the decision to not proceed with the five-bed short-stay unit - I think that's very useful information; having that understanding that it's not just about five more beds and that it's quite a complex arrangement. Thank you for that. It says that locating the car park adjacent to the building now rather than underneath. The car park was originally going to be underneath the five short-stay beds; is that correct?

Ms SIMMONS - When we were looking at that model, we had a ground floor which had the car parking and the short-stay. The short-stay was on a separate floor to accommodate that different service and the car parking extended on that same level. That also made the building taller. A lot of the community feedback we received was around the building height, so part of that was reducing the building height. We've now nestled into the hill, so it's actually only a single storey at the back, but we still have the car park and we still have the visitor drop-off, the two disabled access car parks and two more car parks for clinical services.

Ms RATTRAY - Right, so not a significant increase in car parking availability. I noticed how difficult it was this morning trying to find a car space. The Committee had one allocated for them. Imagine if we hadn't. We'd have been up on the hill somewhere.

Ms SIMMONS - Yeah, sorry - so that's what's in the building, but then we've got adequate - more car parking allocated just in front of the building. We are adding additional car parks to service the new unit and we're meeting all the requirements of that.

Ms RATTRAY - Can we have that number - because it is a really important factor of any new build facility - if that's available? It's probably in the plans, but I thought somebody would have it off the top of their heads. That's fine.

CHAIR - You're also looking for the car parking area once the overall Masterplan is completed, is that also -

Ms DOBSON - There is additional car parking as part of the Masterplan, the delivery of the Masterplan, yes.

CHAIR - Maybe both of those pieces of evidence or that information could be provided. Please continue, Ms Rattray, with your question.

Ms RATTRAY - We also heard this morning - I appreciated the opportunity to meet with some of the staff members onsite - that the current facility, the Spencer wing, was transferred from a Wynyard site around 1993-94. I asked whether that was to be an interim arrangement or whether people understood at the time that it was going to be a long-term arrangement. Can we have a little bit of history about how it ended up - that particular wing for mental health services right next door to the children's ward?

Ms SIMMONS - I would certainly have to take that on notice, unless -

Ms DOBSON - I think so. That predates my time with the service, certainly in the north and north west.

Ms RATTRAY - Nobody at the table's done their history? That's fine.

Mr BANNON - Haven't got our history, but I think that that is our understanding - that it was time limited. We know that the current Spencer Clinic facility was not designed with the intent for it to be - it was an existing piece of infrastructure allocated to mental health services.

Ms RATTRAY - So it was possibly, at the time, a short-term arrangement that's ended up being a fairly long-term arrangement. Hence, we have what the Committee is looking at today. Thanks, Chair. I don't want to take all the questions. There are other members.

Ms BURNET - Thank you, and again, thanks for taking us around. It was a pleasure to be shown around this morning by Ange. I have questions concerning the need in the north west for acute mental health facilities. What are the needs?

Mr BANNON - Absolutely. At the moment we have the 19-bed Spencer Clinic, which has an average occupancy rate at the moment of, well, around 100 per cent. There is absolutely a need to increase our capacity to meet that demand. That is not the only area where we're considering the need to expand and grow. We're obviously looking at community-based services in support of that. There's been the recently commenced and commissioned mental health emergency response service, which has had significant improvement in being able to support consumers to avoid unnecessary emergency department presentations and subsequent admissions. There absolutely is a need and a demand. I don't think that we could sit here and say comfortably that those 23 beds are going to meet the potential future demand. We will need to continue to explore other opportunities that could be an alternative to hospitals and state-based services.

Ms BURNET - In your capacity, what is the projected need? If you were building the best centre, what kind of capacity would you build - the number of beds for an acute facility?

Mr BANNON - That's probably a question that we will take on notice.

Ms SCHOFIELD - It is about looking at the data in terms of projection, which varies in some ways across the world as to what the projections actually might be. Looking at what we've experienced in the south is that the more facilities we've created, the more demand has risen with the creation of the facilities. It's like an unknown quantity, I think, to be honest in some

ways. We will have data around the percentage of people who have mental illness, but I know that's just recently been revised upwards. I think we would need to go back and do some work to provide you with a much more accurate figure.

Ms BURNET - Thank you. In relation to the short-stay unit - and I must not have been in on the conversation before - but is that still proposed as part of the Masterplan? There's no short-stay unit proposed? Could you just provide, for the Committee, an idea of the differences in demand for the patients who would be admitted to an acute psychiatric facility?

Mr BANNON - I think we can probably provide more accurate percentages out of session, but it is a much lower percentage of consumers requiring the short-stay admission as opposed to those requiring that longer, more intensive period of acute stabilisation. We can certainly come back to the committee with a percentage.

Ms BURNET - Okay, but somebody who requires high needs, who has psychosis or whatever, how long do they usually stay in that part of the facility now?

Mr BANNON - The KPI that we attempt to achieve is around 12 to 14 days. I think across the state at the moment we're sitting closer to around 16 days as the average length of stay across all of our bed-based services.

Ms SCHOFIELD - It exceeds that in the north west, but that's often to do with the fact that people live farther away from services. They're possibly kept longer to ensure that they're more stable when they're actually discharged.

Ms BURNET - In relation to discharge, does everybody have a place to go when they're discharged from the psychiatric ward?

Mr BANNON - It is extremely rare across adult mental health services in the north and north west for us to discharge a consumer to no fixed abode. That isn't a common practice. We do make all attempts and efforts to ensure that people have suitable and stable accommodation or at least a time-limited safe space until we can arrange and we rely heavily on our multidisciplinary team, particularly our social workers, to support that discharge planning process.

Ms BURNET - It would be good to get an overall idea of the master planning steps that's proposed for the North West Regional Hospital site for a bit of context. We have been sent the Masterplan but it's 115 pages and I've only got to page 19 so far.

Ms DOBSON - There's an implementation plan that's attached to the Masterplan that outlines that and we can identify which pages.

Ms BURNET - Can you give an overall idea for the Committee?

Ms DOBSON - I don't have that off the top of my head. I would have to take that on notice too. We're in Stage 1 at the moment and this is the first facility in Stage 1. We're in design for the link bridge and the IPU [inpatient unit] and the transit lounge, but I believe that there may be other projects associated with Stage 1 delivery.

CHAIR - We might ask for that information to be provided at a later stage to complement the report.

Ms RATTRAY - A supplementary in regard to the link bridge in phase 2 of the project. My understanding is that that's quite crucial to the functionality of the new proposed facility. Do we have some indication of what sort of timeframe that will be and not having to use the trolleys with some warming devices to get food and supplies up to the new facility. I didn't have the appropriate shoes this morning to go walking, but it's quite a hike by the look of it.

Ms DOBSON - It is. The link bridge that will connect the Masterplan Stage 1, which includes the mental health precinct, to the current hospital will come in at or just above the current main entry to the hospital and that is part of Stage 1 delivery as part of the Masterplan. That's what's in the design phase at the moment. The funding model for that, the state is seeking to match federal funding, so it hasn't been sourced as far as the delivery, the funding for delivery of that, but the design is in process, and the mental health precinct has been designed to allow for the link bridge connection to that.

Ms SIMMONS - Yes, it comes into first floor.

Ms DOBSON - First floor, yes, so connection.

Ms RATTRAY - We will get to the overall project cost, but what's the federal government's contribution to this project, or is there none?

Ms DOBSON - There's none that's been secured at the moment.

Ms RATTRAY - But there's an expectation that there will be for the link bridge and another component?

Ms DOBSON - The rest of the Stage 1 Masterplan services, so it's a transit lounge and other IPU as part of that.

Ms RATTRAY - I don't know what IPU is.

Ms SIMMONS - Inpatient unit.

CHAIR - It is important for it to be on the public record, the briefest explanation about the current state of the existing facility, and that's not to take anything away from the amazing work that the workforce is doing within that facility. I'm not sure, it might be best put to you, Ms Simmons, to explain the confines and whether the current site is appropriate for assisting people to a good recovery?

Ms SIMMONS - I can answer it in terms of what we're providing in this proposed project. It has certainly taken a lot of what is currently there and conceived, what's not functioning so that we've been able to bring it into the brief of this new project. Things like - you saw that the lunchroom is also the activity room and the - it's all in the one space. It's also the media room. In this new project, we've divided up all these spaces. Rather than every room be a multipurpose as it currently is, the new facility will have purpose-focused rooms for each activity. There are the consult rooms, interview rooms, group activity, indoor exercise rooms, sensory modulation and all these kinds of things that actually support healing and recovery.

Yes, certainly the current conditions at Spencer Clinic have provided us with a really good insight of what's not working and what we can improve on in the new facility.

CHAIR - Can you run us through, as well - I'm not sure whether Ms Schofield may be better at answering this question - the care model which would be used in the new facility and - there are two questions - how the design in the proposed project complements that model?

Ms SCHOFIELD - We've done an awful lot of work in regards to the future, I suppose, in relation to the model of care that will be introduced. Obviously, a lot of the same elements will be maintained from, I suppose, the philosophy that the staff bring to the work that they do such as trauma-informed care, least-restrictive, and all the principles that govern the work that they undertake.

In the way that the new facility will be designed, there will be capacity to have a very intensive, I suppose, high-dependency unit where your truly acute admissions will be able to be looked after in an environment that will encourage and support recovery and, I suppose, tranquilly in some ways rather than some of the chaotic nature that exists currently within Spencer Clinic because of the number of people who are just existing within a very small footprint. There will be that capacity with the open spaces, the ability to look out and to have rest and relaxation as well as clinical therapy and treatment and be able to provide for that in a step-down model.

In each of those sort of pods, if we're looking at that from a pod perspective, there will be high-intensity care that will then step down. It will be sort of like a transition from the highest intensity to the lowest intensity through to discharge. That will be enabled by the design of the new facility, whereas at the moment that's all sort of like mixed into the same - I know there's the separation of the high-dependency unit, but in recent times because of the demand, we haven't been able to run a separate high-dependency unit in Spencer Clinic. It's sort of very much an open unit where you're making the best of the environment - the situation.

Ms RATTRAY - Can I ask a supplementary, Chair, around that?

CHAIR - We will just wait and see if you'd like to add anything to how that care model has influenced your design work, and then we will move on to Ms Rattray.

Mr BURBRIDGE - A few of the big points that we looked at during the design is every individual bedroom with private ensuites, whereas Spencer Clinic doesn't have that currently; giving that dignity back to the consumers; making sure all the bedrooms have an outlook, whether it be onto the landscape or towards the back of the site or down over the front of the site to the ocean, also separating the back-of-house services from the inpatient unit. Currently, in Spencer Clinic, if you're delivering some stores to store rooms or stuff like that, you need to actually go physically into the unit. We're trying to - all those people who don't need to be in there, we're trying to keep them out. Big central back-of-house corridor that can access off the backside of the lift. People delivering stores, medication, whatever can do that without having to go into the unit itself; again, with all the maintenance of plant and equipment, doing that outside of the unit; just trying to reduce the amount of people that don't need to be in the unit.

Also looking at lighting, making sure there's lots of natural light into the unit itself. The acoustics was another big one. As you saw today, it was quite loud and a lot of stuff going on

in the lounge areas, so working heavily with the acoustic engineer to make sure the environment is acoustically nice, and not loud and noises going off everywhere. That was a big one, and then also giving choice to consumers, so having the multiple little lounges around the place; so if someone doesn't like what's on TV, they can take themselves off to another little lounge and get away. Someone's annoying them, they can remove themselves. And the sensory modulation rooms as well; if you want to go in and make it pitch black or colourful lights or music or whatever, you have a space to go and do that.

CHAIR - I gather from the design, with the care model, there's also different work areas. At the moment you have Centrelink people coming in to meet in an office which is shared by four different people: that was an example that was given this morning, or a social worker trying to negotiate quite private conversations with a client whilst having to share a workspace. Can you talk through what the new workspaces would look like for the staff?

Mr BURBRIDGE - Within the unit itself, there's one consult room and three interview rooms, so two interview rooms in low care and one in high care: interview rooms for exactly that. If you have a staff member who needs to be with the consumer, a nice quiet space to go and do it. We have a family room in the front-of-house lobby upstairs, so if staff members want to meet with family members to talk about something, there's a nice quiet space for that to happen. Dedicated tribunal room for TASCAT, dedicated meeting room for the staff members to do the handovers and all that sort of stuff. Then we have four offices, a mix of one-person and two-person offices, reception and then two lots of open-plan workstations for the staff members and then a dedicated staff room, which is purely a staff room. It won't have computers or anything in it, like their current facility does.

CHAIR - This morning on our tour, I believe Mr Harriss asked a question about the difference in the size of the proposed site as opposed to the current site. Do you have those dimensions?

Mr BURBRIDGE - The current site is about 950 square metres. The new build is about 2100, and then you have about 190 square metres of courtyard for consumers on top of that 2100.

Ms RATTRAY - A couple of questions, following on from the specialised and dedicated areas, and we did see some examples of lots of overcrowding and hot desking and probably hot chairing I expect this morning. Like the TASCAT, for instance, they wouldn't have a dedicated room that wouldn't be used for other purposes? You wouldn't have TASCAT coming up every week, I doubt?

Mr BURBRIDGE - I'm not sure of the frequencies -

Ms RATTRAY - They do?

Mr BURBRIDGE - but my understanding is if there's a hearing, they get priority over it, so they're first in.

Ms RATTRAY - But it's not solely for TASCAT?

Mr BANNON - TASCAT do attend the unit one day every week. They are reasonably good at just allotting a one-day timeframe, and for that period of time it is purely for TASCAT.

The design of that room does need to meet TASCAT specifications. That being said, when it's not in use by TASCAT, we do use it.

Ms RATTRAY - It will be used for other purposes: that was really a question. My question that I was keen to have some understanding is: the model of care that will be used in this new proposed facility appears to me will need additional staffing, and we heard this morning that staffing for such a specialised service of medical care is difficult on the coast. It's difficult everywhere, but it's even more challenging on the coast. Now I'm not a north west coaster, but I know we have one here. We're not sure why people don't want to live on the north west coast, but what's the thinking around that additional staffing needs?

Mr BANNON - Definitely. I think we've reached a point in the project now, getting closer to reaching the tender stage, where we're commencing what the workforce planning will look like. We know that it will result in an increase in need for FTE, not just of existing FTE, but also as an opportunity to create new positions. We've recently introduced lived-experience workers to our inpatient units, which has been a first in Tasmania, and we're also looking at roles such as Aboriginal health liaison positions, but I think the most important drawcard for us is going to be, with our recruitment and retention - is that this is a new purpose-built, truly contemporary facility.

We know that the environment that staff work in does have a significant impact on how they feel, and I think Spencer has done some incredible work in improving its recruitment strategy. We've gone from having, on average, around 10 agency nurses at any given time to now at around two, so there's been a significant improvement in being able to recruit and retain, and we think that bringing this piece of infrastructure online should only improve that.

Ms RATTRAY - You see the aesthetics of working in a new environment, and it's going to be a strong attraction for those specialised services to come to Burnie.

Mr BANNON - Not just the aesthetic, but the fact that it is purpose built. At the moment, our greatest asset at Spencer Clinic is our staff and our workforce. We cannot rely on the environment to support recovery and de-escalation. We're going to be moving to a facility that allows tools and resources to a workforce to be able to do the important work that they enter mental health services to do, that we're currently not able to support them to do in the current environment.

Ms RATTRAY - I hope you will understand that these questions come from - we've seen a lot of times across Tasmania where we have facilities, but we just don't have the appropriate staffing levels to facilitate what is required, so that's why I'm interested in this area.

Ms SCHOFIELD - We have a number of strategies that we're employing, I suppose, across the state. One is the peer workforce strategy that Jarrod has talked about. The other is increasing sort of right supports to the TTPs, the transition-to-practice, and looking at more effectively recruiting transition-to-practice graduates into mental health who come from the north west, and match need with demand, in terms of growing our own.

Ms RATTRAY - Yes, there were three in the lunch room this morning.

Ms SCHOFIELD - Yes, that's fantastic; and then ensuring that the staff feel supported to support that workforce coming through. As well, we now have a new strategy around allied

health practitioners - again, bringing in novice practitioners, or early-career practitioners, I should say, and growing our own is a very strong strategy that we have. We're not relying on interstate, but gaining that interstate experience where we need experience, but actually looking at supporting and growing our own as a culture. I think that's gone some way to increasing and decreasing our reliance on agency staff. In fact, we've had a number of agency staff who've joined our ranks permanently. In some ways it has surprised us because Spencer would be not the best thing to advertise, as it currently stands from an infrastructure perspective.

Ms BURNET - It would be good to know what sort of breakdown there is of psychiatrists, psychologists and so forth. I'm also interested in what other facilities helped with the design and how you compared the design?

Ms SCHOFIELD - The other thing that I'd just like to say, going back to that model, the model as well as the infrastructure was developed with consumers and carers. Their lived experience was at the beginning of those conversations and then being with us all the way through those conversations. I think it is important that a lot of this has come from what they have experienced and seen, and have said that they would like to see, in future development.

The other thing to say is that some of the model will look at how we use those resources more, perhaps, prudently as to where we need the experience in those high-care settings, and using peer workers more in the softer spaces that don't require so much clinical intervention, because the plans have already been developed and can be undertaken by others.

Mr BANNON - To further respond to your question about where we have sought precedent on other infrastructure builds: I know that within Statewide Mental Health Services, we sent a team across to Northern Health in Victoria to have a look at the new facility that's recently been brought online. We also have some strong connections with Queensland Health and we've had a number of virtual walkthroughs at Gold Coast. I will hand to Dee in the infrastructure team to talk about the procurement of the design team who do have some merit in recent mental health infrastructure projects.

Ms SIMMONS - Thanks, Jarrod. We have ARTAS as our lead designers, but behind them in clinical health planning we have BLP, who are arguably nation leaders in mental health design. Cam, you can probably speak better about projects that they've worked on, but they've definitely brought a lot of experience to the table in terms of health planning, clinical health planning. They're sort of up to date with all the new, I guess, technologies and ways of designing. They've brought a lot to the table; definitely, also having the Mental Health Lived Experience Tasmania and Mental Health Family & Friends Tasmania as part of our working group, they've contributed a lot from a whole different perspective of what's needed in these spaces. Cam, I don't know if you want to talk a bit more about BLP's -

Mr BURBRIDGE - BLP - lots of health infrastructure all over Australia, actually all over the world. One of their last projects, their mental health one was Campbelltown in Sydney. I think that's a four-storey mental health unit. Quite a big unit there. I think they also did the northern one in Victoria as well. They've done lots recently.

They have clinical health planners who are - the one on this project, Paul Longridge, is actually a registered nurse, a registered paediatrics nurse. He knows the AusHealth guidelines back to front. He gave some very useful insights into different facilities, how different facilities work, and pros and cons on all sorts of different facilities. He was involved in all the user group

workshops along with Jarrod and other project reference group members and the lived-experience workers.

Ms BURNET - Just the clinical mix of allied health professionals, psychiatrists and so forth for that kind of size facility, ideally.

Mr BANNON - It isn't going to be too dissimilar from a medical perspective from what we've currently got. It is only an increase in three beds, so that will be a small increase in FTEs. At the moment, we've currently got two SMPs who are our psychiatrists. Supporting them, we've got two registrars and a rotational RMO [resident medical officer], who is a junior medical officer. From a nursing perspective, on-shift, we currently work off nursing hours per patient day, which somewhat translates to around one registered nurse per four consumers. We'd be looking at around eight nurses per morning shift; afternoon shift would be the same and slightly less on an evening. That's the nursing disposition.

Ms BURNET - They're RNs [registered nurses]?

Mr BANNON - They're a mix of RNs and ENs [enrolled nurses]. We have around 30 per cent of ENs on any given shift that make up that nursing workforce. They're supported by what we currently refer to as attendants or healthcare assistants, who support on the unit, and then our allied health workforce is currently made up of one social worker with a part-time psychologist.

In no way do we consider that the current disposition of MDT [multidisciplinary team] is adequate. We would be looking to advocate for an increase in MDT disposition moving forward. There are a range of other supports onsite daily supporting. We've got a senior nurse, who is titled specifically as a discharge planner who you might have met today. We also have a RUSON which is a Registered Undergraduate Student Of Nursing. Again -

Ms SCHOFIELD - We're looking at expanding those.

Mr BANNON - Cat spoke about that entry-level opportunity for people who are undertaking studies but not yet registered, which is part of our succession planning. That's probably the current disposition. That being said, we would be advocating for an increase in some of those auxiliary supports, particularly in the Aboriginal health liaison space and lived-experience workforce.

Ms SCHOFIELD - They're supported by a specialty director, who sits across the north and north west in terms of a consultant psychiatrist as well as a director of nursing and a director of allied health to provide professional guidance, input and leadership.

CHAIR - Thank you. I have a quick question. Why is it that this facility won't be catering to paediatric psychiatry or geriatric psychiatry? Where those services - because the demand and the need is there - where would people needing that assistance living in the north west have to go?

Mr BANNON - I think it is important to state that this is predominantly an adult facility. It sits within my stream, within SMHS [Statewide Mental Health Services], which is within the adult spectrum. That being said, we have very much designed this facility to be able to cater for the needs of all consumers with vulnerabilities across the lifespan because the reality is that

on occasion we do need to admit and provide care to people that fall out of that adult range bracket.

That being said, there's a number of infrastructure projects being developed in southern Tasmania, particularly within the older persons remit, which will have an increase in beds. They are statewide facilities, in addition to an adolescent unit that will be available for north and north west consumers. We acknowledge that that's not preferable to take people out of region, but it is important that we do pull that specialty resource to be able to make it feasible moving forward. Importantly, this design is and will be able to care for those people who have particular vulnerabilities, i.e. geriatrics and people under the age of 18.

Mr HARRISS - When you mentioned design, I'd like to understand - and I appreciate that you've taken some data on notice around future-proofing - I'd like to understand with budgets and design, where do we start with numbers, I suppose? We've landed on a 22-bed project. I'd like to understand how that comes about from the start and whether it works back from future-proofing and data collected, or does it work from a budget and we go, well, this is what we can build right now and we will deal with the future projections later. Does that make sense?

Ms DOBSON - From a Masterplan perspective, the need is identified and it's a bubble on a page effectively to say this is where this precinct will be. We don't have a square meterage or anything like that. It's just a bubble on a page. Once we have the information from the health planning unit around the needs, that bubble then becomes however many square metres which a quantity surveyor makes an estimate at the master planning level to say approximately this budget, and that's the point where we go with the budget to the clinicians and say, well, what does the bubble look like when we iterate the design? That's the process. It's not perfect, and often if it's based on funding availability, then there are market-escalation pressures that come. In this case, we've been able to deliver or propose to deliver a facility that meets the briefing budget.

Ms SIMMONS - That sums up the process.

Ms RATTRAY - Chair, I'm interested to know where we're at. Are we up to project cost yet?

CHAIR - I think we're up to project cost. That's where I'm sitting.

Ms RATTRAY - In the past we've had an orderly process, but I think we've totally lost it. It has gone everywhere. But it's all good information. I want to ask in the project cost - and it talks about the updated estimate will be completed at the end of design development and the final cost estimate will be sought prior to releasing the tender - and I know that that can be a bit of a challenge because once people know what the price is, I think sometimes they get to that price pretty quickly without doing some of the other work. But that's only an assumption of mine. I don't have any facts around that.

There's a very small buffer in what's presented to the Committee and the money that's been provided, the $47 million. I'm interested in what happens - because this is not the final cost estimate, if that is my understanding. Do you want to help me work through that and how you will get to what you will be able to accept tender-wise? I don't need a figure; I just need to know what happens if it doesn't meet this cost.

Ms SIMMONS - I can speak from project perspective for that. The cost plan that we had at the time of this paper was a schematic design cost plan. We have since worked through detailed design, so we know exactly what's going on with the walls, where the windows will be, door handles, right down to very small details. From that cost plan to this cost plan, I'm personally quite confident that we're on budget in that we haven't crept the scope at all. The footprint has remained the same from schematic design through to end-of-detail design.

The schematic design cost plan has the contingencies for any details that might cost more than expected, but I'm fairly confident that the design team has done an excellent job of containing the scope within what we have in that schematic budget. So, confidence is high that we'll be on budget at the detailed design cost plan, which we will be receiving next week, hopefully. Then from there, from detailed design to pre-tender - the pre-tender estimates are more just a double-check that once the team has completed the contract documents, everything is as what we thought in the detailed design. It's rare, and it would be unexpected, that that cost would then increase significantly or there be any major surprises from detailed design cost plan to pre-tender, and then we hope that the contract's pricing is as expected.

Ms RATTRAY - Thank you, I appreciate having that information. I think it's important. I note the design and construction contingency - and the member for Huon would have worked out what percentage of the bill that would be.

Mr HARRISS - I do not have any notes here.

Ms RATTRAY - I rely on this honourable member to do that crunching of numbers because numbers are not my big strength.

Mr DUNNE - Just to add to that process, when we get to that gateway before we go to tender, it is a point that we can check to make sure that we are within the budget because if we were over in budget, we're not going to go out to tender because we know we need to then relook at either the design or other elements. That's why we engage a QS [quantity surveyor] through that process to ensure that it keeps our design team in check as well, and ensure that we maintain budget and we're refining that down, and that those contingencies become where we need them to sit before we do go out to tender. Obviously, the QSs that we're engaging can use the benchmarking against other similar-scale projects so that they can be consistent and we know that they're current, based on what contractors out there are currently pricing.

Ms RATTRAY - They get it wrong from time to time, I can tell you. I've seen it here, and there's not a lot of areas, whether it's some of the furnishings and the finishings that will be compromised - not compromised, perhaps won't be at the same level, if you like, and there's not much there to be able to make too many savings; maybe you can cut back the art in public buildings and put that towards the generator. Thank you for naming up the generator, although there's not much diesel kicking around at the moment, so you might have to look for something else to power it by. Thanks, Chair.

CHAIR - Thank you. Any more questions on the cost?

Ms BURNET - Yes, thank you. I'm curious because - I mean I'm just looking at the Billard Leece projects, and they look pretty amazing. If you can have a facility like some of these, then fantastic, but the price tag and scale look absolutely massive as well. I'm curious to

know if there is a standard for this kind of build in the Tasmanian context as to what you're likely to pay. Is there a quantity surveyor checklist so that you know you're going to deliver to that sort of project cost?

Ms SIMMONS - Yes. In terms of taking things like anti-ligature design and all the specialist type of design details that we put in for a mental health facility, yes, they benchmark against other mental health facilities. The costs of a mental health fit-out is quite different to, say, a cardiac ward or something like that, because there are different details, they benchmark it -

Ms BURNET - Sure, I understand that but is there -

Ms SIMMONS - They benchmark it against other mental health facilities, yes.

Ms BURNET - Right. So that's in Tasmania, or how does that work?

Ms DOBSON - We do have the Northern Mental Health Precinct, that the Committee will see in here tomorrow, there's a different quantity surveyor engaged for that project to this project, but we have received the cost plans and they are like-for-like as far as the square-metre costs for delivery; it's kind of that independent assessment as well.

Ms BURNET - Thank you. I'm just curious, we touched on the link bridge and that is part of Stage 2, but you said that you were doing some calculations in relation to adding that on as part of this?

Ms SIMMONS - Calculations in terms of structure and how to build, not so much to do with the costs. That's a separate project. We're working closely with the project team on the link bridge to make sure that the link bridge can actually be connected structurally, and in terms of buildability as well.

Ms BURNET - Because it could be quite a significant part overall with that connection with the hospital, could you describe how long that link bridge is likely to be?

Mr BURBRIDGE - I think it's around 100 metres, but that's just based on where it's drawn on the Masterplan. The final route hasn't been worked out yet, so that might change.

Ms BURNET - What's the height difference from the current North West Regional Hospital to the proposed acute facility?

Mr BURBRIDGE - The current North West Regional Hospital to the ground floor on our facility is about eight or nine metres height difference.

Ms BURNET - Okay. So there would be significantly difficult engineering to consider, with 100 metres in length.

Mr BURBRIDGE - Yes. I would imagine there would need to be a couple of lifts involved in it to get up there.

Ms DOBSON - The design currently is a lift, or an extension of the lift, in the current lift lobby of the main entry, and then into the inpatient unit and then another lift up to achieve the height of the first level of the mental health precinct.

Ms BURNET - It sounds like a significant build and a significant cost associated with that. I suppose it's a problem with a large footprint well away from the rest of the hospital. I have a question for you, Ms Schofield: in relation to code blues and for emergency purposes for staff safety and so forth, so code blacks, what kind of risks have been considered in relation to that and this build?

Ms SCHOFIELD - I would say quite significant risks have been considered, which is why we lobbied very heavily to ensure there was linkage, because we were acutely aware of the risks of not being connected. It is unfortunate that we have to mitigate, from the completion of this build to the completion of what we see as part of an essential component - from managing, as you say, the code blues and code blacks. We are looking at mitigation strategies and ways of working to accommodate that once this building is commissioned, knowing that we will get a better solution at some point in the future.

Ms BURNET - Do you have an ideal width for a link bridge, as well? I'm curious to know: are there intrinsic risks with a corridor such as this, in relation to safety and so forth, the likely width, as well as any of those other things to consider?

Ms SCHOFIELD - Can I just say that some of the infrastructure, in terms of width, must be prescribed in the same way through the guidelines, the same way as rooms would be prescribed in terms of what's required. Other facilities operate very well with a link bridge with a separate facility and we visited one, or your team visited one in Melbourne where they have a very nice separate mental health facility but linked to the acute-care hospital. So it does work; it does mitigate some of those safety issues. With the transport of any consumer there comes a risk when you're moving somebody from one area to another, but we can't avoid that because of how the health system is set up that people are assessed in one place and then taken somewhere else. We will endeavour to do as many, I think, direct admissions to this facility. That will be a major component of the model of care. At the moment, the majority of admissions come through the emergency department. We will endeavour to ensure that's minimised and so those transfers backwards and forwards will be -

Ms BURNET - It is quite difficult to envisage - if we compare it to the bridge linking the Wellington clinics across Argyle Street to the main Royal Hobart Hospital campus. It's a very short distance and I'm not sure whether that's a standard width that has been considered - but perhaps if you don't know the answer, you could take it on notice.

Mr BURBRIDGE - A standard hospital corridor width is 2.4 metres, so it wouldn't be any narrower than that. I would imagine it would be wider than that.

Ms BURNET - Okay, and so no idea of how much that kind of kit would cost?

CHAIR - Talking about the Masterplan, we learnt today that firstly the helipad has been contentious because of the closeness of that to the proposed facility. It's my understanding in the Masterplan that that helipad may be moved at some stage in the future. Can you talk us through that and then also mitigation around the noise and the reverberation from the helicopter and how you can lessen the impact of that on the proposed facility?

Ms DOBSON - I will talk to the location. Part of the Masterplan is to relocate the helipad to on top of the current ED. I think it's Stage 5, but I might need to come back and check. That doesn't pose an issue as far as flight path currently by leaving it to the final stage. The constructability: we will have to make considerations and work with Ambulance Tasmania during construction because there will be cranage etc. We have precedent to enable that and stand down the cranes to allow for incoming and outgoing flights. I will pass on to Cam.

Mr BURBRIDGE - The current building is outside the obstacle limitation area of the helipad. But as Rachael just said, during construction, there will be cranes and trucks and stuff that potentially will be in that opposite limitation area, so just need to be ongoing consultation with the helicopter operator during construction. It is the same thing that ARTAS did for the Mersey Hospital when they were building that. The construction compound was actually underneath the helipad there, and there was a stern protocol in place that when the helicopter was coming in to land, the builder would have to do various steps to make sure it was secure before they could land and they get notified a certain time before the helicopter was coming in. I imagine it'd be the same.

Ms RATTRAY - Wouldn't the Mersey helipad be just as close as what the one here is? So what's the problem?

Ms DOBSON - It's more the sound and the vibration needs to be assessed for incoming and outgoing and the uplift to the air when flights come and go. It is a considerable amount of planning that goes in to determine what the flight path is.

CHAIR - Is it also potentially problematic because of the nature of the facility being close to a helipad landing and that that may be stressful? Can that be mitigated with design?

Mr BURBRIDGE - Yes, we're working with the acoustic engineer the whole way along the process to both make sure the internal sound reverberation in the space is nice and the sound between different areas is limited and the sound from outside - the helicopter - is limited as much as possible. It is a bit difficult to design out helicopter noise because it's not a static point. It's over there, then it's 200 metres away. We have been working with an acoustic engineer to try to mitigate that as much as possible.

CHAIR - Can we ask on the record the frequency of landings and take-offs of the helicopter or the usage of that currently at the site and what that's projected to be?

Mr DUNNE - We can get that data.

Mr HARRISS - Just to go back to the link bridge - you mentioned that it was in design stage at the moment. This project's down for an early 2028 completion. Do you have a rough timing on the link bridge completion at the moment?

Ms DOBSON - It's subject to funding.

Mr HARRISS - Sorry, funding was approved? I'm just trying to understand the difference between completion of this one and then the link-up with the bridge if - maybe not in a perfect world, but in a funded world -

Ms DOBSON - in a funding approval and progressed through design -

Mr DUNNE - Well, I guess that's what we're working with; the budget that's been allocated at this point in time to progress the design as far as we can to ensure that we're trying to limit that gap between, obviously, starting the link bridge and having the completion. In terms of a locked-in date, obviously it's really hinged on the funding. If we're ready for design, we can then progress into that delivery space a lot faster than actually waiting for the funding. That's the current intent.

CHAIR - Can we move on to page 10? Does anyone have any questions before page 10? I'm just mindful of time. I had a quick question around bariatric beds; whether the site will cater if you want to do that.

Ms SIMMONS - We have what we call special bedrooms to cater for that.

Mr BANNON - From a mental health perspective, obviously, there's a risk associated with the functionality of bariatric beds. I think for within those particular rooms, we've ensured that we've got door width to allow a roll-in bed that could be stored somewhere else within the facility. It wouldn't be a permanent fixture, but again, being able to provide care to people with those vulnerabilities is our commitment.

CHAIR - Wonderful. Any questions on page 11?

Ms BURNET - Just to go back to that back-of-house facility, which I think is one of the features. That's on the car park level, isn't it?

Mr BURBRIDGE - There are two. Car park level there are some backhouse store rooms, comms room, couple of store rooms, dirty loading dock, clean loading dock, and the ambulance bay. On first floor is the rest of - the ground level will be for the items that are used less frequently. The first floor is for the items that are used more frequently; medication room, clean store, cleaners room, dirty utility, general store, patient property store are all up there. They're all off that back-of-house central corridor. If a member of staff needs to access it, they don't need to access the whole inpatient unit. They can just come up and access any of those store rooms as needed.

Ms BURNET - I can't see this on here which should be quite clear. I can see front-of-house, but I can't see back-of-house.

Mr BURBRIDGE - It's the yellow corridor just to the top side of the lift.

Ms BURNET - I see. Right. It's basically quite close to the lift anyway. Coming up -

Mr BURBRIDGE - You just go straight out of it. You come out of the lift - the lifts are double-sided lifts - you would go south - you go north out of the lift at the front-of-house lobby, and if you go south out of the lift, you're in the back-of-house corridor, which obviously is swipe card access, so staff only out the back.

Ms BURNET - Essentially, you're coming up from below for that if you're providing services from elsewhere? Coming up from the basement level?

Mr BURBRIDGE - Yes.

CHAIR - Any questions on page 11?

Ms RATTRAY - Thank you, Chair. Just in regard to the required upgrade to electrical infrastructure into the existing substation - the Burnie Ambulance Station obviously had an upgrade, so there's going to be another upgrade. Has there been some engagement with TasNetworks?

Ms SIMMONS - Yes, we have already begun engaging with TasNetworks. Yes, it's a cost-efficient way of connecting into that one, rather than having to do a whole new system, essentially, for this building.

Mr BURBRIDGE - The substation itself has capacity. It's just upgrading the circuit breakers within the substation to give the extra capacity to mental health. It's not a whole new substation; the substation already has capacity, it's just accessing that capacity for the mental health building.

Ms RATTRAY - Right, okay. Just a little bit of advice from somebody who's been around far too long: get it in writing - your quote - because it won't stay the same if you don't.

CHAIR - Page 12.

Ms BURNET - I have another question around the consolidation of car parking over the site. There was going to be more car parking below the building, but what's the overall plan? It is something that was brought up with me today, in relation to parking on the site. It's a vast site as well, so for people who might have some sort of physical disability, it may be difficult to get from one side of the site to the other. Is there a plan to consolidate the parking in the longer term?

Ms SIMMONS - Consolidate - do you mean make dedicated parking just for this unit?

Ms BURNET - No. Well, obviously you're not putting all the car parking underneath the proposal, as proposed. There is a lot of spread-out car parking, so consolidating, more generally, as part of the Masterplan.

Ms SIMMONS - Car parking for the Masterplan is in various stages, is my understanding. There will be additional car parking delivered as part of Stage 1 as well. Then, I think there's an additional three or four more car parking spots as part of the Masterplan. I think it's important to note that, for this building, we are providing additional spaces to service this building.

Ms BURNET - Okay. I will ask the question again: is there any chance that there might be consolidation of car parking - i.e. stacked parking, so that there's, again, not having to travel or walk too far from your car, for argument's sake, to one of the facilities inside?

Ms DOBSON - We've taken on notice the number of car parks that are to be identified within the Masterplan, so we will provide that to you. I don't have anything, I guess, in addition to what Dee has said, around the delivery of additional spaces across multiple stages of the master plan implementation. We do need to be compliant in each of the projects. They're

submitted to council and they have regulations around the number of spaces, including the DDA [Disability Discrimination Act], or the accessible parking. So as previously mentioned, there are two for this precinct, and future builds will also need to be required to deliver those as well.

Ms BURNET - While we're on parking, just in relation to futureproofing and EV [electric vehicle] parking, is there any likelihood that this has been considered in this part of the development or beyond, in the master plan?

Ms DOBSON - We currently have a project that is delivering two EV spaces for each of the hospitals, or four different hospitals, around the state, including North West Regional, so that would be available. Any future multistorey or car park-specific projects will have EVs. There's a project happening in the multistorey in Launceston that has multiple EV points as well. So, yes, it's a different part of the design and delivery.

Mr BURBRIDGE - There will be no EV parking underneath this building, because if you do that, it increases a lot of fire requirements. It has a lot more requirements for fire sprinklers and detectors, and a cost impact with that as well. If there were EVs for this one, it would be located in the car parks outside.

Ms RATTRAY - Okay. That would encourage the staff to get to work early. Plugged in.

CHAIR - Shall we move on to page 17? Are you quite confident with the dates that have been placed down on the project timelines? Do you want to run through any concerns, or where you actually think that there's good reason to believe that this is accurate?

Ms SIMMONS - I am confident with these timelines. So far we've hit the milestones that we've been aiming towards. We're currently anticipating an 18-month construction schedule. Obviously, until we actually have the contractor on board and a detailed construction schedule, we can't guarantee that, but I feel like 18 months gives us a bit of room. It could be shorter, but we don't anticipate it being longer.

CHAIR - From a clinical perspective, can you give us a really brief insight into the move from the current facility to the proposed facility and decanting both, and what that may look like?

Mr BANNON - We're really fortunate that this is a new build on a greenfield site, so there's no need to stagger or phase that transition. We will be procuring an entirely new suite of furniture and furnishing, so I guess Cat and I as executive leaders would be looking at the implementation and transition process, and developing a really robust plan with additional resources from an internal project perspective to facilitate what that looks like. We imagine that will be over a period of time, particularly given the need to have some familiarisation with a lot of new functionality and technology that we've not currently got access to. We would have a full and complete orientation and onboarding to this new facility.

CHAIR - And to maintain that continuity of care as you're moving from one to the other.

Mr BANNON - Absolutely. There will be a need for a strong piece of consumer engagement there to support the consumers with what would be quite a confusing transition, if you're in a period of unwellness, to be in one facility in one moment and then supported to a

new facility. We will certainly engage with our lived-experience workforce to support with that.

Ms RATTRAY - It is Ms Simmons's first hearing today and I said we'd go easy on her, but there's a glaring omission in your project timelines. There's no reference to this Committee. Now we're starting to get a bit of a complex about that we're an afterthought, so I'm just wondering, is that a mere oversight, Ms Simmons?

Ms SIMMONS - It certainly is. I can guarantee it's in our detailed project plan.

CHAIR - She's feeling bold.

Ms SIMMONS - This is just a snapshot.

Ms RATTRAY - I promised you I would go easy. For the public record, Dee and I are related.

Ms SIMMONS - We didn't have the liberty of the Committee's availability also, so we don't identify that until you let us know.

CHAIR - Page 18 - questions?

Ms RATTRAY - Major risks, and I note that one of the risks is community and local stakeholders, and you've already indicated that they weren't necessarily too happy about the original build height. Is that all? There is no more negative public input, or is that not quite the case? I mean, there will be some disruption. It happened when the ambulance station was built. I recall that people don't like their lives interfered with in any way, shape or form, often. So is there any potential for some negative -

Ms SIMMONS - There's always potential, but we take means to try to mitigate that. We've had two major rounds of community consultation. In our last round we didn't receive any negative feedback, and as we head into construction, we will then implement the next round of engagement. We actually have the personal contact with those residents along Bridport Road there, so we know them by name, and we will give them tailored personal communication along with broader community information as we head into construction.

Ms RATTRAY - Thank you.

Ms BURNET - In regard to the budget, and that's clearly a risk in the current climate, what are the concerns that you have in relation to the budget of the project and deliverability of the project?

Ms SIMMONS – North west Tasmania is a limited contractor market. That's a very real risk and we've already begun market sounding, reaching out to the available contractors and making sure that they're interested in tendering. As we get closer to the time, we're obviously keeping an eye on some other major construction projects in the north west of Tasmania. We're mitigating the best we can through market sounding and early engagement with contractors.

Ms BURNET - Okay. Then there are world shocks that you can't really necessarily predict, although they seem to be coming pretty rapidly at the moment. On the page before, there are specific building contractors that DPAC engages with or helps engage with.

Ms SIMMONS - We have a panel. Because this project - we're anticipating - will cost around $30 million in construction, it opens us up to a larger panel - once you get over the next value it's more limited. We do have between 10 and 12 contractors already pre-approved to that level, so we have a wider availability than if the project was higher in value.

Ms BURNET - Okay, thank you. In relation to sustainability strategies to be adopted, you talk about a 60 per cent reduction target across departments by 2050. Can you describe what fundamental things you're going to be putting in as part of this project?

Mr BURBRIDGE - The first one is solar panels on the roof to help reduce energy consumption. LED lights throughout and insulation to meet all the section J requirements for walls, ceilings, and under floor. Double glazing, if not triple glazing. Basically, all the consumer bedrooms, all the areas consumers can be left alone in, they have actually ended up being triple-glazed windows. We can conceal the blinds behind a window so the consumers can't get to the blinds. Instead of double, it becomes triple glazing, which helps with the thermal there as well. Double glazing everywhere else. Light-coloured roof to help reflect and stop the hot solar heat gain into the building. The selection of all the plants, the air-con units, mechanical units, hot water, and all that sort of stuff.

Ms BURNET - Okay. That would be fairly highly rated, would it, in relation to that response to energy efficiency?

Ms SIMMONS - It's different for commercial buildings. We don't have the same sort of residential star ratings.

Ms BURNET - I understand that.

Ms SIMMONS - Things like the mechanicals - it's more about the zoning and the efficiency in terms of the different zones -

Mr BURBRIDGE - Yes, not having an air-con zone that spans across the whole width of the building, for instance, so you don't have half the zone on the southern side and half the zone on the northern side because the air-con will be fighting itself constantly. Zoning them appropriately around the building to work with orientations and work with how the pods and all that sort of stuff work to make sure they're efficient as possible.

Ms BURNET - You did say that there are solar panels. I can't see that listed here, but I presumed that it was probably the case.

Mr BURBRIDGE - Yes, there's a zone on the big roof for solar panels to be installed.

Ms RATTRAY - If you have triple glazing, why would you need awnings to external windows?

Mr BURBRIDGE - To stop some of the sun coming in as well, so it's more for -

Ms RATTRAY - You have blinds on the inside and triple glazing and then you're having awnings to external windows?

Mr BURBRIDGE - Yes, you can have your blind open and still look outside but you don't necessarily have direct sunlight coming into your bedroom.

Ms RATTRAY - Would you say that it is over the top?

Mr BURBRIDGE - No, I wouldn't like to be looking through a blind all day if there's sun coming through my window without a blind or without an awning on the outside. I prefer to have the awning on the outside and not be looking through grey blinds.

Mr DUNNE - The best practice to manage shading is to do it externally first before you treat the glazing. Always external is the priority first and then you work your way in within the building, so it's always a benefit to treating and controlling the shading externally.

Mr BURBRIDGE - It also gives the consumer the maximum amount of control. Some consumers might want to have the blind down or blind up. We give them the options.

CHAIR - Any questions on page 20? I dare say we've asked a lot of these questions already.

Ms RATTRAY - We are well ahead of ourselves, Chair.

CHAIR - We are.

Page 21?

Ms BURNET - When you did the community engagement or stakeholder consultation, do you think there was a good amount of input from various stakeholders? I'm not sure who I'm asking.

Ms SIMMONS - Definitely the first round received strong input from the community. Also, staff had input.

We can take that from the next round - the level of engagement reduced, so we can take that as a positive that people felt heard and didn't feel like they needed to keep saying things. I believe that's a positive outcome.

CHAIR - Ms Burnet, do you have any more questions on page 21?

I have a question. Is the design for human service delivery inclusive of recommendations by the Mental Health Integration Taskforce? I believe that's what triggered this project.

I believe that taskforce was in 2019, if I'm correct.

Ms SIMMONS - It definitely informed the functional design brief from the beginning and then it's progressed from there in more detail with the more focused live group.

CHAIR - I believe that with tomorrow's project we will be applying some scrutiny to is also part of the recommendations of that taskforce as well.

Any further questions on page 21?

Page 22, I had a question on the planning approvals that states:

> Conditions applied to the development within this permit will be reviewed and incorporated into the design to ensure compliance is achieved.

And there was a development approval application submitted to Burnie City Council on 24 November. Is that process complete and did you have to make any modifications?

Mr BURBRIDGE - No, it's still ongoing. There have been some RFIs [request for information] back from the council and TasWater. They have been answered and sent back to the council. It's now sitting with the council to chase up TasWater to see if those responses are adequate to their questions and then the council will continue with their processing of it.

Our planner has been chasing up regularly with council to make sure that it's still progressing and not stalled anywhere.

CHAIR - Were they significant issues that were raised that could halt this project?

Mr BURBRIDGE - No, they were just clarifications around some footpaths connecting to the building, some gradients, the exact connection point for stormwater into the TasNetworks network. Nothing major, just some clarifications and extra information they wanted on the documents.

CHAIR - We didn't ask the question around the landslip. The landslip was raised a few times within the report. Can you just talk us through very briefly around what some of those concerns may have been or may be around landslip and what steps you've taken to ensure that it's not going to be prone to landslips?

Mr BURBRIDGE - The site is - part of the building is just on the edge of a landslip zone. I can't remember if it's category zone 1 or zone 2, but the civil engineers who have engaged with a geotechnical engineer to do - we've done two rounds of boreholes to test what's under where the site is to get the information on the subsoil. That's all been given to the structural and civil engineers so they can design the appropriate footings and retaining walls to meet the requirements the geotech has set out for us.

CHAIR - Thank you. Any further questions on page 22? Any further questions on page 23? I think we've asked a lot of these already. We have the mats - did you have any questions on the mats at all? Any further questions from the Committee? I think we may be ready to go to deliberation now so that we can scrutinise the information that you've kindly provided us today.

Before you leave the table, I'd like to reiterate the statement I made earlier about committee proceedings. 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 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. They are standard Public Works Committee questions to which you can just answer yes or no.

For the record, does the proposed works meet an identified need or needs 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 - Are the proposed works a good use of public funds?

WITNESSES - Yes.

CHAIR - Thank you very much for attending and giving evidence. We shall conclude the hearing for today.

The witnesses withdrew.

The Committee adjourned at 3.34 p.m.