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COMMITTEE

ON

HEALTH

Tuesday, April 9, 2019

LEGISLATIVE CHAMBER

Cape Breton Health Care Redevelopment

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[Hon. Geoff MacLellan replaced Ben Jessome]
[Eddie Orrell replaced Barbara Adams]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Nicole Arsenault
Assistant Clerk, Office of the Speaker

WITNESSES

Department of Health and Wellness
Denise Perret - Deputy Minister
Kerry MacLean - Special Advisor, Strategic Health Initiatives

Nova Scotia Health Authority
Paula Bond - Vice-President, Integrated Health Services
Mark LeCouter - Senior Director, Cape Breton Redevelopment
Mickey Daye - Clinical Director,
New Waterford and North Sydney, Cape Breton Redevelopment
Dr. Kevin Orrell - Senior Medical Director, Cape Breton Redevelopment
Brett MacDougall - Executive Director, Eastern Zone

Department of Transportation and Infrastructure Renewal
Paul LaFleche - Deputy Minister
John O'Connor - Executive Director, Major Infrastructure Projects
Brian Ward - Director, Major Infrastructure Projects
Gerard Jessome - Executive Director, Building Project Services
Bryan Darrell - Director, Heathcare Facilities Project Services

House of Assembly
Nova Scotia

HALIFAX, TUESDAY, APRIL 9, 2019

STANDING COMMITTEE ON HEALTH

9:00 A.M.

CHAIR
Gordon Wilson

VICE-CHAIR
Suzanne Lohnes-Croft

THE CHAIR: Good morning, everybody. I'd like to call this meeting to order. This is the Standing Committee on Health and I'd like to introduce myself: I'm Gordon Wilson, I'll be your Chair.

Today, we'll be hearing witnesses from the Nova Scotia Health Authority, the Department of Transportation and Infrastructure Renewal, and the Department of Health and Wellness, regarding the Cape Breton Health Care Redevelopment.

First off, I'll remind everybody about their cellphones: please have them off or on vibrate. I'd like to start by asking the committee members to introduce themselves.

[The committee members and witnesses introduced themselves.]

THE CHAIR: We'll have opening remarks from Mr. LaFleche.

PAUL LAFLECHE: Thank you very much for inviting us here today. I have a very short speech here today and then I'll turn it over to Dr. Orrell.

I want to put in context the people over here. I realize it's a very large number, but this is a very important project; it's the largest public project that we can find that has ever been implemented in Cape Breton. We're very proud to work on it. I think everyone here views it as a privilege to be part of this team.

I'll just point out that we have a division in Nova Scotia Lands which is set up to do health infrastructure, and several of the people here either work for or are seconded to that division. John heads the design and construction side of that division; Paula Bond, at the far end, is the vice-president of the clinical side of that division.

Working for Paula, you have Mickey Daye in the back row, Mark LeCouter, and many other employees who are not here who are working on the project. Working for John, you have Brian Ward, who's actually the director of the Cape Breton project and others, too, who are not here today.

Bryan Darrell is our director of health infrastructure generally, and he's here today because there are lines that are blurred; some of the projects we're doing in Cape Breton on the health side may not be perceived to be part of the major capital project we're discussing here today, but there might be questions on them. Brian is also familiar with the long-term care facility, so he's here today.

Brett is an NSHA leader, the leader for the NSHA in the Cape Breton region. Beside me are also two officials from the Department of Health: Kerry MacLean, who's specifically assigned to be the liaison with us from the Department of Health and Wellness for the Cape Breton project; and, of course, the deputy, who tells me this is a Guinness book of record appearances - 11 times. I'm proud to say we probably have the Guinness book of record attendance appearances, too, here today.

With that, I'll turn it over to Dr. Kevin Orrell, the clinical leader of the project in Cape Breton.

THE CHAIR: Dr. Orrell.

DR. KEVIN ORRELL: Good morning. On behalf of our CBRM Health Care Redevelopment Project team, I would like to thank the committee for having us today.

I was born, raised, and educated in North Sydney, and my passion for this project comes from my 30-year career as an orthopaedic surgeon in Cape Breton. I have witnessed, and I have been involved in, many of the changes that have occurred in health care during that time.

As the Senior Medical Director, I co-lead the project with our Senior Clinical Director, Mark LeCouter. Two other members of our team are here today: the Clinical Director for New Waterford and North Sydney, Mickey Daye; and our Senior Director of Operations for the Eastern Zone, Brett MacDougall. There are a number of other local

leaders who represent our senior leadership team and they are working hard to ensure this project continues.

In keeping with the health care strategy that the Nova Scotia Government and the Department of Health and Wellness, and the NSHA have set in place, we understand the need for an update in the way health care is delivered in Cape Breton. This is designed to meet the needs of changing-population health, human resources, aging infrastructure, access to quality services, and improved health outcomes, which is most important.

Physicians and clinical leads of many specialties in family practice are in place to represent the Cape Breton health care team. We have representation from Sydney, North Sydney, New Waterford, and Glace Bay. Our team has been working with front-line workers, nurses, doctors, and members of the community to proceed with this project. We recognize the advantages of this for improved patient experience by enhancing consistency of care and coordinating care and access to service to enhance and increase primary health care; to provide a more patient-centred health model to help patients navigate the system; to increase the use of telemedicine and other technologies; and to improve our ability to teach for community members, families, medical learners, medical residents, and members of the allied health and nursing professions that now have students in Cape Breton and at our university.

There will be an increased number of long-term care beds, which will improve flow through the health care system. We have state-of-the-art facilities to help attract and retain physicians and other allied care professionals. This is a very significant opportunity to leave a legacy, an exemplary health care system that will meet the needs for the future.

Since the announcement was made last June, there have been hundreds of meetings with physicians, staff, community health boards, foundations, advocacy groups, service clubs, the business community, Opposition members, and community interest groups as we plan for the change, alteration, and adjustment of services to meet the needs of our community.

We're in the process now of recruiting patient and family volunteer advisers who will help us with the next stage of the design for this new system. We welcome their participation as they represent their patients, families, and other aspects of the community in which they live.

We look forward to the future planning; we look forward to the changes that will help us to deliver better care; and we look forward to the education of our community members, so they'll understand the full aspect and scope of this project.

THE CHAIR: Thank you for your opening remarks. To start with, I will attempt to - for those of you here, if anybody feels that they have something to add to the question, I'll try to keep eye contact with you, if you just give me a quick little nod if you feel that you have something to add to that, if that's okay with everybody here.

That's for Hansard also. I need to recognize everybody. They're not used to having 12 people flicking on microphones quickly.

We'll start with the Progressive Conservatives for 20 minutes - Ms. MacFarlane.

KARLA MACFARLANE: Welcome. This is a very exciting project. It is a good news story and it's definitely needed. It's a huge project and there are a lot of questions. I was amazed in the last month or so just the number of emails that have come to me as the Health Critic for the PC Party - a lot of ideas and solutions, but most importantly, a lot of questions. They're definitely valid questions.

I would start with Dr. Orrell. In your opening remarks you had mentioned the consistency of care which brings me to the question of human resources. Was there a human resource assessment conducted with respect to the overall development in moving forward?

KEVIN ORRELL: It's been long recognized that we are under a great deal of stress in terms of meeting the needs of the various specialties; meeting the needs of the allied health professions. I joined the project this January, and prior to that, I understand, there has been some assessment of that. But I have no formal report of any human resource issues.

We, as clinicians, know how difficult it is to get many things done in our hospital: for example, with physiotherapy; with specialized nursing; and with some of the clinic care that's given. We've witnessed the stress on the system.

Organization of this - bringing it into a consistent centre and having people that are able to concentrate in one area - will certainly improve flow. Removing it from some of the places where it's currently located in the hospital will help that as well. This project will help to redesign where the care takes place and how consistently patients can access it.

The other part of that is knowing exactly where the care will be. For example, if you take the emergency department, which is highly discussed, we have four emergency departments within 30 miles; we have three that are working at less than their capacity, they're closed 70 per cent of the time. There's certainly an inability of people to recognize exactly where this should go in the event of some type of emergency room requirement. By consolidating that and having people informed about that will make a big, big difference.

KARLA MACFARLANE: Just to clarify, there has been no written human resource assessment in projecting what the needs of doctors, nurses, and allied health care professionals will be in moving forward with this project.

MICKEY DAYE: As we move along with this project, with the functional programming process, after the announcement last June, one of the things we've done in functional programming is that we've worked with our clinical leaders in all the different services, as we programmed and moved forward. We're developing the new clinical spaces, but they're looking at the operational side of things and how they can operationalize that down the road.

As we say, we're going to increase renal dialysis on the Northside moving forward in a new facility, the actual department of dialysis is looking at that and how they're going to operationalize that - what staffing resources they need and how they would recruit those and move those forward. There is a process for the HR side of things as we move forward to make sure we can operationalize the new community health centres and the new departments as we move them forward and redesign them for the future.

KARLA MACFARLANE: We realize that recruitment and retention is challenging as it is right now. Is there a new plan that's going to be injected in order to ensure that there will be enough allied health care professionals to fill these vacancies? Right now we have close to about 250 openings right now in Nova Scotia for nurses. Is there anything you can provide today to reaffirm that there is a functional plan in place for recruitment and retention?

MICKEY DAYE: We are continuing to move forward. As I said, we hire numbers of nurses every year because we put a plan together every year as to our projection of what we need every year. We put that recruitment request forward and we recruit as many nurses as we can hire, pretty much every year, within our Eastern Zone to try to fill the vacancies that we have.

We also continue to recruit on an ongoing basis throughout the year to try to fill those vacancies. There are deficiencies in certain departments, but we continue to come up with ideas and try to move things forward to try to fill those vacancies as best we can.

KARLA MACFARLANE: Is one of those ideas - I think it would be a great idea - to have some system in place for exit interviews? We're seeing such a large turnover of health care professionals, and feedback I'm receiving is that there's no exit interview. Now, I understand they can have an exit interview, but there's no actual system in place or anything that's set for health care professionals to understand that they can have these exit interviews. I think that is one of our first steps in trying to identify with those who are exiting what was good while they were here, what they believe can be improved upon, and the real reason they're exiting.

[9:15 a.m.]

I'm not sure who can answer this question, but I'm wondering if perhaps there is something in place to address that issue so that in going forward in this five-year project, we will know better and have better systems in place for recruiting and retaining.

MICKEY DAYE: I'm going to refer to Brett. Brett is our operations executive director. I'll let him handle that one.

BRETT MACDOUGALL: Thanks for the question. It's an important one. It varies between department to department and service and program whether or not we do an exit interview on every person who leaves the organization. If we have a department that's in good standing in relation to its turnover and it's healthy in relation to its workplace and not much in relation to recruitment and retention, we don't really go in to do an exit interview in that particular program or service or department.

However, if we do have and know about departments where there is a fair amount of turnover, in relation to staff turnover, we do target those departments with human relations and begin to do exit interviews to see, to your point, what the specifics are around why there is so much turnover in those departments. Then we look to develop plans for each individual department in relation to - maybe it's the emergency department, per se, or it's a specialty service, and we have to incorporate and change the way the education program is delivered for that service and/or what additional supports we put in place for those programs and services.

It's not a cookie-cutter approach for the entire organization and/or each region. It's really dependent on the program and the specific department. You could have an emergency department in St. Martha's in Antigonish, for instance, in the Eastern Zone, where there's very little turnover, as opposed to, say, the Cape Breton Regional, where there had been some turnover in the past and we have to dive deeper into why there is turnover in relation to that department.

KARLA MACFARLANE: Continuing on this, actually, I believe St. Martha's has lost 10 specialists just in the last year, and of course, we know the numbers of individuals who have left hospitals in Cape Breton.

I'm just wondering, is there any way that I'm able to find out the number of individuals who actually had exit interviews? Is that information available for us so that we can read as well and understand why they're exiting?

BRETT MACDOUGALL: Some of the reference I was making was in relation to nursing specifically. If we get into the medical turnover in relation to staff, I don't believe we've done a great deal of exit interviews in the past. I know that there's some effort put toward that currently. I know Dr. Miller, who is the interim medical executive director for medicine, is working with HR in relation to those physicians who are requesting exit interviews.

To my knowledge, I don't believe that we do an exit interview on every person. Perhaps that's an opportunity to improve in the future. I do know that those who have requested exit interviews have either had an interview or there's one in the queue to proceed with an interview based on third-party interviewing.

PAULA BOND: I'd also like to add that we are certainly understanding that there are certain areas, as Brett just mentioned, that are harder to fill. We know that we have overcapacity issues in the system, particularly in emergency departments, critical care.

We are working with our education within the Nova Scotia Health Authority, as well as our community partners, to look at how we can improve on orientations to help retain the new nurses. Just this Spring, we have hired 250 new grads, and we're looking at hiring up to 400 new grads this year, understanding that we also need to put in supports around new graduates who are going into specialized areas. That's one of the areas that has been recognized as an area that we can improve on.

KEVIN ORRELL: Just a comment about the exit interviews. They've been done for many of the people who have come to look at jobs in the medical professions, and a great deal of what they had to say had to do with facilities and services and collaboration, all of which can be addressed through this redevelopment project.

KARLA MACFARLANE: How so? How can it be addressed through this development?

KEVIN ORRELL: For example, we had two geriatricians who came, and we were quite interested in why they took jobs in New Brunswick. It largely had to do with the facilities with which they would have to work, as they currently exist, and what they were offered in New Brunswick. If we had what we foresee as being a health care centre that meets those kinds of needs, they would have been much more interested in Nova Scotia. We believe we can do that in these new health care centres.

KARLA MACFARLANE: Knowing that doctors in Nova Scotia are the lowest paid across this country, do you believe that has any influence on why we're unable to recruit and retain?

KEVIN ORRELL: Well, the issue of remuneration is outside my mandate. I mean, many people choose to work in Nova Scotia because this is where they would like to live, and accept the fact that they're not going to be compensated like they are in other provinces. I'm a classic example. I've spent 30 years doing orthopaedics knowing full well that my colleagues in other parts of the country and in other parts of North America are being paid much more. People come for different reasons, and I don't think the remuneration of the service is the only reason why people decline.

KARLA MACFARLANE: I would agree. Thank you for your dedication and service to our province. We do appreciate it.

You mentioned earlier about having community advisers. I'm wondering if you could elaborate on that. Have they been chosen yet? How will they be chosen? What role will they actually play in this redevelopment?

MICKEY DAYE: The patient advisers we're looking for to be part of the redevelopment - we're looking to have members from each community that will be part of the redevelopment, so we're looking at having two members from Glace Bay, two from New Waterford, two members from North Sydney, and two members from Sydney.

There was a posting, an expression of interest, that was put out, and we had applicants who submitted. We've gone through those, and we're currently conducting interviews, actually. We started conducting some interviews last week and will continue to do that. We're holding some interviews just to make sure people are interested for the right reasons. At the end of the day, this project is about improving health care down the road, for 10, 15, 20 years, so we want to make sure people have the right intentions as to why they want to be a patient adviser.

Hopefully we're going to get those eight together, and then we'll come to them, review the project as it is and where we are based on the functional plans moving forward, and get their input. We want people who have real patient experiences, have used the health system, are members of the community, have children in the community, and can really give us the outside opinion and outside ideas to make sure we're not missing anything as we go forward.

We really want to make sure that we are truly inclusive and providing holistic health care at the end of the day. We want to make sure we get all of their opinions so that we can try to incorporate that into the plans going forward.

KARLA MACFARLANE: Just to confirm, will these be volunteer positions?

MICKEY DAYE: Yes, they will.

KARLA MACFARLANE: Thank you. I'd like to move on to questions around the capital plan expenditures. I guess for me the big question would be, what is the risk of not building it, in the sense of what specific assessment would have been conducted to evaluate the risks associated with the redevelopment plan? I'm not sure who I should direct the question to.

BRIAN WARD: We did an evaluation of the four facilities that are on the redevelopment project. With the Northside and New Waterford facilities, because of the aging infrastructure there, in order for us to bring those facilities up to what we would consider today's standard, it would have cost a significant amount of money.

The biggest thing we ran into in these facilities was the low floor-to-ceiling heights. It would have been incredibly difficult to try to introduce air conditioning, to try to update some of the other services within the facility.

As we went through that project, knowing that renovations are extremely expensive and are very trying for staff and patients, that's when we started to look at the new community health centres.

KARLA MACFARLANE: Are we able to have access to that report? Who gets to look at that assessment?

BRIAN WARD: I think we can make that available. For some reason, I thought it was already available.

KARLA MACFARLANE: Okay, great.

PAUL LAFLECHE: I think it was available online and then somehow it got off-line, so we'll look into what happened there. I believe it was available at one time.

KARLA MACFARLANE: Within that assessment would it include what the risk would be in closing the existing facilities, such as Northside General, would it include what the risk would be in closing that?

BRIAN WARD: I'm not certain which types of risks you mean, but as we go through with the replacement of those two facilities, the Northside and New Waterford, the facilities will remain open until the new facilities are built.

KARLA MACFARLANE: Are the decisions final on where they're actually being built - the locations of them?

BRIAN WARD: We're going to put the new facilities in North Sydney and New Waterford back within those communities, yes.

KARLA MACFARLANE: The actual locations though, is the land already owned by the province?

BRIAN WARD: We're going to go through a process very similar to what we did with the QEII when we were looking for the Bayers Lake site. We're looking at multiple locations within the communities to try to identify where the best place to put the facilities would be.

THE CHAIR: Mr. LaFleche, you don't have to push the button. If you push it, you turn it off.

PAUL LAFLECHE: I have button-pushing issues, I like to push buttons. That's why they don't have the nuclear launch facility in my office, they put it in that other guy's office down in Washington. (Laughter)

Anyway, we should have some news, I think, in the near future on location. We have a team that's working with Brian and also liaising with the clinical side, which is looking at land acquisition. The specific question of whether it's provincial land or not, is not known yet. We do have provincial options in both those communities. We also have private options and we have municipal options in both those communities. I think it's no secret that we have been exploring in North Sydney, at least one case, a municipal option. I say that because I think it has been publicly revealed at council.

Those are the options we have. They're near the current facilities, they're not distant from them, and hopefully we'll finalize some options in the near future. They have to be of a sufficient size and scale to handle all of what we're talking about, which in some cases may be larger than in the past so we have to look at that.

KARLA MACFARLANE: I'm just curious: Who is on that team and how is that team determined?

PAUL LAFLECHE: Brian, do you want to talk about that?

BRIAN WARD: The team is mainly made up of the folks on the redevelopment project. The folks at TIR are leading where it's a land item and Mark and his team, of course, are giving us some inputs with their knowledge of the area. We do have a local staff member, Roy MacDonald in the Sydney office, who has been leading that for us.

KARLA MACFARLANE: Currently, how many full-time employees are with the health infrastructure division of Nova Scotia Lands?

PAUL LAFLECHE: John is probably best to speak to that. We'll have the full answer at 3:00 p.m. today when we present the org chart to our committee of deputies and the CEO of the Health Authority. John, do you have a preview of that?

JOHN O'CONNOR: I can give some information on that. The Division of Nova Scotia Lands is set up as a structure to oversee the work of the QEII project and the Cape Breton project, but the number of positions under Nova Scotia Lands are somewhat limited at this point, because it's just being set up, the structure.

A lot of the people are working on the project currently, there's about 80 or 90 people in total between the QEII and the Cape Breton projects, and all those folks are not employees of Nova Scotia Lands. They are currently employees of the Health Authority or TIR or the Department of Health and Wellness, but we're consolidating the resources and the monies under Nova Scotia Lands.

[9:30 a.m.]

THE CHAIR: Order. The time has expired for the Progressive Conservative Party. We will now turn to the NDP, and Ms. Martin.

TAMMY MARTIN: Thank you, and I thank the committee for being here - such a large committee, so we'll try to get through it as quickly as we can.

First, a few opening comments about concerns that have been brought to me about the redevelopment project in Cape Breton. While the announcements for the cancer centre and the revitalization of the emergency room at the Regional Hospital are wonderful announcements, they still pose some concerns to those residents in New Waterford and North Sydney. Aside from that, we know that kids are going to Halifax for mental health treatment - there are 363 days for the first appointment for an adult to receive mental health treatment. People in Cape Breton are waiting months for home care, spouses are being separated from New Waterford to Tatamagouche, being placed in long-term care facilities.

In Cape Breton we know that our patients are dying at a higher rate than anywhere else in the province. We also know that doctors in the CBRM are retiring or leaving, and we know that last week, or over the last couple of weeks, 20 have resigned. We also know that the Regional Hospital emergency department is already overloaded, so we're going to add 20,000 more people to that? We also know that over the last week or so that there was not one empty bed in the emergency room at the Cape Breton Regional Hospital.

Finally, we also know that we had the benefit of having EHS here at our last meeting and when I asked Terry what happens when there's no ambulance available and I call an ambulance for a loved one in New Waterford and the ambulance is coming from Baddeck or Antigonish - what happens? His answer was - and it's in Hansard - my family member would be non-living by the time the ambulance got there.

These are the concerns that this redevelopment project has because while it's a wonderful idea, people want to know what they do today; people want to know how they get medical services today. In two or three or five years it is a wonderful plan, but people are dying today.

Having said that, did the minister go over the bulk of the announcement with the cancer care and emergency room expansion, or is there more information to come from that?

PAUL LAFLECHE: I think the question was: Did the minister release all the information or is there more to come? Obviously, the announcement was a high-level announcement, generally describing where we are. There's a lot of detail which will come through a functional planning process.

Maybe I could ask someone back there - is that you, Brian? - to describe that process, and maybe Dr. Orrell could talk about his side of the process so you understand what flows down, in a detailed level, from those higher-level announcements.

BRIAN WARD: Following the announcements and during the announcements, the health care staff were doing the functional programming with Kasian Architecture and Agnew Peckham. Then as we started to work out through the process it became evident that the program that was required at the Regional Hospital for the emergency department, the space requirements certainly weren't sufficient, so we went to government with a proposal to provide a new emergency department so that we wouldn't interfere with the existing emergency department.

Also, the same with the cancer care - as we started to look at cancer care we realized that there was a large addition and a significant renovation within the existing cancer care. It's very difficult to renovate a space and still provide the health care needs of the people in the Cape Breton region, so the decision was also made to ask government to provide a new cancer centre.

The same with the critical care, we started to look at critical care - how can we renovate critical care when we're actually using it? As you all know, the hospitals are running at 100 per cent, so the team decision to provide the government with an option of a new cancer care, new emergency department, and new critical care was brought into government, and we had approval prior to the minister making that announcement.

KEVIN ORRELL: Health care is enormously complicated. I feel the mandate for the redevelopment project has to be well defined or we will get bogged down in all the day-to-day things that happen. All of the things that have been pointed out by Ms. Martin are certainly well known to us, and they have affected us in the way we are functionally planning for the future. But our project is for future care delivery, and we cannot address all of the issues that currently exist because we wouldn't get our mandate accomplished.

Having said that, many of the things that have been pointed out are going to be much, much easier to deal with in a redesigned health care system that we're planning.

TAMMY MARTIN: With all due respect, I doubt it would be easier to deal with people dying today in a redesigned health care system. My concern, as with most of Cape Breton, is what is going on today.

If I could just go back to the building specifics, I guess what I was trying to get at is: Have all of the announcements regarding the redevelopment of the Regional Hospital been announced?

PAUL LAFLECHE: There are other things happening in the Regional Hospital. Obviously, we're vacating the existing ICU and CCU space, we're vacating some of the ER - way down the road when we get the new facility built. There will be things that go into those spaces but I think that will be announced in due course. We haven't done all the planning for that. Brian, maybe you could talk about where we are in the planning for all that other stuff going into the Regional?

BRIAN WARD: With the most recent announcement, we're starting now to look at the facilities. Part of the master planning strategy is to start looking at the existing facility, the existing Glace Bay hospital, the existing Regional Hospital, start looking at - well, we have been looking at - what services are provided in North Sydney and New Waterford, and then we're trying to bring them back into the Regional facility.

The vacancies that will finally occur as we open up the new emergency, cancer care, critical care - then we'll be starting to renovate within the existing hospital to provide more room for the services that require more room that will be in that hospital, and also any of the other services that will be brought in from North Sydney or New Waterford.

TAMMY MARTIN: Is there a time frame assigned to that?

BRIAN WARD: We're looking at the full master plan to be done late August, early September. The master programming is being finalized this month and the programs themselves have been pretty much finalized this month also.

TAMMY MARTIN: Thank you for that. I'd like to speak about in-patient beds now. We recently talked about this in Budget Estimates.

Right now, adding the intensive care or the critical care or the intermediate care beds to the existing 24 - so that will bring us to 36 - right now there are 21 in-patient beds in New Waterford and 45 in North Sydney, for a total of 65. Losing those acute care beds in those two in-patient hospitals, we'll be down one-quarter of the total patients in CBRM. The 12 new beds that have been announced recently are not enough to mitigate that loss.

The minister has said though in Estimates that we shouldn't assume that these beds will disappear, that the functional processing hasn't been completed. Could somebody please clarify that we have a glimmer of hope that these 40-some-odd beds will remain somewhere, and where would that be?

MICKEY DAYE: Based on the functional programming we're doing, we're looking at all in-patient services that are currently in existence within North Sydney and New Waterford and Glace Bay, the Regional Hospital, and even Harbour View which is kind of the forgotten entity within the whole mix of the redevelopment.

In the future, we're not going to have any less beds than what we currently have, so how do we redesign the system that we're doing? We know services are going to change, we're not losing those 45 beds in North Sydney, so we need to figure out where they're going to go and what mix they will be. Maybe they will look differently in the level of care that they provide, but how are they going to look?

We're still working on that as part of the functional programming, so hopefully as that moves forward and we get that finalized, we'll be able to give you a real answer as to where they're going to be and what it's going to look like.

TAMMY MARTIN: So specifically, would it be possible that some of those beds would be in the new facilities in New Waterford and North Sydney, as they are now currently in the community?

MICKEY DAYE: We don't know that yet. We still have to work in that functional programming. That in-patient part is still ongoing. We haven't finished that one yet, so as we look at that redesign with our clinical leaders, we're still trying to figure that stuff out.

TAMMY MARTIN: Thank you for that answer. I'd like to talk about long-term care and the new buildings, the new facilities that will be created or reconstructed. Will the nursing homes be free-standing in the community where they are, where the beds are provided now, and will they be funded publicly or privately?

PAUL LAFLECHE: They will be in the same community, yes. The facilities in general will be in the same community. We talked about that earlier. In terms of a decision on - you're talking about how the building will be funded, not the service?

TAMMY MARTIN: The service.

PAUL LAFLECHE: The service, yes. Maybe I'll let Denise answer because in terms of the building, no decision has been made yet - we're not at that stage. Maybe Denise can talk about the service.

DENISE PERRET: We're expanding the long-term care capacity in both of those communities. They may not be entirely free-standing - they may be associated with the community health centres that are there - 74 net new beds and it's a publicly-funded system.

TAMMY MARTIN: And publicly run?

DENISE PERRET: I'm not sure if all those decisions have been made, but I can assure you it's publicly funded.

TAMMY MARTIN: What will be done with the empty hospitals in New Waterford and North Sydney?

PAUL LAFLECHE: We'll add them to the existing stock of empty hospitals we have, like Colchester. That's a bit of a joke, but we will have empty hospitals anywhere we build a new facility and don't renovate, just like we have empty schools anywhere we build a new facility and don't renovate.

In the case of the hospitals, we'll have to determine the legal status of those sites, but generally if the legal status is that they return to the province, then our land division will take care of the future of them.

TAMMY MARTIN: I would beg to differ with New Waterford though because I believe that New Waterford Consolidated Hospital is community owned and was community built.

PAUL LAFLECHE: As I said, we'll do some legal work on that to see where they go. As in the case of schools, there's always a complicated history. In some cases we find we think we own a school, but then it was actually owned by another group and then willed to some third group. So we'll go through that process and I assure you that we are not looking to keep facilities that we don't have to keep.

TAMMY MARTIN: What sort of considerations are guiding the functional planning team in making these decisions around the facilities for long-term care?

PAUL LAFLECHE: Could you describe a bit more what you mean by that question?

TAMMY MARTIN: What's guiding the location, the process, the size, the staffing, whether public or private, attached to the health centre or not?

PAUL LAFLECHE: Only a couple of those would be in the field of Nova Scotia Lands and the Department of Transportation and Infrastructure Renewal. We'll address those and then I'll turn over some of the questions, some parts of the question, to Denise.

In terms of a location, our instructions were to put them back in the communities they're in - whether they're exactly on the same site or the site 500 feet away. A lot of that is determined by the size of the land we need, whether we can easily acquire the land, the access to the land. We have made a decision to co-locate the long-term care facilities with the community health centres, so that right away gives you a certain dimension of land. In doing that, we also have to consider entrances and exits, egress to the sites in terms of transportation.

All of that factors in, which gets us to a smaller set of available land portions in those two communities - we're talking New Waterford and North Sydney - that are possible.

[9:45 a.m.]

Our land division is working with Brian who is the project director at Cape Breton to see what is available and, of course, we talked to the clinical people to see if there are any no-gos, whether there are any issues that they have which, again, would allow us to constrain to a smaller subset, the available land. So, we're going through a process like that and maybe - I don't know, Brian, if you can add to that process.

BRIAN WARD: As the deputy mentioned, co-locating the long-term care in the community health centres on the same properties will allow us also to use some of the same resources, possibly one heating plant. We'll be able to possibly, if there's some sort of an amenity within the community health centre where you want to sell sandwiches and that sort of thing, you could use the kitchen that's in the long-term care. Also, if you had long-term care patients who needed to have certain types of health care needs, we can move them from one facility to the other without bringing in some sort of a patient transfer. There are a lot of pluses on that side of keeping the two on the same site.

PAUL LAFLECHE: The other part of the question you asked how they were going to be operated - is that right? Then there was another question.

THE CHAIR: I believe Mr. Daye has comments.

PAUL LAFLECHE: Okay, I'm going to turn it over.

MICKEY DAYE: I think what Brian briefly hinted at is, there are real benefits to having the long-term care and the community health centres co-located together in the same structure. One of the issues mentioned earlier, Tammy, was about EHS. As you know, if somebody in a long-term care facility right now becomes ill and they have to be transported to a hospital site, that requires an EHS transfer. Co-locating them within the same structure

actually provides some benefits and eases some of the strain on EHS, because if a person in long-term care becomes ill, they can go directly to an attached community health centre, get the lab tests that they needed, get X-rays, those sorts of things, which actually provides a relief on the system that way.

It also has other opportunities where their primary care physician may be co-located in the same structure and those sorts of things. There are all kinds of benefits to co-locating those in the same facility.

TAMMY MARTIN: Thank you for that clarification. I'd like to talk a bit about staffing concerns in the recent NSGEU survey that was discussed last week: 93 per cent of nurses surveyed say they are being put at risk because they work short; 69 per cent say they've witnessed a near miss; 92 per cent say their workload has increased; 80 per cent say their employer's decision to change the way they interpret overtime language in their contract has increased their workload; 85 per cent say they work short at least once per week; 77 per cent say their employer's decision to change back to the overtime has actually increased the time on the unit they are working short; only 12 per cent of the respondents said they feel safe at work, which is pretty disturbing; 84 per cent of respondents say they have had physical or verbal threats or abuse or violence; and 35 per cent of nurses asked say they have sustained injuries over that same period of time, during that period.

Going forward with the redevelopment, although the crisis is now, building this capacity and these new facilities, the staffing component, is any part of this planning going forward?

BRETT MACDOUGALL: I think, overall, we're taking into consideration health service resourcing for the Eastern Zone as it currently stands and allowing the Cape Breton redevelopment planning - and when I say "planning," the functional planning and then the master programming to help develop the future state in relation to what our resource plans would be.

Currently, we are able to determine the amount of long-term care - or, sorry, the LTD mat leaves and those types of things that impact our overall resources, and we build that into our recruitment strategy for nursing in particular, and that helps articulate to the organization what our needs are, each year, going forward. With that, in combination with the service planning for the Cape Breton redevelopment, we will be able to develop service planning needs that we can work with government and our education partners to help build the platform for our health services needs in the future.

THE CHAIR: Order. Time has expired. We will now move to the Liberal Party with Mr. Mombourquette for 20 minutes.

HON. DEREK MOMBOURQUETTE: I appreciate the opportunity to be here with the committee. I'll start us off, and I want to start by thanking each and every one of you for the work that you've been doing in our community. This has been a long time coming, I believe, for Cape Breton. Successive governments have received reports, studies, and recommendations in regard to what we need to do to better support health care services that we provide to Cape Bretoners, and the work that you're doing is exceptional. I know you don't hear it as often as you should, but I can tell you, as a local MLA in the community, that people are very positive about the announcements that we've made. People are very positive about the work that you all have done, and I want to thank you for that.

To the local leadership team, Dr. Orrell and your team, we've known each other a long time and you've done a tremendous amount of work in our community, both as a physician and as a volunteer. You stepped up again, so thank you, sir, for the work that you're doing along with your team.

I will start my questioning off with - throughout this process, you hear questions come through about what the consultation has been in the community. I know it's been discussed here in various parts of this proceeding, and I open the floor. I think it's important for folks at home to know how much consultation actually went into a decision of this magnitude. That's my first question, just to elaborate a bit on the consultation.

MARK LECOUTER: Thank you for the question. We've had well over 100 engagement meetings with health boards, special interest groups, chambers of commerce, rotary clubs, anybody who's interested in hearing about our project, and we're more than willing to meet with them.

There's over 100, and they started even before I was on the team. Brett McDougall, the executive director, is meeting with many special interest groups. It's very exciting. We're getting a lot of great feedback, and we're meeting in each community. We're going back now to look at regrouping with those groups to update them on our project.

Certainly, a lot of great feedback - this is a huge project. It's an investment of hundreds of millions of dollars in our local economy and our health infrastructure, and along with that, we'll create a more sustainable, reliable health care system. It's exciting, I've been in the Health Authority 16 years as a nurse, and I'm really excited about the project, and so is our team. It's an evolution of health care in Cape Breton, and it's certainly the right thing to do.

DEREK MOMBOURQUETTE: Thank you, I appreciate that. For me, we have these conversations on a daily basis in our community. There were a lot of questions, and as Mr. LaFleche said, it's the most significant public project in the history of Cape Breton.

I want to talk a bit about recruitment and what the facilities mean. You know, I've had great conversations with Brad Jacobs and the leadership with the hospital foundation in regard to the role they want to play in the expansion of the cancer centre. Dr. Brake, during the announcement, talking about what the critical care unit is going to mean for Cape Breton as it serves the entire Island - he calls it, when it's done, it will probably be the best we have in the province. So these are exciting announcements Sydney-specific, and for the entire Island.

Dr. Orrell, back to your doctor recruitment. This is a conversation that we have had in the past, and this is a conversation that MLAs have on a daily basis. Through some of the statistics that are coming through the NSHA, we know that approximately 13,000 Cape Bretoners have found access to primary care in the last two or three years. We know that in some communities - I was looking at the numbers last night, and we still have challenges when it comes to access to primary care and some of the services that we provide. We know we're also strong in other areas of the Island when it comes to recruitment, specifically up in the Chéticamp areas and whatnot. The numbers are very strong.

But I want you to elaborate, Dr. Orrell, if you can, on what this means to continue that work to recruit and retain physicians on the Island.

KEVIN ORRELL: Historically, I could go back to 1993, when I was a member of the regional services committee that closed the three small hospitals in Sydney and moved to the Cape Breton Regional Hospital. At that time, we did much of what we are hoping to do through this redevelopment project. There was a consolidation of care, there were facilities provided that were very attractive to new graduates and to people who were working in locations that didn't have the same type of work environment.

What we saw at the time the Cape Breton Regional Hospital opened was an influx of people attracted to the facility and attracted to the working conditions. By that I refer to the fact that instead of having internal medicine specialists who did everything - cardiology, gastroenterology - we developed a group of people who were most interested in cardiology and could concentrate on that. An infectious disease consultant was attracted to the hospital - it was bigger, there were more patients, we could support that kind of a specialty practice.

We had people with other subspecialty interests come. We had a thoracic surgeon, and a number of oncologists for medical oncology and radiation oncology who came to the cancer centre when it was built. Radiology improved and we began to develop radiologists who were specialized in different types of investigative procedures and interventions. I was one of two orthopaedic surgeons who became one of three and now we have five.

There's no question that the type of facility that is offered to people looking for work makes a big difference; I think this is definitely going to be the case. We're going to recruit people who will be interested in the redesign of modern health care delivery. The benefits of having services in the communities where they're needed - not everything has

to come to the big house. They are going to be able to consolidate their speciality together, as a group, who practise and learn together and co-operate together and share call schedules together. This is very attractive to new graduates.

The other thing about recruitment which we often forget is that if this is sustainable and if it is a system that offers everything we know we will be able to create, we'll be able to retain those people. Cape Breton has seen a lot of doctors come and go, but this type of design will be a retention tool as well.

Thirdly, which is not often discussed in terms of recruitment - there have been a number of doctors in our local community who have withdrawn, for various reasons, sometimes because they're frustrated, burnt out, sometimes because it's an objection to something they don't agree with. We can recruit these people back and many have already expressed an interest and shared that with us. So we can recruit people who actually still live in our community who are willing to step up as medical leaders and be involved with this. From that point of view, I think recruitment is very rich.

DEREK MOMBOURQUETTE: I have one final question before I pass it over to my colleague, for the last 10 minutes of this round. Just in regard to a comment Mr. LaFleche made, and it is important - first and foremost, this is about providing the right health care for the Island and this redevelopment project is very significant. It is one of the most significant public projects Cape Breton has ever seen.

I know that a lot of the work is not done yet, but would you elaborate on the point you made earlier about your experience when it comes to projects of this magnitude?

PAUL LAFLECHE: There's a lot of capital work that is going to go on in Cape Breton in the future. We've got some projects that are proposed but we've got a number that have been announced and they include this. The Premier put a label of about $0.5 billion on this one - we don't have a definitive figure yet but it will be at least that.

We've got the community college project, we've got the second berth in Sydney, we've got the Bayplex under construction now, we've got a number of potential waste-water projects which have to be done before the new environmental rules come in, and we've got a lot of other proposals. So there's a lot of capital work that is going to be done in that area. This is going to cause quite a boom in activity.

Maybe I'll let Gerard Jessome - who is our executive director of project design and construction, but was the regional director for the transportation side for many years in Cape Breton - describe what that means and what plans we have to ensure that Cape Bretoners benefit from this activity.

[10:00 a.m.]

GERARD JESSOME: Thanks for the question. Yes, this is a significant project that's being planned right now, plus there's many more significant expenditures planned for Cape Breton. Being a Cape Bretoner, I have never seen this amount of investment in the economy, in Cape Breton, and it will definitely have big potential benefits for all Cape Bretoners in the community as well.

We're working on a labour strategy now. Like Deputy LaFleche mentioned, we have not only the health care projects, we have the NSCC Marconi Campus relocation, we have three schools that will be built and all this work, probably over the next three to 10 years. It's a substantial amount of work, but we have to plan it accordingly to make sure we maximize the benefits for Cape Bretoners and Cape Breton itself.

As we all know, the economy is not great in Cape Breton, but I think if planned properly through these public infrastructure investments, we can maximize the benefits, and I think set the train in a different direction.

We are working on a labour strategy for all this work that's upcoming. We're working with Labour and Advanced Education as well as local groups, minority groups, MEBO, the Mi'kmaw Economic Benefits Office and other minority groups as well, to try to strategize in the best way to carry out and complete all this work that we have planned, that's ahead, for sure.

It's exciting times for Cape Breton and I think if I had a tool belt on and I was working out West, I'd be looking home for work again, for sure.

THE CHAIR: Mr. MacLellan.

HON. GEOFF MACLELLAN: I appreciate the team being here today. I have a question that's personal in nature for Dr. Orrell, but first, I just want to do a bit of a preamble/soliloquy about what this means to me.

It's an enormous sense of pride every time we talk about the Cape Breton redevelopment plan - for us, for MLA Mombourquette and me, but in fairness, for all MLAs in Cape Breton regardless the political stripe, because it's been such a long road for health care. The Opposition MLAs get the questions, but as government reps on the Island, of course, we get it the most and the heaviest in terms of intensity. It's been a long road and it's been a tough challenge.

I think there was a period when we were in the transition and getting to a place that we would get some of these projects announced and out the door, it seemed as though nothing was happening. I think that now, it's very clear and evident that there's a lot of things happening.

Paul, you referenced the $0.5 billion in spend. This is an enormous change. This is going to, as Mark said as well, reshape the entire landscape of health care delivery. Not only in Cape Breton, we'll be the benchmark, but this will transcend to the rest of the province and in areas where infrastructure has to take place. I think for us, this is something that I stand behind 100 per cent. Personally, this is a legacy for me, because we're making a difference and we're making the change that's necessary.

As far as being happy and supportive of this, I don't hear the negativity in terms of this decision, and this $0.5 billion, and this massive spend for our four hospital sites that we have. One of my next questions in the second round is around that short-term piece; I don't think it's lost on anyone that we have to get to that point where the doors are open, there's no doubt about it.

My question for you, Dr. Orrell, as we go forward - I think for the security and the support of Cape Bretoners who are focused on what this is going to mean for them and their health care delivery, the health care professionals and the doctors at the forefront become incredibly important. Your face, your reputation, your integrity is of critical importance for Cape Bretoners; not for us as the government side, not as politicians, but for Cape Bretoners.

You have a tremendous legacy in the community. I know you've got a collection of body parts from the MacLellan family, between my dad's hips and my shoulders, and cousin Eddie also had some work done as well. I will see him soon.

Dr. Orrell, in discussions in this Chamber - and this isn't political and I'm not looking to call anybody out - there were discussions around your motivation here. You had been a critic up until two years ago; you led a rally that was very critical of our government's decisions and direction. Look, as I always say, health care professionals, their opinions matter the most. If that was your opinion at that point, then that's reasonable that you would be there.

In my opinion, biased of course, but you see that this is a real thing and it's going to change health care in Cape Breton forever. The insinuation was that you went from being a critic to a champion, and there would be some wonderful position at the end of this process for you and that somehow you are motivated by that as opposed to - for some reason there are questions around why you would support this plan.

We haven't rehearsed this, I don't have any idea how you will react to that, but in this world of political discourse you're going to be the person who matters the most in terms of reputation. I would like you to address - doctors and people in the community are asking what has changed for Dr. Orrell - I would like to ask you: What has changed?

KEVIN ORRELL: Firstly, I had a number of calls concerning that after those remarks were made. I believe there was some reference made that I was appointed by the government. Nothing could be further from the truth. I applied for this position when the expression of interest came out. I rehearsed, planned ahead, prepared. It was my first job interview since first-year university when I applied to Marine Atlantic to be a ticket clerk. I fully respected the process of the competition, and I was very fortunate and very grateful to receive the appointment after the committee met with a number of other candidates.

I've been very vocal - I consider myself a medical leader in our community - and there were a number of things that were very difficult to understand as a practising surgeon, as a clinician. In co-operation with my colleagues, my overriding protest, if you will, was that as Cape Bretoners we didn't have a voice, so I applied for a position where I thought I would have a very significant voice in what was going to change in Cape Breton in terms of health care delivery. That basically corrected my objections - I had a voice and I felt that I could significantly contribute and I'm very excited about the contributions so far.

There were three aspects to why I was interested in this position - one was from a career point of view. In my early career, I made reference already that I was on the regional service committee that redesigned and reorganized services provided at the Cape Breton Regional Hospital when the three smaller hospitals closed. That was early career; in mid-career I was involved as the only physician with the Department of Health and Wellness for the models of care. That significantly changed care delivery and the way allied health professions interacted with patients, doctors, and staff. I consider that a mid-term interest that I think was very successful. In my senior years, this is something I feel I can contribute. As far as an appointment at the end of this, that would be retirement.

The second thing is we need to change things. When you're involved with the day-to-day grassroots activity of looking after patients and interacting with families, you have to recognize that things have to change. We're not inventing something new, which is a misconception by many people who hear about this project. This is worldwide - many countries have enjoyed the success of this kind of redevelopment.

The third thing is that I have children now; I have a son who's a nurse, and two daughters who are studying specialties. Perhaps we may make Nova Scotia an attractive place for them to come, and I'm very interested in that as well.

GEOFF MACLELLAN: Just quickly, and maybe this is a yes or no - one of the concerns in the community is that in the transition, particularly for the Northside and New Waterford, that there will be a gap where those sites will be closed without the new spots reopening. Could Mark or Paul address that quickly?

MARK LECOUTER: Our master planning all involves having facilities open before any type of decommission of any buildings. Absolutely. We've had that comment from a few community meetings, and we assure people that's not the plan.

THE CHAIR: Order. Time has expired.

We'll now move to the Progressive Conservative Party. We have 13 minutes for the next round. Mr. Orrell.

EDDIE ORRELL: Thank you for appearing before our committee today. Continuing with what Minister MacLellan just asked about the closures of the Northside General and New Waterford while the build is taking place, my opinion is that they're being kept open because they're needed. There is not enough capacity at the Regional Hospital now to handle the mass volumes - one, of emergency care; two, of acute care; and three, of long-term care - until this build is complete.

The build is great. I think it's the best thing that happened to our cancer unit, because we see a lot more people, but the emergency room expansion is going to be 12 beds. The Northside General has over 10,000 visits a year in its diminished capacity now because there are no physicians.

Does keeping these facilities open mean acute care, long-term care, and emergency care? Because right now, emergency care is not happening at our facilities. It's not happening in New Waterford, and in the months of January and February, Glace Bay has the bulk of the times that their emergency room was closed. The Regional just can't handle it. It was never designed to handle five hospitals. It's designed to handle two actual acute care facilities and a mental health facility at that time.

Does keeping them open mean all aspects of it, and what are we going to do to keep those emergency rooms operating to take the strain off the emergency room at the Regional Hospital until that happens?

BRETT MACDOUGALL: Thanks, Eddie, for your question - very concerning for Cape Breton. We hear comments from patients and families frequently about this issue.

In relation to keeping those departments open, the emergency department physician resource challenges that we face within the Eastern Zone, Cape Breton, provincially, nationally - very difficult to correct that within a short time frame. We are working with our physician colleagues in the Emergency Program of Care, in collaboration with senior executive leadership, to see what possible options are available to us, to look at what could be possible in relation to North Sydney and Glace Bay, in particular. New Waterford, the physicians in that facility and that community, resource the emergency centre at that site fairly well. There are certainly some gaps from time to time and month to month.

We have looked at additional payment schemes in relation to challenging shifts and in relation to different shifts that are difficult to cover. The ED Program of Care, Dr. Milburn, is working with Dr. R.J. MacKenzie to see what could be possible in relation to shift incentives for evenings, nights, and weekends to help ensure that the resources at the Cape Breton Regional facility are able to take care of emergencies.

To your point about North Sydney and the 10,000 visits they see, and similarly in Glace Bay with the visits that they see there, we know historically that 60 to 70 per cent of the visits are not emergency in nature. That doesn't mean that those patients do not require care. It's more, how do we ensure they have primary care access?

We're looking at a number of different options in relation to what could be possible in the short term for North Sydney and Glace Bay. We have also put out locum asks. There are some challenges with that in relation to gaining licensure through the college, so we work with the college to try to see if there's the ability to influence a change in relation to how we intake locums to the area. We've recently just had some locums who worked in North Sydney to provide some coverage.

In the short term, it is very challenging. I'm not going to pretend we have the silver bullet to correct that. We have put some additional measures in place at the Regional facility. We're looking at non-traditional spaces to try to create some capacity, so there are some additional beds on some of the units that we moved into over the last number of months to help with that flow.

As Ms. Martin pointed out, the last four months have been very challenging. Health care is difficult and challenging. It's hard to predict when people require emergency care or urgent care. As she had mentioned, the last couple of months have been difficult, and we've been in some overcapacity situations.

With that being said, the last week we've been doing quite well with a limited amount of admissions in the Cape Breton Regional emergency department, which allowed for patient flow to go through the facility and allow for the appropriate care in the appropriate places.

[10:15 a.m.]

I don't have a quick answer, a quick solution to the current issues but we are working with our partners, our physician colleagues and leaders within the organizations to try to come up with some solutions in the short term while we work on the Cape Breton redevelopment project.

EDDIE ORRELL: Thank you, Mr. MacDougall. So the real concern is you're saying that 60 per cent of the visits to these emergency rooms aren't necessarily emergency room visits. I've been given those stats before. I was told that the acuity of the Northside General, when they were talking about reducing the pay that the doctors get when they

work in these facilities, compared to what they got at the Regional, that because they weren't necessary emergency visits, the percentage of emergency visits is the same in the outlying hospitals as it is at the Regional Hospital. So that goes out the window that the acuity was different.

I've had doctors in my office who have volunteered to work these facilities when they were being closed and they were told by the people in charge that they weren't going there because the facility was being closed. So we had the opportunity to keep them open and we, as a group - and I take it as a government, as a health care authority, as politicians - we're blocking that. The "build the hospital and they will come" regime, I hope it works.

I've seen the movie *Field of Dreams* where they build a ballfield and the players came and played, but we've got to do something more. We've got five years before that happens and we've got nothing right now as a plan to bring these doctors and keep these departments open.

They're having difficulty with the Regional Hospital keeping physicians there at any given time in the emergency room because they're just not there. The fear is that with the closures, doctors and health care professionals aren't going to apply to these facilities right now and they're having difficulty staffing them. What are we going to do in the meantime to prevent this from happening, to keep people here and to bring them here while we're in the build phase?

BRETT MACDOUGALL: Your point in relation to physicians who have asked or come forward and said they're willing to work in those facilities in the emergency departments as they currently exist, I'm unaware of those individuals who have come forward and put in that request. Following this meeting, if you want to identify who those individuals are, we can certainly follow up with them and see if there's the opportunity for them to help support and resource those facilities that support the communities.

I know we have the nursing staff available and we just currently transferred them over to the regional centre to help with the increased demand on that site. Certainly if we have physicians who are willing and able to work in those facilities, we can place those nursing staff back in those facilities to ensure there's care in those communities.

EDDIE ORRELL: Thank you, that's good to know. That's well appreciated.

I guess my question to you, Dr. Orrell, is you took this job to be a voice, which I understand. You were very vocal about it at first. I know that and I've talked to you since then and it's because of the voice.

If your voice has something to offer that's different than what the go-ahead plan is, will that be accepted by the committee, by the group, by the government? I know in something like the Northside General it's not going to have an emergency room, but they're going to have a collaborative practice-type hospital. Will there be an acute care, minor

injury clinic in this facility so that if someone cuts their eye or a child has an earache, instead of waiting at the Regional for a length of time for what they call non-emergency care, will there be an acute care facility there with maybe two or three beds that doctors who work in that facility will be able to staff that on an hourly basis so that not all one person is taking up their time with that? So it will be an hour a day or an hour every second day, or whatever it might be.

Will there be any possibility of an acute care bed for someone who just might need observation, say for an overnight, that would take that strain off? The acute care beds that are at the Northside now and acute care beds that are in New Waterford, there's not enough facilities at the Regional Hospital to handle those numbers. Is there something that might be, with public input or your input, if there's something different will that be accepted, and will the committee look at that as something that the community has come forward with and it's something to look at?

KEVIN ORRELL: That's very important. When we talk about a health care centre, we have to recognize truly what it is. There's an impression that we are just adding on a little clinic like a dental clinic at the Mayflower Mall. These are stand-alone, world-class facilities that are large, that will contain many clinics.

To reduce the strain on an emergency department in terms of numbers of people, there will be facilities in these health care centres that will address the earaches, the wound changes, the IV drugs that have to be administered to patients who are living in their own homes - all of those things where people are going to receive the care in the community in which they live.

That's a very strong benefit of what's being redeveloped. This will make it much easier for the seniors in these communities - because there are populations of seniors that live there - to access care exactly where they live. It will have the benefit of reducing the need for ambulance drives to a big hospital. It will reduce the amount of patients that are waiting to be seen and waiting for examination rooms.

The family medicine residence - over half of the medical residents that we train, want to do a plus-one year in emergency medicine. It's a young man's game. People resign because they get tired or they get burnt out. These people are going to train to be emergency room physicians. They welcome the chance to come back to a facility that will allow them to do what they see on television as emergency room physicians. They want to look after the people who are in distress, the people who have heart attacks. They're not interested in seeing someone whose child has a runny nose - they want to do the television emergency medicine stuff. This is kind of the set-up that's going to take place at a redeveloped emergency at the Cape Breton Regional Hospital. The recruitment of that kind of trainee back to Cape Breton is very real.

MICKEY DAYE: Thanks for the question, Eddie. You and I have chatted in the past about this sort of stuff. We talked about the collaborative practices and I've talked to the physicians in North Sydney and we talk about the access to these next day/same day kind of appointments that people don't necessarily need to go to an ER for, and how we do that.

We work with the physicians - Stephanie Langley, Joan Salah, the physicians on the Northside, and we're working with them to try to figure out what works best to see that population of patient. It may not be the exact same in North Sydney as it is in New Waterford, so we're working with the physicians in New Waterford - Jen Lange, Peter Littlejohn, Steve Farrell. Those physicians are there to say, we have this population that you're currently seeing in your CEC but don't necessarily need an ER visit: What's the best approach to do that?

We're trying to work with them. Maybe it's after-hours access in their collaborative practice, maybe it's some sort of walk-in clinic - we don't know yet. But we are having those conversations with them because we have identified that those are patients that still need to be seen moving forward, but don't necessarily need to be seen in an ER, so how do we do that best?

THE CHAIR: Order. We'll now revert to the NDP - Ms. Martin for 13 minutes.

TAMMY MARTIN: Somebody mentioned the list of people on the drawing board, so to speak - community members, doctors, involved community people. I wonder if we could be presented with a list of names that are on these redevelopment committees for each site - for New Waterford and North Sydney?

PAUL LAFLECHE: Mark, do you have that info?

MARK LECOUTER: Yes, I can provide that for you.

TAMMY MARTIN: Perfect, thank you. I want to go back to what Dr. Orrell talked about - the IV, antibiotics, those types of things, and hopefully that there would be acute care services, even though we're losing emergency services. You said that these clinics would include colonoscopies, X-rays, bloodwork, dialysis, mental health, those types of things. Is the functional planning including the specifics that are required for staffing?

MICKEY DAYE: I feel very popular at this meeting. As I said, Tammy, as we move through the functional process and the programming - the announcement last June came out and said nine to 12 months for functional programs, and we're moving that forward. When we look at DI services in New Waterford moving forward, for instance, we've asked the clinical directors for that service, and the managers who provide administration to it: Where do you think the future needs to be for DI services in New Waterford, like X-ray and ultrasound; what other things need to be there in the future; and what staffing model do you need to operationalize to provide that down the road?

That is a consideration as we move forward through the functional plans. The actual departments are saying this is what we want, or this is what we think we need to have in the future to provide appropriate services, and this is the staffing that we will need to operationalize to be able to manage that.

We're doing that for all our services. We're doing that for DI, lab collections, physiotherapy, occupational therapy, public health, primary health care, and when we look at our collaboratives. We're doing it for mental health and addictions. We're looking at all the services that we're providing, so in North Sydney, for instance, renal dialysis - I mentioned that earlier - is going from eight to 12 chairs. That's an increase of 50 per cent - how do we operationalize that?

That's part of the functional plan to say, well, we have X number of nurses now that provide care for eight patients or for eight chairs; in the future, we're going to have 12. This is what we're going to need for staffing for that.

In North Sydney, we're expanding endoscopy services on the Northside. That's one of the things that doesn't get mentioned a whole lot. We currently have one room; we're increasing to three and going to operate two on a regular basis. What's the staffing we need for that, to move that forward, to make sure we can operationalize that and get that appropriate? Continuing care is another one.

All the services that we're doing and looking at, we are looking at how we need to operationalize that. What are the staffing models for that? We're not doing that in isolation. We're doing that with all the different members of all the different services - the managers, the directors, the senior directors - to make sure that we're not saying, well, this is what we want to do, but we haven't talked to the people over here and how they're going to run it. We want to make sure that we're doing it all together, working together as a group and as one whole Health Authority.

TAMMY MARTIN: I believe it was Mr. Jessome or Mr. Ward who talked about the timeline around the Fall, when the announcements would come out about what's left to do. Initially, when the announcement was made in June, that would put us at about a year. I wonder, is this an extension to what you initially thought, or six months to nine months to a year? And what Mickey just spoke of, will that be included in the final report?

BRIAN WARD: I spoke earlier about the timeline for the master planning work and I talked about the functional program in the master program work. The master planning work, we had been focusing on a 12-month from the time of the announcement by the Premier. With this being such a complex project, we're looking now at probably late August, early September for the final document to be received.

But what you'll notice is our most recent announcement with the Regional. It's certainly part of the master planning work; as projects become obvious that we can pull them away and start to make some announcements, then we'll go back to the government, we'll explain what we think are our next steps, and then we'll be asking if we could move forward on various phases. The two community health centres with the long-term care, those are projects; the laundry in North Sydney is another project; we have the redevelopment of the Regional; we have the redevelopment of the Glace Bay facility; and we have the expansion of the emergency department.

We're exploring all those individually, and as we start to see projects that are available prior to the master planning being finished, then we'll start to move forward and ask government for permission to move forward on them.

MICKEY DAYE: Tammy, just to elaborate on what I was talking about earlier, the services in the facility, when you think of what we're trying to do here, we're trying to - think of one-stop shopping. One of the best descriptors I give for people, and people on the team are probably tired of me talking about it, is the Walmart on SPAR Road in Sydney. That's your one-stop shop; you go in and you get everything done.

What we're trying to do is provide the one-stop shopping for members of the community. If you go to your primary care practitioner and they're in a collaborative practice in the community health centre, if they give you a requisition for bloodwork, you can just walk down the hall and get that bloodwork done. Whereas, currently, if you go see your family physician and they're outside of the hospital, if they give you that requisition for bloodwork, you may be less likely to get the bloodwork done right away because it's another trip for you.

We're looking at trying to bring it all together. If you need mental health and addictions counselling, you can do that while going to see your primary care practitioner; while you get your bloodwork done; while you go see continuing care for your mother, who needs some continuing care supports in the home.

What we're really trying to do is to provide one-stop shopping, make it easier for people. I know transportation is an issue that we've talked about. This will also help alleviate that because you won't need to make as many stops as you go forward, because you can go to that one facility and get it all. If your mother is in a long-term care facility, and it's attached, that's another bonus as well.

We're really trying to improve things for New Waterford and North Sydney and make sure that people have the appropriate access to care that they need moving forward; not only now, but for my kids who live in the community 20 or 25 years down the road.

[10:30 a.m.]

TAMMY MARTIN: Mr. Chair, that's a good segue into my next question.

While I appreciate all this information and, believe me, I do realize it is going to be wonderful, but I will continue to advocate for what we're doing now and for the lack of services that we have or don't have now and the fact that people are dying, now.

Going forward with long-term care, my opinion is that we can't make enough long-term care beds because that's part of the backlog and part of the huge issue why your loved one is in a home in Tatamagouche and you live in Sydney. Hopefully, at the end of the day when we have all of these in place, that won't be the case anymore.

There are currently long-term care beds in New Waterford and North Sydney and an ALC unit in Glace Bay. Of the new build, the announced beds that are expected, how many of them are actually new beds? We know that we already have those in place, so truthfully, how many new beds are coming that we don't have already between those three facilities?

MICKEY DAYE: Tammy, if you know, North Sydney has Taigh Solas which has 22 beds and we also have 4East, which has 14 beds as well, which gives you a total of 36. We're adding 60 on the Northside. The original announcement was for 48, that has since been increased to 60, which I think is a great addition. That will provide us with 24 new beds on that side, based on those two units that are currently there.

We have 24 beds in New Waterford Heights. In addition to that we're adding 60 in that community, which gives us an additional 36 in that community. That also provides us some leeway to help out with some of our ideas of moving and not trying to decant patients that are tying up hospital beds, acute care beds which are more expensive. It gives us that opportunity to decant them into long-term care facilities where they need to be, and they can get the appropriate care and the appropriate level of care they need.

The announcement of 48 in June was fantastic. That has been increased to 60, which is only a greater benefit. It will allow us to offset what is currently in those two long-term care facilities in those community hospitals and then allow us to decant other members who are also on a wait-list in the community or also tying up an acute care bed, which goes back to the ER backlog as well. It's all a bed-flow issue. The ER gets tied up because we don't have acute in-patient beds. They're tied up with long-term care patients. That's one of the reasons.

If we can get those long-term care patients into a long-term care facility where they need to be, provide more appropriate care for them, it frees up acute care beds which also gets our ER patients who are admitted and waiting in the ER for an acute care bed, gets them moved out of the ER and up into a more appropriate bed. It basically provides a better flow and more appropriate care to patients all throughout the health system.

TAMMY MARTIN: Does that mean then that there are 60 new beds not anywhere yet? We do know there are ALC patients in 4North in Glace Bay, so I don't know where they're going, as well as how many we could canvass today who are in an acute care bed right now that are taking up a bed - so is it 60 new beds?

MICKEY DAYE: Overall, we have the 24 I talked about in New Waterford, so that's in addition to what's currently on 4North - sorry, on Taigh Solas and on 4East because that's 36. If you want to count the 4North from Glace Bay as well, you have 24 and 18, that gives you your 34, your 42 gives you another 18 there, so you're adding in those 20, the part from New Waterford and North Sydney. That still provides us enough of what other acute patients would be or long-term care patients in acute beds to off-load that for sure. That was one of the objectives: making sure we had that ability.

You could provide all kinds of long-term care beds and you could always find somebody to fill them, but we also need to provide other services to those members. If we can find enhanced community services and those sorts of things, which we hopefully will identify as we move this forward, there may be additional supports that we can provide as well.

KERRY MACLEAN: Just to confirm that with the 60 additional beds in Northside and North Sydney, it would be . . .

TAMMY MARTIN: New Waterford.

KERRY MACLEAN: I'm sorry, New Waterford, it would be a total of 74 net new beds.

PAUL LAFLECHE: I just want to point out that those figures are what's part of this project. There may be other things done in the CBRM, or nearby, which are not part of this project in terms of long-term care, so that's the minimum you would see.

THE CHAIR: Ms. Martin, one minute.

TAMMY MARTIN: To be clear then, we're not including those patients that are already in an acute care bed that should be in a long-term care bed in CBRM?

MICKEY DAYE: That's a hard number to calculate on a regular basis because that number fluctuates so much. Currently, as Brett alluded to earlier, the Regional Hospital bed situation is very good. At certain times of the season or part of the year, we do reach max capacity and we are full at that point in time. Right now, we have very few ALC patients in the current facility and there has been a lot of work done with that over the last number of years to try to reduce that number on a regular basis, so it's not as huge of a number as it used to be.

THE CHAIR: Time has expired. We'll go to the Liberal Party - Mr. MacLellan.

GEOFF MACLELLAN: I think this question would be for Dr. Orrell, maybe there might be something to add from Brett and Mickey. Again, obviously with the significance of this investment and what we've seen at the Regional, the two new sites in Northside and New Waterford and of course, the expansion in Glace Bay, as I said in the previous round, people are extremely supportive. I think they know and feel that this will be the difference maker, no question, in terms of getting to a place of stability where the services are right-sized and properly aligned, where the recruitment and retention aspects of what the department, the Health Authority, and the medical community in Cape Breton do, will be maximized.

There are two things - and it was touched on before - that I hear in response to this, as much as people are incredibly supportive. Number one is that based on the history of political promises from all Parties in all jurisdictions in the world, I guess, they're not sure if it's actually going to happen to this magnitude. I think that as we roll out plans and really shore up those details, people are becoming very confident that all these things are going to happen to the tune of $0.5 billion at these four sites. I obviously have no doubt these are done deals, we just have to get there. I think that's part of my question, as the capital unfolds and the infrastructure comes into fruition and gets built, there is that space.

With the strain, with the pressures now on our current complement, my read - again, this is as an outsider, I'm certainly not inside the medical community, but I listen to a lot of people and talk to doctors and health care professionals. When we're talking about recruiting, retention, and all the functions that go into that, the medical community itself, the men and women who do this every day have a significant role to play. When it is about recruiting in other jurisdictions and making sure that those that we have here we retain, I think doctors and medical professionals lean on each other.

With that being the case, Dr. Orrell, this is probably more anecdotal than scientific, but what is the reaction from your colleagues in terms of both the physical infrastructure and the plan that's in place? Is it sort of widespread support, are there pockets of concern about what the plan is that's rolled out? I think that speaks to MLA Mombourquette's consultation question. Secondly, how will it affect recruiting and retention in terms of the way in which we hold the line between now and the day that the doors are open on the new facilities?

KEVIN ORRELL: The day it was announced that I was successful in acquiring this position, I had almost the entire medical staff text me or call me because they were very encouraged that somebody local was going to be involved and they were very supportive, that based on my interests and the things I had done in the past, as well as my experience in working there for 30 years, that things would happen that would be very agreeable to them as practising internists, family practice people, and surgeons.

I've since heard from a number of the specialties that we don't often consider - the radiologists and pathologists - and everybody who has a thought about how to make this even better, is very quick to liaise and to express themselves, which I'm very encouraged about.

The ability to attract people comes as a double-edged sword, if you will. If you're struggling for a facility - some specialists will say they would love to have another colleague, but they don't want to divide up what they have now in terms of being able to offer their service and to practise their specialty. This redevelopment will take some of that concern away.

If there is space, if there's a redesign, that will consolidate care and that will use resources efficiently, then they are much more interested - our best recruiters are our own physicians and surgeons, and they will be much more interested in approaching new grads, new trainees, to come because they know that there won't be a significant impact on their own ability to practise when they attract new people, so this is very, very progressive.

GEOFF MACLELLAN: Just before I turn it over to my colleague MLA Mombourquette, I just want to say something. This is a statement, not a question, so I just want you to think about it. I think that for all of this, the entire plan was very comprehensive, and a major spend to actually work properly. You're going to have to do the Glace Bay project first. (Laughter)

With that, I'll turn it over to MLA Mombourquette.

THE CHAIR: Mr. Mombourquette.

DEREK MOMBOURQUETTE: Thanks for that, Mr. MacLellan. This has been talked a bit about through these proceedings, and it's something that has come up in the community a lot. As community members, regardless of where we live, facilities have been built by our families. They have been built by community organizations. They have been built by service clubs, et cetera. They're part of our fabric, and it's always very difficult when you make changes where facilities that are older will close, and you're looking at new facilities, and there's a lot of a process that goes through that when you look at it.

We heard a bit about it today in regard to some of the challenges with some of the older infrastructure. I remember St. Rita's Hospital and the shipyard. I'm a shipyard guy from Sydney, and St. Rita's meant the world to the community, but eventually it closed for newer facilities. Some people found at the time that they were sad about that, but that was the reality of the situation. That hospital closed for the Regional.

We're in a situation now at home where these buildings mean a lot. They mean a lot to these communities. They were built by community members. We've heard that passion from my colleagues on all sides of the floor in regard to that. The facility in New Waterford was built by the community. The facility on the Northside was built by the

community. There's a lot of attachment to these facilities. There's the emotional side of this, of course, the community ownership of it, and then there's the infrastructure pieces as well. We know the patients coming into our cancer centre have doubled and that the capacity wasn't there. We know that our ER at the Regional, as well, was not at capacity, so we need to make some changes.

The point I'm getting to, if you could elaborate on some of those challenges that you looked at when you were making the decisions. Ultimately, we've made decisions to move forward with newer facilities. Can you elaborate a bit on some of the challenges that you faced when you were actually doing the assessment of those current properties that we have now?

PAUL LAFLECHE: The two people who accompanied some external consultants on those assessments are Brian Ward and Bryan Darrell. I know that Brian Ward talked earlier, so maybe Bryan Darrell could talk a little bit about the assessments and what you found up there.

Bryan has been familiar with the facilities because he's taken care of them, as an employee of the Department of Health or TIR for many years. In fact, he is working on the first part of the project, which is the dialysis unit at Glace Bay, so Mr. MacLellan, that is at the front end of the project. Bryan, do you want to say a few words on the trips you made up there and what you found?

BRYAN DARRELL: Thank you for the opportunity to actually address this because this is an area that has bothered me a long time. I have spent a lot of time in those facilities, and I see the passion that the people who work there have for those facilities. In many cases, they are almost in love with the buildings, and they take great pride in it. It comes as a hard thing when they actually have to say that maybe it has reached the end of its life.

You walk in, and you see the facilities where you just cannot put any more equipment in that space between the ceiling and the floor above it. You just cannot fit any more. The standards in our new hospitals are such that the air changes on an hourly basis. It just cannot be carried by the pipes that are there. You see the existing pipes in place - soil pipes, copper tubing - that need to be replaced.

[10:45 a.m.]

To knock a hole in the wall to put this in, the cost is just going to be astronomical. If you look at the washrooms, you cannot actually get a wheelchair into the washroom because they were designed in a different era. These are things that, to try to renovate them, to actually build them to accommodate our current standards - you're not doing the people there any kind of justice or service. It's almost better that you say we've reached the end of our lifetime; everything has a cycle. Those facilities just have.

DEREK MOMBOURQUETTE: Thanks for your work on that, because that's a very difficult conversation to have. As I've said, these buildings mean a lot to our communities. They've been established for a long time, and as I've said, they were constructed and loved and cared for by the communities where they exist.

A follow-up to that is the cancer centre. We have world-class care at home, and we all have family members who have gone through or know someone who has experienced the amazing service they receive in Cape Breton. This was a big part for all of us, the expansion of the cancer centre. We knew it was needed in the community.

Dr. Orrell, I'll pass this off to you, if you want to just elaborate a bit about what this is going to mean for cancer care at home for Cape Bretoners.

KEVIN ORRELL: I'm going to refer to Mickey to address this as well, but I can say that for many years, a large part of the reputation of Cape Breton health care has centred around the care that Cape Bretoners receive at the cancer centre. An enormously devoted group of people, well educated and very modern - they're communicating with protocols and other cancer centres all around the world. This facility has really been a very renowned facility for treatment of Cape Bretoners. My hat's off to the people who have worked there.

Like anything else, it was designed at a time and has become antiquated in terms of the space. They look after twice the number of patients it was intended for. As well, it met the standards of the day, but this is a very, very sensitive area for treatment. The facility doesn't lend itself to the privacy, to the special needs of families and relatives and caregivers and support people and to the auxiliary care that people need. This has to change, and this redevelopment will do that in the expanded cancer centre that's going to be created.

THE CHAIR: Thank you all very much. We have 10 seconds left.

PAUL LAFLECHE: Earlier there was an indirect question of how much stakeholder input there was. I think the cancer centre is a good example, together with the one in Halifax, where the physicians themselves, the practitioners, had a significant input in changing the direction of what we were going to do.

What you saw announced for the cancer centre a couple of weeks ago was a significant augmentation and difference from what we originally announced in June. That was mainly due to the input of the professionals.

THE CHAIR: Time has expired for questions. Are there any closing comments? Mr. LaFleche.

PAUL LAFLECHE: Just a general closing comment. I think it's been alluded to that this is a really exciting project that people want to join. Dr. Orrell indicated that he applied for the position and was very happy to get it. I think everybody here, many of them applied for their positions and they viewed it as an opportunity of a lifetime to work on this project and the QEII project.

I can tell you that all across Canada, the interest we're having from people to work on these projects is very exciting for us. We're very privileged and happy to work on them. We're going to do the very best we can as a group.

We're working together as an integrated team ourselves - the Health Authority staff, and the Department of Health and Wellness staff, as well as Internal Services on the procurement side and the IT side. We're proud to have an example here of a team that works across different departments and different Crown agencies to deliver something very good on behalf of Nova Scotia citizens. With that, I'll terminate my comments. Thank you.

THE CHAIR: Dr. Orrell.

KEVIN ORRELL: As I stated, I feel very privileged to be working on this project. I feel enormously grateful to the team that I joined in January. Paula Bond has provided exceptional leadership, and it has taught me a great deal about leadership in the short time that we have spent together. Mark, Mickey, and Brett, I have the highest respect for them. I have worked with them for many, many years in other capacities. I guess as the senior guy, I'm extremely proud of the fact that they have become such important leaders, as are the other members of the team.

This is a legacy issue for us. This is something that we are going to do correctly, and we are going to make sure that the delivery of health care for Cape Bretoners will be as excellent as it can possibly be. We'll feel very proud of leaving this legacy when we're finished.

THE CHAIR: Personally, I would like to thank all of you very much for being here today. It was an extremely informative session. On a personal note, Mr. LaFleche, thank you for being here today also, in light of the circumstances. I appreciate it. (Interruption) You don't get to talk again. (Laughter)

You can be excused now. We have some committee business to deal with. Again, thank you very much. (Applause)

We do have one order of business for the May 14th meeting. The QEII redevelopment - we are going to have a motion, I believe, to have a delegate change in response to Mr. Craig Beaton. Ms. Lohnes-Croft.

SUZANNE LOHNES-CROFT: In light of the deputy minister not being available for our May 14th meeting, I would like to make a motion. I move that for the May 14th meeting on the QEII redevelopment topic, we substitute Craig Beaton with the Department of Health and Wellness for the deputy minister. Mr. Beaton is the best fit for this topic and can provide the necessary information to the committee on this very important topic.

THE CHAIR: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Our next meeting is scheduled for May 14th from 1:00 p.m. to 3:00 p.m., but if the House is still sitting, just to put you on notice, we're going to be meeting from 9:00 a.m. to 11:00 a.m. That will be the Department of Health and Wellness, and Transportation and Infrastructure Renewal, on the QEII redevelopment.

Thank you all very much. We're now adjourned.

[The committee adjourned at 10:53 a.m.]