2026 (No. 11)

PARLIAMENT OF TASMANIA

PARLIAMENTARY STANDING COMMITTEE ON PUBLIC WORKS

Northern Heart Centre

Presented to Her Excellency the Governor pursuant to the provisions of the Public Works Committee Act 1914.

MEMBERS OF THE COMMITTEE

Legislative Council	House of Assembly
Mr *Harriss (Deputy Chair)*	Ms *Butler (Chair)*
Ms *Rattray*	Ms *Burnet*
	Mr *Shelton*

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1 INTRODUCTION

To Her Excellency the Honourable Barbara Baker AC, Governor in and over the State of Tasmania and its Dependencies in the Commonwealth of Australia.

MAY IT PLEASE YOUR EXCELLENCY

The Committee has investigated the following proposal:-

Northern Heart Centre

and now has the honour to present the Report to Your Excellency in accordance with the *Public Works Committee Act 1914* (the Act).

2 BACKGROUND

2.1 This reference recommended the Committee approve the construction of a new facility located within the main campus of the Launceston General Hospital (LGH), to improve access to healthcare for northern Tasmanians suffering from heart disease.

2.2 The Northern Heart Centre will be funded entirely by the Australian Government through a Federal Funding Agreement, with a commitment of $120 million towards the proposed works.

2.3 The *Long-Term Plan for Healthcare in Tasmania 2040* identified gaps in cardiac medical and surgical services. The Northern Heart Centre is part of a broader effort to address these gaps, while also aligning with the recommendations from the *Statewide Cardiac Cath Lab Capacity Planning Clinical Engagement Report 2023* and the *Tasmanian Cardiac Strategy 2025*.

2.4 Tasmanians from the north and north west coast have the highest incidence of cardiovascular events in a non-Aboriginal population in Australia, with chest pain being one of the most frequent presentations to the emergency departments of the LGH, the North West Regional Hospital (NWRH), and the Mersey Community Hospital. The gaps in access, infrastructure, and workforce in this region, as well as the projected increase in demand for cardiac services, has led to a critical need to establish a purpose-built, accessible cardiac facility.

2.5 Current cardiac services at the LGH lack adequate capacity, storage, and clinical functionality, which limits the ability to expand services such as coronary care, electrophysiology, and outpatient diagnostics. These constraints compromise patient experience, staff workflow, and the ability to deliver contemporary models of care.

2.6 The Northern Heart Centre will consist of four floors, with the first floor at the same level as level three of the LGH. The site is located to the south on Frankland Street. The building envelope is approximately 980 metres squared, with an approximate total floor area of circa 3,750 metres squared.

2.7 The proposed works will include the following:

- The creation of a new coronary care unit (CCU) featuring 18 inpatient cardiac ward beds and six CCU beds (24 beds in total);
- The establishment of two cardiac catheterisation labs equipped with dedicated recovery and holding bays, allowing direct access for patients requiring procedures without needing to go through the Emergency Department;
- Provision of dedicated diagnostic testing facilities for echocardiography and outpatients services, including five echocardiography testing rooms, one exercise testing room, and six outpatient consultation rooms; and
- Direct access to the Intensive Care Unit (ICU), the Emergency Department (ED), and medical imaging services.

2.8 The Northern Heart Centre will significantly reduce reliance on interstate transfers and improve timely treatment for time-critical cardiac events.

3 PROJECT COSTS

3.1 Pursuant to the Message from Her Excellency the Governor-in-Council, the estimated cost of the work is $120 million.

The following table details the current cost estimates for the project:

ELEMENT	ALLOWANCE (EX GST)
Authority & Headworks Charges	$1,080,000
Authority Charges (Contingency)	$50,000
CoL – Frankland St Closure Fees	$912,000
Underground Asset Contingency	$1,000,000
Tasmanian Health Services (THS) Staff Costs	$2,020,000
Project Manager	$1,237,115
Lead Design Consultant	$6,720,806
Lead Design Consultant (Pneumatic Tube System (PTS))	$150,000
Stakeholder and Community Consultant	$429,640
Quantity Surveyor	$290,000
Superindendent	$600,000
Consultant Fee Contingency (program prolongation)	$1,000,000
Project Specific Trade Works – Heart Centre	$50,536,000
Project Specific Trade Works – Level 1/2	$1,956,000
Level 2 Allied Health Carpark	$606,000
Franklin [Frankland] St (External Services)	$24,000
External Services	$794,000
Sequencing/Staging Allowance	$1,617,000
Design Contingency	$1,943,000
Cost Escalation Contingency (to start)	$3,161,000
Cost Escalation Contingency (to finish)	$6,367,000
Asbestos Contingency	$500,000
Department of Health (DoH) Contingency	$2,400,000
CCTV Storage Allowance	$500,000
Contract Contingency	$5,026,000
Medical Equipment Group 1 items	$4,000,000
Medical Equipment Group 2 and 3 items (HC)	$7,837,000
Medical Equipment Group 2 and 3 items (L1/2)	$314,000
CT Disruption Allowance	$4,032,000
PTS Replacement Allowance	$500,000
NHC/NMHP Link Bridge Allowance	$3,750,000
Enabling/Disruption Works (Contingency)	$1,000,000
Audio Visual/ICT (Heart Centre)	$5,553,000

Audio Visual/ICT (L1/2)	$209,000
Public Artwork	$80,000
Legal	$100,000
TOTAL	**$118,294,561 (Ex GST)**

4 EVIDENCE

4.1 The Committee commenced its inquiry on Wednesday, 4 February 2026 with a site inspection of the proposed works. The Committee then returned to Room 2, Launceston Library High Street Centre, Launceston, whereupon the following witnesses appeared, made the Statutory Declaration and were examined by the Committee in public:-

Proponent

- Fiona Lieutier, Chief Executive Hospitals North, Department of Health;
- Simon Dunne, Director, Programming and Delivery, Department of Health;
- Rachael Dobson, Senior Project Manager, Programming and Delivery, Department of Health;
- Adam Martin, Project Manager, Infrastructure Services, Department of Health;
- Dr Matthew Lee-Archer, Director - Department of Medicine (Cardiac Services), Launceston General Hospital, Department of Health;
- Dr Paul MacIntyre, Clinical Director Acute Medical, Royal Hobart Hospital, Department of Health; and
- Alisdair McPhee, Architect and Lead Design Consultant, ARTAS.

The following Committee Members were present:

- Ms Jen Butler MP (Chair);
- Hon Dean Harriss MLC (Deputy Chair);
- Ms Helen Burnet MP;
- Hon Tania Rattray MLC; and
- Mr Mark Shelton MP.

Overview

4.2 Mr Adam Martin, Project Manager, provided an overview of the proposed works:

> ***Mr MARTIN*** *- …The proposed Launceston General Hospital Northern Heart Centre is a significant initiative aimed at improving health outcomes for northern Tasmanians suffering from heart disease. Funded entirely by the Australian Government through a federal funding agreement, the Australian Government has committed $120 million towards the establishment of the Northern Heart Centre.*
>
> *The project is part of a broader effort to address the gaps in cardiac medical and surgical services as identified in the Long-Term Plan for Healthcare in Tasmania 2040 and is aligned with the recommendations from the statewide Cardiac Cath Lab Capacity Planning Clinical Engagement Report 2023, otherwise known as the Cardiac Report, and the Tasmanian Cardiac Strategy 2025.*
>
> *Key components of the project include the creation of a new coronary care unit featuring 18 inpatient cardiac ward beds and six coronary care unit (CCU) beds. There are 24 beds in total. The establishment of two cath labs equipped with dedicated recovery and holding bays,*

allowing for direct access for a patient requiring procedures without needing to go through the emergency department; provision of dedicated diagnostic testing facilities for echocardiography and outpatient services, which will include five echo-testing rooms, one exercise testing room, and six outpatient consultation rooms. Also there's direct access to ICU, the emergency department, and medical imaging services.

Need for the proposed works

4.3 Dr Paul MacIntyre and Dr Matthew Lee-Archer provided evidence on the prevalence of heart disease in the north and north west of Tasmania, and how the proposed works will address the current gaps in cardiac services in this region:

> ***Ms RATTRAY*** *- … A submission from the Heart Foundation talked about people living in the north and north west having a higher rate of heart disease than anywhere else in the state. I think, for the public record, it would be really good to have an understanding of if there is any rationale behind that and, obviously, this particular project will have a positive benefit on that, is what I'm expecting.*
>
> ***Dr MacINTYRE*** *- Absolutely. The north west of Tasmania, you see, has the highest incidence and prevalence of cardiovascular disease in the state and, except for some Indigenous communities, is probably up there in Australia. The reasons for that would be about the level of cardiovascular risk factors in that environment, plus the genetic component where people living with heart disease pass on that genetic present to the offspring.*
>
> *The other thing that you're alluding to is, I suspect, around equity of access to cardiac services for people from the north west of Tasmania. There are definite barriers to us getting timely care to these patients suffering from acute coronary syndromes and other complex cardiac conditions. There's a geographical component to that. There is also a model of care component to that, which we hope to address within the project. We see the Northern Heart Centre as unlocking the issues around equity of access for the north west of Tasmania, and that includes the Mersey Hospital and North West Regional Hospital in Burnie.*
>
> *We see the Northern Heart Centre as being the nucleus of a northern hub of cardiac services that is integrated across the northern corridor. There will be a southern hub, but the northern hub will consist of those three hospitals and there will be outreach facilities into the north west from the Northern Cardiac Centre. There will also be much better access to acute interventional services as a result of this build.*
>
> *To take you back - I may be going too far - to how this came about, we commissioned an independent external report that was conducted by Professor Andrew MacIsaac, who was the previous Chairman of the Cardiac Society. He came from St Vincent's in Melbourne with very much a public sector focus. Myself and others were involved in that review, and we toured Tasmania looking at cardiac services, trying to work out what was required for the future. He visited Launceston as part of the group and we interviewed a whole variety of people.*
>
> *We went on the patient journey from ED through to the cath lab and the first comment was that he was absolutely appalled with the infrastructure that the current cardiology group were working in and delivering, in some cases, very good services, particularly around the cath lab activity which had been set up over a number of years, but recognised there were major gaps in the service and that we weren't delivering the broader range of cardiac services from LGH. There was no dedicated cardiac ward and there were various issues around the model of care being delivered in that current environment.*
>
> *He produced a report which was submitted to the Secretary of the Department of Health and the Health Minister and the Premier. I'm sure it's not news to you that that report was not released publicly. The understanding behind that was that the public confidence would be diminished for the current service. Instead, it was turned on its head, which I think was the*

correct decision, focusing on the very positive recommendations that have been incorporated into our cardiac strategy, which was published last year, and that's what we're now trying to implement.

The Northern Heart Centre is a key component of the deliverables within the capex strategy. We were incredibly fortunate to get federal government funding. There was a point where I thought it was not going to happen, but fortunately we have the money that we need to build the Northern Heart Centre. It's an absolutely key development for heart disease in the north of the state.

…

***Dr LEE-ARCHER** - … I'm very excited about this project because there's such an incredible clinical need because of the prevalence of heart disease, and it really is important for equity of access for all our people in the north and north west.*

4.4 Dr MacIntyre provided further evidence on the causes of such a high prevalence of heart disease in the north and north west:

***Ms BURNET** - … Why do we have such a high incidence?*

***Dr MacINTYRE -** The major risk factor for cardiovascular disease is social deprivation and we've got higher levels of social deprivation in Tasmania than we have in most other states. Obviously, there's pockets on the mainland, but we have a very high-level of social deprivation. That is, the social determinants of health drives cardiovascular risk factors, drives cardiovascular disease and increases the incidence and prevalence of cardiovascular disease. I suspect there is a genetic component. We went to Agfest last year to do cardiovascular risk screening with the Heart Foundation….*

We measured cholesterol levels, measured blood pressure. The incidence of hypertension and the incidence of hypercholesterolaemia was unbelievable in that population. I would probably suspect that access to primary care services is also an issue in terms of prevention of coronary heart disease, and the overall investment in upstream prevention is significantly deficient, but it is a geopolitical issue in terms of social deprivation, and how do you turn that around in a modern world.

Benefits of the proposed works

4.5 Having discussed the need for the Northern Heart Centre to address the current gaps in cardiac services, the Committee sought further evidence on how the proposed works would alleviate pressures on Emergency Departments (EDs) and reduce the need for patients to travel interstate:

***CHAIR** - … hopefully that will also provide some relief for the ED with representations; is that correct?*

***Dr MacINTYRE** - Yes, depending on the model of care. We'd be looking to bring patients straight to that facility and bypass ED. I think that would be a major achievement because of an increase in capacity and an improvement in the model of care, the idea of ambulances coming straight to the Northern Heart Centre with patients who need to go to the cath lab. It will fast track that process.*

***CHAIR** - There will also be, I understand, less of a reliance on that interstate travel that patients may have to currently use…*

***Dr MacINTYRE** - Absolutely.*

CHAIR *- That should minimise costs, but it's also much better for those patients if they can be treated in a timely fashion here; is that correct?*

Dr MacINTYRE *- Correct.*

CHAIR *- Can you run us through what that looks like from clinical care?*

Dr MacINTYRE *- You're talking about transfer of patients predominantly to Melbourne. That happens because the services cannot be provided locally and therefore there is a desire to send patients to Melbourne. It's about trying to develop, or to address the gaps in the level 5 services, such that they don't need to be sent elsewhere. There are significant gaps in the current service in the north of the state. A lot of that traffic at the moment is coming from private providers, who are then going privately to Melbourne.*

However, you will be aware of the patient transport assistance scheme (PTAS) - we cannot fund patients to go to Victoria if we can provide the service here. It's really about filling the gaps in and the services that are missing in the north, in the broader sense, not necessarily intervention.

There will always be a small number of services that we can't provide in Tasmania and that will have to go to Melbourne, such as heart transplants, as the obvious example. There are other complex things that they do as a high-volume centre that we should not be doing in Tasmania and should be sent, but the idea would be to minimise that flow.

I think that what you might see is a rebalancing of the public/private cardiology services in the north of the state. We are very keen that public patients who cannot afford to go privately are treated within the public hospital in Tasmania, and there's an adequate service provided so that they don't have to, and are not forced to, go privately for access issues.

4.6 The Committee also heard evidence on how the proposed works would reduce bed-block:

CHAIR *- … Fiona, could you speak to how, once operational, the Heart Centre may help reduce bed-block within the Launceston General Hospital?*

Ms LIEUTIER *- … we're going through a two-stage process at the moment which hopefully will decrease the bed-block, particularly relating to cardiology patients, where we're going to actually cohort the cardiology patients on one ward rather than being dispersed across the hospital. That will make sure that we have the right patient being cared for in the right place. Therefore, we won't have beds being blocked in wards where medical patients need to go through straight from the ED.*

Then, when the Heart Centre comes online, obviously we will have the additional beds. One of the difficulties we currently have at the LGH is managing the number of patients that are requiring beds versus the number of beds that we actually have. Again, it's not necessarily a funding issue; it's more the fact that we are landlocked. That will certainly help the bed-block.

The other thing that will assist is the movement of patients through will be a lot more efficient than it currently is. That contributes to our bed-block because we have people staying longer than they should, which means that our beds are actually held for longer than they need to be, which means that the risk is then converted back into the community and to the ED.

…

Dr LEE-ARCHER *- … Patients, after they have their procedure that we're talking about, the angioplasty and the stent, actually usually go home very quickly soon after. You can imagine one of our rate limiters is only having one laboratory trying to fit all the north and north west*

patients into one laboratory. With this infrastructure and increased capacity, they will get their angiogram quicker and then they're well enough to go home, usually, within about 24 hours. It will definitely help bed-block.

...

***Ms LIEUTIER -** And it will help it out in the north west as well because at the moment we leave patients, in Mersey in particular, who have to wait for us to have the availability of the bed or the cath lab to bring them over to Launceston. So, with that throughput, we will be able to bring them, divert them out of the Mersey and bring them straight over.*

Staffing requirements

4.7 The Committee heard evidence on the upcoming changes to staffing arrangements for cardiac services at the LGH and the planning undertaken to ensure the proposed works will be adequately staffed once operational:

***Ms RATTRAY** - ... What about the staffing component? I know this might seem somewhat outside our scope, Chair, but we know that having a wonderful facility, when we don't have adequate staff, or the right complement of staff, that's another issue that's not going to be picked up in a contingency or anything else. Do you have something that you might be able to share with me and Committee members and the rest of our Tasmanian community?*

***Dr MACINTYRE** - There's a staged process map - I want to come into this - that would create a dedicated ward that will have 14 beds and that will be fully staffed. That process is ongoing at the moment. We're hoping that that dedicated ward will open early in this year. That then cohorts all the patients with cardiac problems together. It's 14, it's not 24, but it's as much as we can do at the moment.*

As we move into the Northern Heart Centre, we recognise that we will have to staff the Northern Heart Centre appropriately, and there will be a bigger increase in staffing. That's recognised within the Department of Health. There will be a separate business case to deliver that staff, but we're not going to open up a facility and not have it staffed. There are assurances that it will be staffed closer to the point where it's built.

***Ms RATTRAY** - Do we have access to those staff, or are we able to attract them to our state?*

***Dr MACINTYRE** - Training and education is part of that equation. We can do that from a nursing staff perspective. We've also got to do it from an allied healthcare perspective, which gives us some challenges. We see the Northern Heart Centre as being a massive attraction to people to come and work in Tasmania. There are always challenges of getting people from the mainland, but training and education is going to be part of this process so that we are adequately staffed to the right level in the Northern Heart Centre going forward. We're providing that service as an outreach service across the north west as part of the integrated model I described. Matt, do you want to add to that?*

***Dr LEE-ARCHER** - I wanted to share that late last year we had a vacancy for an interventional cardiologist, so the person who saves your life during a heart attack. We had a lot of people apply from all over Australia, and even internationally. We shortlisted down to five. All five of those at interview spoke of the Heart Centre and how exciting this is for northern Tasmania. So I think this project does give a lot of optimism and excitement about coming to Tassie to work from a medical point of view.*

Paul and I in particular have talked at length about some of our allied health staff, and who we call echo-sonographers, people who do ultrasounds of the heart. We want to work on ways to train people locally and give them a pathway from the university degree that they will do and

into staying and working with us. We're confident that there will be a lot of interest. It's a great, very exciting thing.

4.8 The witnesses expanded on the training opportunities and other incentives that may attract staff to work at the Northern Heart Centre:

***CHAIR** - … because of the duration between the turning of the sod of the Heart Centre to it actually being operational, and I believe that's 2030 -*

***Dr MACINTYRE** - We're thinking 2028.*

***Dr LEE-ARCHER** - 2028-29.*

…

***CHAIR** - Would that provide an opportunity to develop or enhance those stronger training relationships, say, between UTAS and different institutions around the country, to attract and start training up more staff? Does that give you more of an opportunity if you know that it's not like we need these people tomorrow, we need them in three years' time?*

***Dr MACINTYRE** - As Mark said, when we appointed the new interventional cardiologist, that was part of the sell, that we've got this facility coming on board. We've got potentially some finance to attach to the strategy that will address some of the gaps in the existing service, particularly at consulting level and also nurse practitioner level. There's some resource now to try to make appointments to fill in the gaps of the service in advance of the Northern Heart Centre.*

There's a training program. We're part of the national training program where we get registrars. We train them. There's a college process attached to that. We could always expand that. We can expand that in Hobart as well, and that might be one of our objectives to try to get additional registrars into that facility. It's about, I think, showing off to would-be cardiologists that this is coming, it's coming in the north of Tasmania. Would they be interested in being part of that going forward?

***Ms LIEUTIER** - If you couple it, too, with the fact that we've got the new research and innovation centre which is literally right within 10 millimetres of your cardiac centre, that also provides an attractiveness for cardiologists to come to the northern part of Tasmania.*

4.9 The Committee heard evidence on the barriers to attract staff and the strategies used to address such barriers:

***Ms BURNET** - …I'm just going back to something that you were talking about before, about filling those positions - you think that it's likely that there will be an interest in working there. What are the barriers though, in relation to filling those positions because you're looking at nurse practitioner positions as well, and presumably some allied health, not that I think it's touched on in this report. Can you just tell us about any of the headwinds you might have?*

***Dr MacINTYRE -** First up is … funding: we have funding attached to the strategy and this is confidential. We're waiting for that to be signed off, so we can't actually say that it's there yet, but we've put forward proposals as to what we need. That's the first tranche and that's related to implementation of the strategy, so all has to align with what's in the strategy document.*

The next obvious target is to try to fill in the gaps, I think, in medical consultant level as to what we need in terms of additional medical staff to provide the services that we don't provide at the moment. That's really what I did in Hobart as head of the Department: to try to identify the gaps and then address those through business cases, get them funding and

develop services. I think I've probably got it to the point where I'm happy with it in Hobart. Although I'm no longer head of the Department, we have robust level 6 services. We send very little to Melbourne; we can do most of the things here.

What I want to do is replicate that in the north, at level 5. That would be my focus: get the level 5 services sorted, and we need personnel to do that. We need to embrace modern ways of working, which would be nurse practitioners involved in delivery of care and allied healthcare staff. There are major gaps in terms of echosonographers that we need to address. We need to find solutions to bringing those allied healthcare professionals into that environment, in advance of the Northern Heart Centre.

Training your own is the philosophy. Having gone out to market, particularly for nurse practitioners and allied healthcare professionals, we struggle to appoint people from the mainland because of the differentials in salary, or the perceived differentials in salary. That's always been a barrier. There are various workforce category barriers to bringing people to Tasmania from mainland Australia, so really training and growing our own. We've had some very successful examples of that in Hobart where we've appointed good graduates, with biomedical degrees from UTAS, who have flourished in the environment.

There's a period of training required, and part of our strategy is to deliver that training program statewide, so that we support that growth in the north of the state and we try to get these allied healthcare professionals and the whole service out into the north west. Whether virtual healthcare has a role to play, which I suspect it will have, but also bodies on the ground, because at the moment we have very patchy services in terms of cardiology in the north west of the state that we need to support.

Impact on current services

4.10 Mr Martin provided evidence to the Committee on the impact the proposed works will have on existing services provided at the LGH, and how the risk of disruption is being mitigated:

***CHAIR** - … could you provide the Committee with information about the - I suppose, the hardest part of this project will be how you triage services and still operate the LGH effectively during the construction of the proposed heart centre. Could you provide us with some detail, an overview of some of those challenges and how you may overcome them as a team?*

***Mr MARTIN** - … I consider the heart centre project almost having almost two personalities. We have the main heart centre scope of work, which is effectively the main scope in terms of the clinical cardiac response. Then we have a heavy and significant disruption component, which is really around the project, in terms of how it impacts existing services within the hospital. As the scope of the project has expanded from very much a concept through to design development, schematic design, the understanding, or comprehension, of the disruption footprint - of what this project is going to implicate for the LGH precinct - is developing constantly. It's gone from very much a high-level understanding to now a pretty well detailed comprehensive strategy and design response.*

*The disruption to the services at the hospital range from backhouse services - laundry, sterile stock, and access to the principal loading/unloading areas. We understand that there is disruption to mortuary in terms of how those services access their current functions and facilities. There is a bigger piece of work that's being understood around disruption to clinical services, that being in the capacity of CT [*Computed Tomography*] services within the Department of Emergency Medicine. They've all required a level of triage. They've all required - and still have an ongoing - level of risk rating applied to them. That risk rating is adjusted through mechanisms like ongoing stakeholder engagement with those core cohorts of stakeholders within the hospital.*

The CT disruption element of the project has required that stakeholder group to broaden. For example, we wouldn't necessarily liaise with, say, medical imaging or radiology to the extent that we have, but they've now had to form part of the project working group to understand the clinical requirements risks.

Not to speak on behalf of the sponsor of the project, but it has required an extensive deep dive into understanding clinical risk, not just operational risk. They all have a different profile of risks. They're evolving at different speeds, but I feel as though, in support and consultation of the lead design and sub consultants, we have a very good read on disruption. I think we have a very good read through the continuous stakeholder engagement that all key stakeholders are ready and prepared.

I acknowledge the fact that some of these solutions on the table aren't necessarily ideal, but compromises had to be afforded from both parties. I think that if we zoom out and look at what this project is trying to do, it's going to be long lasting and deep reaching. For the challenge of trying to keep the hospital operational for three-plus years, that compromise is worth it.

4.11 The Committee sought further evidence on how the proposed works will impact the Intensive Care Unit (ICU), the ED, and medical imaging services at the LGH during construction:

***CHAIR** - ... may I ask what the interim... construction impacts on the ICU, the ED and the medical imaging will be in the interim as you transition and as you're undertaking this build?*

***Mr MARTIN** - If we start with ED, there are minor to somewhat intermediate -*

***CHAIR** - Interruptions?*

***Mr MARTIN** - Yes. We have structural incursions happening there around the links that will connect the heart centre to DEM. We spoke about those links this morning and where those occurrences are happening. In the nuts and bolts of that, the insertion of, say, structural columns, for example, will interrupt things like, say, the kitchenette within DEM, is a good example. That may be a six-month interruption, it may be shorter, may be longer. We then have another range of interruptions with DEM. The CT scanner safe room, for example, they are a bigger risk, bigger profile areas of disruption. I think that's -*

***CHAIR** - ICU?*

***Mr MARTIN** - The ICU is somewhat contained, although - it's probably out of the remit of this project, but the connection point between the Heart Centre and ICU, and also the confluence of where the northern mental health link bridge will connect the LGH and the mental health site, enable this sort of confluence of work that needs to happen in that transition point. ICU's current cleanup space will need to be rebuilt. Also, the DonateLife office, which is currently occupied in that area, will also need to be rebuilt. They will be done as part of the disruption enablement scope. So, effectively, their existing spaces will be maintained, and when the new spaces are finished, it will just be: move in, get on with doing the demo of the old spaces, so there will be very little disruption with that.*

4.12 Mr Martin expanded on the risk associated with the CT scanner:

***CHAIR** - Can you run through the risk to the CT scanner from vibration and how you're going to mitigate that risk?*

***Mr MARTIN** - There's two risk profiles associated with the CT service. One is vibration. From a vibration perspective in terms of how we're going to construct the Northern Heart Centre, in terms of the foundation structural methodology, we know that through the provisions that*

are being proposed by the subconsultant group have our vibration tolerances in alignment with the CT to be used up until the point that we can't use it any further.

The point that we can't use it any further is not vibration-related. It's to do with the structural works that are required to link the Heart Centre to level 3, 4 and 5; so those structural incursions need to happen either through or close to the existing CT space in DEM, that requires the risk to be too high. At that point we term it as mothballing, but we will effectively have another CT space conditioned ready to go, the relevant equipment ready to run, and we will effectively turn one on and turn the other off, which will basically maintain redundancy service provisions, but also enable the contractor to basically commence the true Heart Centre footprint build. That will stay like that until such time that the risk is such that the DEM CT can effectively be switched back on.

We will maintain the CT machine through the construction of the build. It can't be switched off for two-and-a-half-odd years. It needs weekly maintenance, effectively, to keep it operational. It will still be livened up, but it won't have any patient or clinical interface.

4.13 Mr Martin also provided evidence on the impact to LGH level 2 services, including pathology and the mortuary:

***Mr MARTIN** - … The footprint of the Heart Centre and its incursion on level 2 effectively severs public and clinical access from Frankland Street into any level 2 access, so that is mortuary access, the tunnel access to the loading dock, then the LGH mortuary is mentioned, and radiology. In terms of its clinical interface and public interface to the street, that will have to be disrupted for a period of construction time.*

One of the points we spoke about this morning was the fact that until we actually get a contractor to site, we are optimistic that at some point during the construction process, we can reintroduce clinical interface to some measured extent; public interface probably not, but we would be very hopeful that at some point when the structural conditions of the build are safe enough, and we have effectively a safe structural deck down, that we can start to introduce some clinical interface in those areas. Public would be off-limits.

4.14 The Committee also sought evidence on the Frankland Street road closure during construction of the proposed works:

***CHAIR** - …will Frankland Street require closures during the construction? I know it's how long is a piece of string, we don't have a crystal ball, but can you give us a general idea of what that might look like?*

***Mr MARTIN** - We term it a partial closure. From Wellington Street up to Frankland Rise is still accessible, so minimal impact for residents from Frankland Rise. They can still access - noting that there's also concurrent construction activity happening with mental health as well, which is adding some strain to that. That street partial closure is effectively running from the eastern side of NICS (Northern Integrated Care Service) up to DEM (Department of Emergency Medicine) so it's about a 1500 square metre footprint of closure. It's been supported, validated, ratified through traffic modelling, and it's been approved by City of Launceston as part of a condition of the DA as well.*

What we intend to do is make that a condition of the contractual conditions for the contractor. Upon forming a contract, we will effectively be able to hand over a zone of Frankland Street. We know that the private function of that closure is simply just a site; cranage, for example - the cranage complications of being able to not lift over live wards. Even the simplicity of being able to get a crane out if it's located somewhere else is very challenging. We still know the suspended concrete deck there, in the kitchen area in level 1, has minimal structural capacity to hold a crane that's required. The function of that closure is significant

to the success of the project being tendered and built, but we are running on a worst-case scenario that that could be for the full duration of the build.

Site selection

4.15 Having noted the significant impact the proposed works will have on services provided at the LGH, the Committee sought further information on the process for selecting the site:

> ***Mr HARRISS*** *- Through our visit this morning, we touched on some of the complexities with location and site selection. I'm interested to understand the final site location, I suppose, and how that came about.*
>
> ***Mr MARTIN*** *- I can't speak to anything post the adoption of the Master Plan recommendations of 2022. That's the driver of the location of the proposed Northern Heart Centre. There is a potential - Fiona, I'm not sure if you're aware, but there could be a model or an option paper that was presented that led the Master Plan to be adjusted.*
>
> ***Ms LIEUTIER*** *- The issue with the Launceston General Hospital, I think you're all acutely aware, is it's largely landlocked. There were different options put forward putting the Heart Centre initially down closer to the private urgent care clinic-type area. That was locked in or combined with the Northside Mental Health Facility being moved across the road in Frankland Street. That was revisited because we needed to make sure that we had the Heart Centre close to the Intensive Care Unit and also close to the Emergency Department.*
>
> *We felt the distance of travel was too great for the patients. I think it was 2023 we revisited the location and it was decided the best location was actually that location on Frankland Street where it's closer to CT, although there will be disruption to radiology very close to the Intensive Care Unit and the Emergency Department. It will cause disruption, but that was the primary driver of that location.*
>
> ***Mr MARTIN*** *- I suppose, Mr Harriss, in terms of the discussion this morning around the various options that then live within the ultimate decision around what is now - or we know the Heart Centre to look like was derived through various options. We spoke this morning around a modularised construction planning proposal versus a traditional design construct. We know that through the optioneering and the acceptance of going with a traditional design that, I suppose, the allowances or some of the amnesty in terms of size that the modular options provided the Heart Centre in terms of its size and scale had to pivot and change because that was heavily reliant on departures of AusHFG (Australasian Health Facility Guidelines) requirements.*
>
> *We spoke about bed bays versus bedrooms. Ultimately, all those decisions have led to what we now know the Heart Centre to be. It's had to grow in terms of its size and scale. It hasn't grown much, but we've had to maximise its footprint to be able to accommodate what we need to accommodate. I guess that is a contributor to a number of the disruptions and enabling requirements of the scope.*

4.16 The Committee then heard evidence on whether the size of the proposed works would meet future demand:

> ***Mr HARRISS*** *- With that location and [*we*] touched on size, then… somewhere it says that cardiac procedures are predicted to increase by around 37 per cent by 2033. Are we futureproofing, I suppose? Has that been taken into account for that?*
>
> *…*

Dr MacINTYRE *- We had our report commissioned by KP Health that looked at current activity and then projecting over a 10-year period to find it - really, I think it was even 20 years and then onto - and it is futureproofed for that. I think if we build this in the north and we have a second cath lab coming on as part of the strategy in the south, then we should be futureproofed for the growth in population, and the prevalence and instance of heart disease. There are some specific services that we need to expand such as electrophysiology. There's a big growth area in that, but I think that we can achieve that by four cath labs in the public sector in Tasmania.*

Design

4.17 Mr Alisdair McPhee, Architect and Lead Design Consultant, provided the Committee with evidence on the design of the proposed works:

Mr SHELTON *- … With the five levels, it's a multi-storey building, and so, from the Committee point of view, why multi-storey? Obviously, you haven't got room to go one-storey. The comment that I'm interested in is the connectivity issue as you go up on each different level… Therefore, the benefits that happen with this connectivity from each level that you have through and into the main hospital. If you can run through those benefits, because we know what the negatives are and the timelines.*

Mr MCPHEE *- Yes, sure. Thank you. The level 3 of the cardio cath labs are located on the same level as the Emergency Department with direct horizontal adjacency to medical imaging. The main patient lift, which connects all levels of the Northern Heart Centre to the rest of the LGH campus, is centrally located. Level 4, which is where the inpatient beds are, and the CCU, have direct horizontal adjacency to ICU, also. Level 5 is basically the diagnostics ward where we have consult rooms, echo rooms, stress-test rooms, things like that. That has directed adjacency to other parts of the LGH.*

We have connections at both ends of the building, not only from a fire egress and safety egress, but also a medical response. So there's an ability to - correct me if I'm wrong here, Dr Lee-Archer, but the medical or the code blue team is situated in ICU which just quite nicely sits in the middle of the Northern Heart Centre. The response time from the code blue team is super rapid, super quick and they can access multiple parts of the Northern Heart Centre as well. From an Australasian Health Facility Guidelines perspective as well, they actually know from within the Guidelines that the horizontal and vertical adjacencies align pretty much spot on with what we've designed and the connectivity that we have as well.

It's tight, it's constrained. It's not necessarily always the right option to go with everything on the same level. We've worked within the constraints of the site. Miraculously, I've managed to fit in a full schedule of accommodation with minimal to no departures. We mentioned onsite earlier today that we've been working with tolerances that are within millimetres pretty much from concept design. When it's just blobs on a page, we were working in tolerances of millimetres. That's how fine we've been pushing the boundaries here, with input from our full consultant team. We have upwards of 20 subconsultants on this project, everybody from cranage and lifting, structural engineers, risk advisers, safety and design with a full suite of consultants who've managed to coordinate all their requirements into a feasible built form. Now, we just need to start digging holes.

4.18 Mr McPhee provided further evidence on how the design complies with the Australasian Health Facility Guidelines (AusHFG) and the *Disability Discrimination Act 1992* (DDA):

Mr McPHEE *- Through the design process, there's a whole suite of information around standards of care and health planning unit data that forms a national document called the Australiasian Health Facility Guidelines. As architects and health planners - clinical health planners - it's one of the standards that we refer to when it comes to designing health facilities. Included in all that, there's a whole gamut of information from services and infrastructure*

requirements, proximity of entries and exits, car parking, all that kind of stuff, but there's also another suite where it's just standard room layouts. The idea is to standardise the health system throughout Australia.

We refer to that document the whole way through our consultation across each phase with our project working groups, including Dr Paul MacIntyre and Dr Lee-Archer. We present the room layouts and it's everything from the location of medical gas panels, for example, to desks, to nurse calls, pendants in the ceilings, all those kind of things.

If we ever depart from that, we have a register noting the departure, and we seek sign-off and endorsement from the project working group and ultimately the project sponsor. So, we monitor that the whole way through. It's ultimately just to keep consistency in health design and care for the community. That then forms our documentation, which the builder ultimately needs to comply with. It's also under the local provision in the National Construction Code that in Tasmania we have to comply with the Australasian Health Facility Guidelines.

***CHAIR** - Is the accessibility DDA compliant with inclusive design?*

***Mr MCPHEE** - Yes, absolutely. We have a DDA consultant on board who has been advising us the whole way through on everything from tactile indicators, to hand rails, to ramps, clearance around doors, circulation space, lifts, the whole thing. They've been fantastic, actually - very proactive in their reporting, and we've managed to capture all that. When it comes down to equitable access to care we're all good.*

Budget

4.19 The Committee sought evidence on the disruption allowance and whether the proponent was comfortable that the amount allocated will be sufficient:

***Ms RATTRAY** - ... around the disruption allowance in the budget. Now, I can see, for one, there's a $4.032 million. Given that there is significant disruption, are you comfortable with that figure? I mean, you've got a million in contingency-enabling disruption work, so potentially $5 million.*

***Mr MARTIN** - There are a couple different ways of answering that. For the public record here, these projected cost estimates are based on an 80 per cent contract documentation, so we're getting pretty close to 100 per cent documented, ready to go to market. We're pretty close. That 20 per cent difference in terms of the documents that the QS [quantity surveyor] has seen versus what's yet to be completed is probably minimal. It's schedules, it's the total final detail.*

Working through the various cost plans, and we've had cost plans at all gateway approvals, a lot of those contingencies have now worked back, so those disruption contingencies or allowances are now captured in physical drawings. So they are actual construction elements the QS has been able to embed within the construction cost. A lot of the risk around what those enabling works will be and won't be are now minimised. To answer your question, 'Is it enough?' -

***Ms RATTRAY** - It was really, 'Are you comfortable with what's there?'*

***Mr MARTIN** - I am comfortable, yes. I'm comfortable in the sense that, from where those disruption allowances started as just general contingencies, because we didn't have the detail in the drawings, to now understanding what those schedule works will be, the QS has been able to capture it, embed it, but until we've got the final set of documents on the table, we're still allowing some risk items there to be captured as a small contingency.*

4.20 Mr Martin provided further evidence on the contingencies contained in the budget:

CHAIR *- … there is a significant amount of contingency within the budget. I didn't work out the percentage, but it is quite significant. I'm gathering it's because - we will talk about the crystal ball again - a contractor needs to be appointed, because it is such a complex build, which is going to require quite a bit of change management. I understand that that contractor is also probably working with you as the project manager. Maybe we will have some different ideas about how to roll things out and what the cost might be. Is that why there is such a large contingency aspect to this budget? Could you run us through it? It is a lot larger than what we normally see. Is it the unknown facts?*

Mr MARTIN *- Again, we are still at 80 per cent, so we understand that some of those contingencies might likely work their way right back. Those contingencies exist - not all these contingencies, but some of these contingencies exist for the QS or for us as the PMs to narrow up where numbers may go up or down depending on the QS getting from 80 to 100.*

CHAIR *- It's also the long duration of the project too, isn't it? A lot can change in that four years.*

Mr MARTIN *- Correct. If we talk about design contingencies, for example, they are effectively QS-directed. Design and construction contingencies are QS-directed. Now, that design contingency that we're saying there, at about 1.9, we're expecting that to close right up. At 100 per cent documentation completion there will be no need to be showing any design contingency, really, unless we are expecting some potentially - what's a good example of that? - a during tender addenda to go out. For example, if there are additional drawings to go out which might not yet be consolidated, we would be leaving some site contingency.*

Construction contingencies, or contract contingencies again, they, to me, feel about right for the size of the project. Again, they are QS-dictated and we are allowed to question them, but we typically don't massage those numbers too much, primarily around the risk there. It may move a little bit between now and 100 per cent, but unlikely. Again, how we report that is up to Rachael and Simon. To me, that sort of 5 per cent construction factor there, seems about right.

The other allowances in here which sit into that construction or project contingency are things that we know are embedded into the market at the moment. So, cost escalation from start and cost escalation to finish, is the point we mentioned this morning about just how quick the market is growing. We know that the market is growing 3 per cent - 3 point something per cent - per quarter. That's likely to increase.

Once we see the stadium come on, the private sector up here is - the liquidity of the market, this marketplace, the supply and demand thing is tight. It's driving the market factor per quarter higher and higher and higher. The QS has been able to capture what the market will do between tender to start, and from tender to finish. They are costs that we have to build in. They are costs that will effectively be passed on by the contractor, too, because they are subjected to the same escalation rates as well.

Does the Project Meet the Requirements of the Public Works Committee Act?

4.21 In assessing any proposed public work, the Committee seeks an assurance that each project meets the criteria detailed in Clause 15(2) of the *Public Works Committee Act 1914*. Broadly, and in simple terms, these relate to the purpose of the works, the need for and advisability of undertaking the works, and whether the works are a good use of public funds and provide value for money to the community . The Committee questioned the witnesses who provided the following confirmation:

CHAIR *- …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.*

5 DOCUMENTS TAKEN INTO EVIDENCE

5.1 The following documents were taken into evidence and considered by the Committee:

- *Northern Heart Centre,* submission to the Parliamentary Standing Committee on Public Works, Department of Health, 8 January 2026; and
- Submission from the Heart Foundation, 27 January 2026.

6 CONCLUSION AND RECOMMENDATION

6.1 The Committee is satisfied that the need for the proposed works has been established. Once completed, the Northern Heart Centre will provide a new, purpose-built facility for northern Tasmanians suffering from heart disease within the LGH precinct.

6.2 The proposed works will address the current gaps in cardiac services in the north and north west regions of the state, by creating a new coronary care unit with 24 beds, as well as the establishment of two cath labs equipped with dedicated recovery and holding bays, and the provision of dedicated diagnostic testing facilities for echocardiography and outpatient services.

6.3 The proposed works will reduce the pressure on emergency departments within the region, the prevalence of bed-block, and the need for patients to travel interstate.

6.4 Accordingly, the Committee recommends the Northern Heart Centre, at an estimated cost of $120 million, in accordance with the documentation submitted.

Parliament House
Hobart
31 March 2026

Ms Jen Butler MP
Chair