# HANSARD

## NOVA SCOTIA HOUSE OF ASSEMBLY

## COMMITTEE

## ON

## HEALTH

**Tuesday, May 14, 2019**

**LEGISLATIVE CHAMBER**

**QEII Redevelopment**

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**HEALTH COMMITTEE**

Hon. Gordon Wilson (Chairman)
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Karla MacFarlane
Barbara Adams
Susan Leblanc
Tammy Martin

[Hon. Iain Rankin replaced Hon. Gordon Wilson]

In Attendance:

Judy Kavanagh
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

**WITNESSES**

**Department of Health and Wellness**
Craig Beaton, Executive Director, Corporate Policy, Planning and Process

**Nova Scotia Health Authority**
Paula Bond, Vice-President, Clinical Infrastructure
Dr. David Kirkpatrick, Professor & Head, Department of Surgery, Dalhousie University & Chief of Surgery, Central Zone
Victoria van Hemert, Planning Lead for QEII Ambulatory, QEII New Generation Project
Brian Butt, Senior Director, QEII New Generation Project

**Department of Transportation and Infrastructure Renewal**
Paul LaFleche, Deputy Minister
John O'Connor, Executive Director, Major Infrastructure Projects
Brian Ward, Director, Major Infrastructure Projects

House of Assembly
*Nova Scotia*

**HALIFAX, TUESDAY, MAY 14, 2019**

**STANDING COMMITTEE ON HEALTH**

**1:00 P.M.**

CHAIR
Hon. Gordon Wilson

VICE-CHAIR
Ms. Suzanne Lohnes-Croft

THE CHAIR (Ms. Suzanne Lohnes-Croft): Order, I call this meeting to order. This is the Standing Committee on Health. My name is Suzanne Lohnes-Croft, I am the MLA for Lunenburg and Vice-Chair.

Today we will hear from the Department of Health and Wellness and the Department of Transportation and Infrastructure Renewal, as well as the Nova Scotia Health Authority, regarding the QEII redevelopment.

I'd like to remind everyone to turn off your phones or have them on vibrate. I will ask the committee members and witnesses to introduce themselves.

[The committee members and witnesses introduced themselves.]

THE CHAIR: We will have opening statements by Mr. LaFleche.

PAUL LAFLECHE: I am pleased to be here to talk about the QEII New Generation Project and the role of our department and our colleagues in the Health Authority and the Department of Health and Wellness.

This project is a once-in-a-lifetime opportunity that will allow us to better meet the health care needs of Nova Scotians with access to services, modern facilities, and new spaces and technologies. This massive complex project will support the eventual closure of the Centennial, Victoria, and Dickson buildings in downtown Halifax.

The new QEII Generation Project includes a major expansion of the Halifax Infirmary site. This includes a new cancer centre, a new outpatient centre, a new in-patient centre, a new innovation and learning centre, and major renovations to the existing Halifax Infirmary.

The project also has several associated components. These include a community outpatient centre in Bayers Lake, a major expansion and renovation of the Dartmouth General Hospital is well under way, and a second operating room at the Hants Community Hospital and extensive renewal of its existing operating room.

The Department of Transportation and Infrastructure Renewal is a key partner in this project. We oversee all of the construction, expansion, and renovations. We also work closely with the Nova Scotia Health Authority, the Department of Health and Wellness, and the medical community, to ensure that our infrastructure is built to deliver the best health care services to Nova Scotians and those Atlantic Canadians from other Atlantic provinces in a fiscally prudent manner.

Since we launched this project in the Spring of 2016, a lot of work has happened - we've completed the Hants Community Hospital's renovations to the unused and existing operating rooms in February 2018; we completed renovations to Dartmouth General's third and fourth floors in September 2017. Construction of the Dartmouth General Hospital expansion is well under way and will be completed this Fall.

Construction work is also under way on the Halifax Infirmary's third and fifth floors that will support Atlantic Canada's first hybrid operating room, and two other interventional rooms with state-of-the-art imaging equipment to perform less invasive procedures.

For the project's largest components - the Halifax Infirmary site expansion that includes the new cancer centre, the outpatient centre, the in-patient centre, the research and innovation centre, and the Bayers Lake community outpatient facility - we are using a design, build, finance, maintain, delivery approach.

At the front end of such an approach, there are a lot of technical details, including legal, which need to be worked out and need to ensure that we are attracting the right interest and expertise from potential bidders. It is essential for government to get it right from the very beginning. This takes extensive front-end planning.

We've been updating Nova Scotians on the progress of the QEII New Generation Project every step of the way and will continue to do so. This is a huge project, one that Nova Scotians should be proud of. It is one of the largest ever in Canada in the health sector. When it is complete, all Nova Scotians will benefit. Thank you.

Now I'll turn over to Dr. Kirkpatrick for his remarks.

THE CHAIR: Dr. Kirkpatrick.

DR. DAVID KIRKPATRICK: At the QEII on an average day, there are 950 in-patients, 4,000 clinic visits, 270 cancer treatments, 130 surgeries, and about 200 emergency room visits. That's over a million visits every year.

People from across Nova Scotia, and indeed Atlantic Canada, come to the QEII for care not available elsewhere in the region. Ten per cent of our patients live outside Nova Scotia. The QEII is the Atlantic region's tertiary and quaternary care centre for programs like multi-organ transplant and cardiac care. The QEII and the Dartmouth General are also community hospitals for residents of the Central Zone and provide the same secondary services that other Nova Scotians receive at their local hospitals.

The QEII is Atlantic Canada's largest regional academic health institution, and as such, is the principal teaching hospital for multiple health professionals. It is also home to a number of clinical research programs that are transforming health care delivery.

How we deliver patient care has changed vastly over the last 50 years, and so in our preparation for the next 50 years, we know that we must not try to replicate the past. Where we can, we are moving care closer to home. At the Dartmouth General Hospital, we are doubling the number of operating rooms from four to eight, adding 48 beds, and expanding outpatient clinic space. Construction on half of these new beds will be completed this Fall. This will accommodate approximately 20 per cent of the current VGH volume of in-patient and surgical care.

Renovations at Hants Community Hospital were completed last year, and we exceeded our first-year target of doubling the number of surgeries performed compared to the previous year.

We're building a community outpatient centre at Bayers Lake that will be more convenient for those who travel from areas outside Halifax-Dartmouth. In addition to outpatient clinics, blood collection, and diagnostic imaging, the centre will have 24 dialysis stations, as well as a primary care clinic with after-hours access to better serve the rapidly growing communities surrounding the outpatient centre.

Through this project we're building capacity and improving efficiency. By consolidating the QEII functions at one site, we will be eliminating 3,500 patient transfers between the Halifax Infirmary and the Victoria General Hospital every year. Although this project is about replacing the functions of the VG, it is also about creating a contemporary facility incorporating modern standards and new technology that all Nova Scotians will be proud of. During recruitment interviews, candidates ask about this project with great anticipation. The innovation and learning centre will feature spaces that consolidate in one location much of the innovation development and teaching activity that takes place now at the QEII. Co-locating these activities fosters greater collaboration and serves as a visible declaration of the QEII's commitment to the academic mission.

As part of the initial phase of the QEII redevelopment project, Atlantic Canada's first hybrid operating room is scheduled to open late in 2020 in the Halifax Infirmary building on the fifth floor. This space will bring together highly specialized multidisciplinary teams working in collaboration for the benefit of patients. Young specialists who are trained to work this way see it as an exciting development.

Health Authority staff and physicians have been intensely engaged in this project. Starting with master planning in 2016 and now informing functional output specifications, they have either led or participated in all of the planning committees and working groups, making sure that the design meets current and future needs.

Our foundations, auxiliaries, and community partners have been major supporters of this project. Their efforts are making it possible to incorporate the latest innovations into the design, therefore ensuring that our facility remains modern and highly functional for many years to come. Thank you.

THE CHAIR: We will open up to questions. I'd just like to remind our witnesses to wait for me to recognize you. There's quite a list of you, so it may take me some time to find your name if I'm not familiar with it.

We will start with the PC caucus for 20 minutes.

Ms. MacFarlane.

KARLA MACFARLANE: Thank you very much, Madam Chair. My first request is we're wondering if we could get a copy of what was just said, for review. That was requested on behalf of all of us. Thank you.

Thanks so much for being here; we're excited to have you here. Obviously, everything that we would like to discuss certainly isn't going to be able to happen within two hours, but we certainly appreciate you taking the time. We know that all of you are very, very busy.

I would like to direct my question to Deputy Minster LaFleche. In your opening remarks, you indicated that you were informing Nova Scotians along the way with every step of this project - I tend to disagree a little bit with that. My conversations in my community and beyond, as Health Critic going throughout this province, has been that the public is aware that there is a huge investment of $2 billion and that there are going to be new shining buildings, but other than that they have no information. This is coming from the public, from the citizens, but as well it's coming from allied health care professionals who are telling me that they're not informed of how this is being rolled out.

I think there's a little bit of confusion and perhaps many are feeling a little bit discombobulated in what is actually taking place, so if you could just perhaps clarify what means your department is taking in communicating this process to Nova Scotians.

PAUL LAFLECHE: Thank you very much. That's actually a great point because we are aware, in anything we do in our department, or for that matter in government, it's always hard to get communication out to everybody and there are a lot of people who don't know what's happening because we are maybe not in the right media or anything.

I'm going to allow John to explain what we're doing. We actually have quite a sophisticated communication program. It's based on the Web, but I have a lot of highway workers and they often tell me they don't look up the Web, so they wouldn't be getting the communications that way.

Maybe we're not doing it perfectly and we can take some advice on that, but I can assure you we are trying our best to get communications out. This committee is one part of that; it's one tool in the quiver, but maybe John could explain what exactly we have done.

THE CHAIR: Mr. O'Connor.

JOHN O'CONNOR: I'll try to explain it a bit and probably have to also pass it over to the Health Authority to speak to some of the internal communications.

Overall, this project has many, many components and as with many large projects, it has been broken down into various small projects. As we move ahead with the different components of the project, we go ahead and make public announcements around what we're doing with respect to awarding contracts, tenders, and design. From that end of things, we put out communications to the public and to the media around the various components - we started construction at Dartmouth General or we started construction and renovations at Hants.

Those announcements get made, so all together it has been rolled out over many years. Then again, last Fall in October, we had a larger announcement around the major components of the project, namely the four new buildings at the Halifax Infirmary site and the new building at the Bayers Lake site. We rolled out what those buildings would include and the timelines which we are moving ahead on procuring for the design, build, finance, and maintain.

[1:15 p.m.]

In many ways, there are a lot of communications happening in the way of milestone announcements, so one that came out - a project was just awarded back in April, we make an announcement talking about the contractor that's awarded the contract, when they're going to start work. Then of course those components are communicated internally to all the folks who are required to know that that work is going on in their area, and the Health Authority that have been involved in the planning and involved in getting ready to operate those spaces later are aware of what's going on and when it's going to be complete and what it means to them inside.

On a number of fronts, there are the public announcements, but it's also a lot of internal communications for all the people who are involved and how it affects them day to day. On Dartmouth General, for example, there is a lot of work going on on any given day for the last couple years. It affects many people coming to the site - visitors and patients. It affects people working at the site, and the public as well.

We try to communicate as best we can the activities that are going on - for example, if there are activities that are going to be coming up that are going to affect parking this summer, they're trying to communicate that to people in advance. Those are the kinds of things that are happening regularly - or at least we feel they are.

I'll pass it over to the Health Authority if they want to speak any more about what happens internally.

THE CHAIR: Who would like to take that? Ms. van Hemert.

VICTORIA VAN HEMERT: Our focus has been on the internal communications, both with those who will receive the services - our staff and physicians - as well as many of those who are actively involved in the planning. So when we look back over the last two years in particular, when the planning activities have been very vigorous, we have had regular updates to all of our operations groups within the Central Zone, our zone medical advisory committees, our executive leadership team and board of directors, our staff via forums, emails, blasts, newsletters, poster boards, and many other different modalities.

We've also had over 360 specific planning meetings with our users just since a year ago February, when we were last at this committee. So we have had extensive involvement - not only seeking input to the planning but also in sharing information and, as Mr. O'Connor said, providing regular updates as to the status of the planning.

KARLA MACFARLANE: I think it all sounds well that there are internal meetings happening. I would hope that those meetings would be open to any allied health care professional. I think what we need to be doing, though, is educating Nova Scotians on how this huge investment, for which we will be paying for generations - I will be long gone - is actually improving health care.

They want to know how this is going to improve health care. It's fine to have media there for announcements, and I think that's great - milestones. I think people want to know progress. But we have to remember, from Yarmouth to Cape North, many of us - many in my area of Pictou West - we don't have Internet and we can't go online, unless we go to the local library.

I'd like to have confirmation from someone who can tell me: How is this project actually going to improve health care, and how are we going to get that message to Nova Scotians so that they know that their tax dollars are going to be going towards an investment that is going to protect and oversee their overall well-being?

DAVID KIRKPATRICK: If we go back to the original premise under which we decided to engage in this planning process, the Victoria General Hospital has failed and is failing on a regular basis and it needs to be replaced. I don't think that is really up for debate.

The facilities in Halifax that are providing advanced care are under duress and they need to be upgraded; they at least need to be maintained because the facilities actually include some expansions in capacity, and this will actually future-proof our ability to provide services for many years to come. Right now, for example, we have an emergency offload situation in all the hospitals in Nova Scotia, but it's bad in Halifax as well. There's nothing wrong with our emergency rooms. Our emergency department is excellent, it has more than enough capacity. The staffing is adequate. When the ambulances arrive, there are no beds because all the beds are full, the patients have been assessed but they need some disposition. They need to go to a hospital bed. Very often our beds are filled so this is the issue that we have so we need some capacity.

Sometimes there are empty beds at the VG but there's no one down there to look after the patients if you put them in those beds. With this consolidation in one site and with an increased number of beds, we're going to have more than enough capacity to alleviate that issue. That's just one example.

KARLA MACFARLANE: Thank you. I think that's a good segue into when we speak of consolidation. What aspects of the $2 billion master plan led to the purchase of the Bayers Lake land? Was this a deciding factor that ruled out any expansion perhaps for the Cobequid Community Health Centre that we know is struggling and is just 20 kilometres away?

I'm just wondering where in this master plan did that area of Bayers Lake - who decided on that?

THE CHAIR: Ms. Bond.

PAULA BOND: Thank you for that. That was part of the consolidation as we were looking at where the services are. I think we tried to say from the very beginning that this project was not about just rebuilding buildings, that we really had to look at what we were doing provincially, where services could be delivered. In consultation with some of our patient and family advisory groups, one of the things that came loud and clear was that travelling into Halifax for people outside Halifax is almost as traumatic as the treatment that they need to receive.

When we worked with our TIR colleagues, the Department of Health and Wellness, we looked at where the population was growing. Certainly, out in the Bayers Lake area was one of the areas where we saw, over the next 15, 20, 30 years, significant growth. As I said, one of the guiding principles in this project is trying to deliver care as close to home as possible. By putting this particular community centre out at Bayers Lake it enabled us

to then look at what services are being delivered in Halifax that could be delivered in Bayers Lake. It enabled us to look at Cobequid as well, looking at what services are there. One of the guiding principles is we can't take a service and divide it into five different places, we don't have enough staff. We need to consolidate where we're providing services, so it gave us an opportunity to look at Cobequid, look at Bayers Lake, and look at Halifax.

We will continue to have to provide similar services in Halifax because we are also a community centre for the peninsula. So working with our clinicians and multidisciplinary teams, we came up with the guiding principles of where these services could be and then looked at the availability of the land, which is obviously working with TIR, and what would be the best location, then once we provide the services that we want to deliver in the communities.

If you look at Hants, for example, when we looked at the services that could be delivered at Hants, we looked at if we had an extra OR there - Dr. Kirkpatrick already alluded to the fact that we have actually expanded more than we thought we would, the surgeries delivered in Hants Community Hospital. So that was what really came. We were looking at two or three different spaces. Constantly we look at Cobequid, how can we expand services in Cobequid. I'll have to ask John to go into further details, but certainly to my non-educated engineering degree, some of the factors out there are it's a bit landlocked. To expand out there, they are looking at, do we expand up or out? That has been part of the planning as well.

KARLA MACFARLANE: If anybody wants to add to that, feel free. Moving forward, I would like to know what the total cost of the land was. I know almost two years ago, I guess in April 2017, we even had the municipality of HRM and a number of stakeholders indicate that the congestion and the traffic flow out there was going to be detrimental. I'm wondering what steps have been taken. We all know - we have all probably driven out there. It's not easy access. There's no denying that.

I'm sure that out of this $2 billion, there must be a plan in order to combat transportation issues. I'm just wondering if someone could fill me in on those steps that you're taking.

JOHN O'CONNOR: I can fill you in on some of the background as well. You're correct: 2017 is when we did the work to look at properties that might be available to build a community outpatient centre. With the help of the Health Authority, we identified geographic areas outside of the peninsula that we would look at and look for properties. We searched through those areas within a certain radius of downtown for properties.

We had certain criteria that we were looking at: a parcel of land 15 acres, approximately - similar to the size of the property at Cobequid, which is around 16 acres, if I remember correctly, because this facility is the same size as the Cobequid facility. We also looked at property that would be available, that could be developed, and was zoned

properly to be able to used in our timeline. That exercise is similar to the process we use when we look at property for any facility.

We arrived at a shortlist of potential properties and talked to the property owners and worked through with them to see if they were willing to sell and so on and so forth. We worked our way down to a couple of properties that were available to buy, and we got approval from government to negotiate some details of costing. Then we made our decision, based on all of that work, to enter into a purchase and sale agreement with the developer for the piece of property that we purchased in March or April 2017.

One criterion was to have a pad-ready site. That was part of the purchase and sale agreement. We paid $7.5 million for 15 acres, with an option to buy five more acres adjacent to it. It's 15 acres of a 175-acre development in Bayers Lake.

There's a lot more development happening there, with more of a road network than you see today. Since we bought the property, Susie Lake Crescent has been extended up to that location. Another street - which I can't think of the name of, but it goes in back of Access Nova Scotia - has now been extended through to join up to Susie Lake Crescent. There's another road that's going to go in next to the Burger King up into that same location off of Chain Lake Drive. There's a whole road network that is under development. A lot of it has been built up to where we are, up to that site, and it's going to be further expanded into the future.

Getting into that site, people don't only have to come in through Chain Lake Drive. There's access in from Fairview and up over Main Avenue, and also from Highway No. 103, from that side. There's Horseshoe Lake Boulevard. There's also the other back road, which I can't think of the name of right now, that joins into that area.

I can't recall if you had another part of a question. Okay.

KARLA MACFARLANE: I guess one of the biggest concerns I have, and I have been calling on the government, is I can't understand why it's so confidential to release the Deloitte report. I really believe that releasing that report would outline a number of concerns that Nova Scotians have and would help us, as MLAs, to be able to have that dialogue with Nova Scotians and explain to them how we came to $2 billion? I'm wondering why we are not releasing that . . .

[1:30 p.m.]

THE CHAIR: Order, time has elapsed for the PC caucus. We will turn it over to the NDP caucus. Ms. Leblanc for 20 minutes.

SUSAN LEBLANC: Thank you very much for your opening statements. I was just remembering as you were talking about the development of the new buildings or the main site at the HI, that when I was in university, my mom was working in the old Infirmary as

a chaplain. I remember very clearly her transition from her teeny little hole-in-the-wall office to her new office in the new hospital and it was very exciting. I still walk into that hospital and go oh, this is so shiny and new. That's like 25 years old now, but it still feels new.

The idea of expanding all of these facilities is very exciting for Nova Scotians, and of course, we know we need to replace the failing Victoria General Hospital and we know that there's so much new medical technology that we need to sort of make our buildings accommodate. It's all very exciting.

Of course, a shout-out to the changes that have been happening at the Dartmouth General Hospital. I represent Dartmouth North, so I've been invited to lots of the planning discussions and also to the opening of the new entrance and all that. We're always being kept up to date and it's fantastic what's going on there.

I wanted to just talk a little bit about Mr. LaFleche's opening comments; there's a method to my madness here, but I wanted to point out a couple of things he said. One was that we wanted to do this redevelopment in a fiscally prudent manner so I'm going to come back to that in a second. Also, there's a lot of legal details to work out and I'll come back to that. It is essential for us to get it right, and something that my colleague has already picked up on is updating Nova Scotians every step of the way.

I want to echo what you've said there because that's going to sort of frame some of my beginning questions. We know that the development has calculated that the full lifetime cost of delivering the hospital redevelopment through a P3 contract, compared to a public alternative, delivering the same level and quality of service - or more accurately, that this calculation was completed by the consultants at Deloitte.

It's really difficult to trust that the decision to use a P3 for the construction of the new build portions of the QEII redevelopment was a good one, if the government refuses to release the methodology or the findings on this question. This is something I brought up in Budget Estimates with the minister and the deputy minister and I'm not satisfied with the answers I received there, so I want to ask again: Can the representatives from TIR or Health and Wellness please share how the costs compare between a P3 model and a public alternative?

PAUL LAFLECHE: This will probably answer Ms. MacFarlane's question, too, is that correct, so we're good. We were going to answer it. I was going to answer it on the Liberal time, but I'll answer it here now. I was going to steal Ben Jessome's questions.

John is going to give you a more detailed answer and then he'll switch back to me because I can tell you a way you can find out the information, but they can't. Maybe I'll let John have a go at that answer and remember, I didn't get to speak at Estimates. I would love to, but I didn't.

JOHN O'CONNOR: I'll just go backwards a little bit on this one. The business case is probably what you're referring to that was prepared by Deloitte and value for money. In Nova Scotia, we don't have a lot of experience with delivering P3 projects. We rely heavily on advice that we get from elsewhere. Deloitte had been our adviser that had been selected, with a lot of experience in managing and overseeing the procurement process for P3 projects.

We also are following similar practices used elsewhere, in Ontario and other places, with the procurement process for P3 projects. Part of the initial work is to do a business case value for money to make your decision whether a P3 project has value to the taxpayers. Now we're currently in the procurement process. We started the procurement process for the DBFM work - so the P3, the DBFM design, build, finance, and maintain - work for the P3 contract. The RFSQ – I am using a lot of acronyms - request for supplier qualifications, closed for both the RFPs that we're planning, so we're right in the midst of the procurement process.

We started last December and the first stage, which is the RFSQ stage, has closed. It's currently being evaluated for the Bayers Lake proposals that we received, and the evaluations have started for the HI. We have two different RFPs that we're planning to issue to the short-listed teams for each of these sites. One complete procurement process for Bayers Lake and one complete procurement process for the four new buildings at the Halifax Infirmary site.

Getting back to the business case and value for money, that is the information that will help make our decision to go to a P3. We have yet to see the prices and the bids and the proposals that we're going to get from the teams. Once we have the short-listed teams in a number of months - I'll explain some of that if you want me to - we will be issuing an RFP document to these short-listed teams which will contain enormous documentation on our part, which outlines our requirements that they must achieve and meet with their design and construction and their 30 years of maintenance.

All of the requirements for the design, construction, and 30 years of maintenance are being created now by us and all of our teams to go into the RFP which will get issued to the short-listed teams - this is happening for Bayers Lake and for the HI.

The business case and the value for money is what we're measuring to, so we're going to update the business case and value for money as soon as we finish the output specs. We'll update them to make sure those numbers that they prepared for us capture the requirements that we are currently creating - clearly capture them so that we have a good comparison and then, when the bids come in, we'll be able to compare against the projected value for money that we have calculated with the work that we did originally with Deloitte.

What Deloitte did is they took all of our existing projects that we have done over the last 15 or 20 years in government and they mapped out the starting costs and the finishing costs of various projects, traditional. Then they mapped out what change orders

and what changes happened to those and then they take those risks and those potential risks and use that to help us, say if we go with our P3 model we can transfer this risk or that risk, and we can transfer construction costs overrun risks and so on.

That's how the value for money gets calculated, but we have yet to see the results. When the bids come in at the end of the RFP period, we'll have fixed pricing for the design and construction and largely fixed pricing - there might be some variables - for the 30 years of operations. That will be compared back to the work that we have.

You can see why we don't want to give it out while we're in the procurement process because we're really giving out the benchmark that we're expecting people to meet.

SUSAN LEBLANC: I just want to pick up on a couple of things you said. Number one - and I had mentioned this too - you said Deloitte was the organization that was contracted to do this work. Deloitte has a lot of experience in P3 builds, is what you said. It's interesting that Deloitte was even the company that was chosen. Deloitte has a lot of experience with P3s so it makes a lot of sense that Deloitte would think that P3s are the way to go in this case. I might come back to that in a little bit.

Your answer, unfortunately, doesn't really answer my question. Basically, what I'm asking for is the methodology which Deloitte used to decide that P3s were the way to go. I understand that maybe Nova Scotia doesn't have a lot of experience in building hospitals, but with P3s we do because we built a whole bunch of P3 schools and I believe the Cobequid Centre was a P3. We do have some experience and we do have lots of skilled people who can do the work here.

I've heard this before that we couldn't possibly be able to manage such a project on our own and, again, this is one of the themes that seem to be happening with our current government right now is that we couldn't possibly be that good, we couldn't possibly do that ourselves. I disagree; however, I'm not Deloitte and I haven't done the comparison. All I'm asking for is to see the methodology that Deloitte used so that we can know, and Nova Scotians can understand, that we are getting value for money.

If you won't tell us those numbers right now, could you please at least release the comparisons between a P3 build and a traditional build with percentages instead of actual money in dollars?

JOHN O'CONNOR: The methodology is one thing. We probably could explain the methodologies. The numbers and the value for money that we're going to be measuring against when we get the bids in, we do not want to release. We don't want to give away our numbers, our cost estimates, and what we expect to see in pricing.

As far as methodology goes, how was a value for money calculated and what was included in the calculation of value for money, we likely could explain in a general way of what components go into a value for money calculation. It's the numbers and the

assumptions that we made with respect to how much value we get by transferring that risk versus keeping it.

To your point, we are capable of managing large projects. What this is really doing here is trying to bring a number of different contracting arrangements in under one. We do design builds; we do regular design, regular construction tender. We do design builds. We've done some P3s in the past, so it's just different methodologies with delivering a project.

The importance of the P3 is the maintenance. The 30 years of maintenance really helps keep the focus on good quality design and a good quality build so that you have a full picture of the overall costs of that asset for 30 years.

SUSAN LEBLANC: I'm going to move on. When firms and organizations that favour P3 deals compare the cost of P3 projects to the cost of public projects, they often make inaccurate assumptions in these comparisons. For example, inaccurate assumptions about the timing of spending that inflate public costs, applying private rates to public borrowing, and using unfinanced public sector comparators rather than costing out government borrowing to finance big infrastructure projects, and comparing P3 costs to the most expensive possible public model when more efficient and desirable models can be used.

These assumptions have been made by organizations like Partnerships BC and Infrastructure Ontario, resulting in flawed comparisons that were ultimately criticized by the Auditors General across the country as misleading.

I think it's fair to say that Deloitte is a firm that is in favour of P3 deals, as I mentioned, with many P3 clients. What guarantee can the Department of Transportation and Infrastructure Renewal and the Department of Health and Wellness make to Nova Scotians that Deloitte - the firm that we've contracted to make this comparison - has not made these same flawed assumptions about the cost of a public build?

JOHN O'CONNOR: We were aware of that concern before we hired Deloitte. Just to go back - we hired Deloitte through an open RFP process. A number of different firms responded. They were selected but going into it we were well aware of the criticisms from various Auditors General Reports around the country. So, part of the work of Deloitte was an objectivity analysis looking at the history of P3 projects, some of the flaws that were identified by the various Auditors General Reports around the country - in Ontario and other places.

That was part of their work so that when we created a business case under their leadership we didn't fall into the same criticism - that the business case would be extensive enough and include the aspects of analysis that are needed, that were criticized, have not been included by the other jurisdictions. We did take that into account when the business case work plan was created.

SUSAN LEBLANC: The Premier said in the Fall that the cost of the redevelopment was sitting at approximately $2 billion. Can you confirm that this figure is from Deloitte's report, comparing the public and private options for Nova Scotia?

[1:45 p.m.]

JOHN O'CONNOR: No, I can't confirm that. It's a general number that we put out overall for the entire QEII project, including the Dartmouth General Hospital and Hants and other projects that we're doing, like renovations at the HI. It's an overall number that we published.

Again, we didn't want to publish what specifically we expect for costs for the four or five new builds. We didn't want to put that number out. We have an overall number based on estimates we have for the DBFM, but we didn't want to break it all out again because we were starting a procurement process and we're still in the procurement process now. The best advice was not to give out the numbers in advance of the results.

SUSAN LEBLANC: Can you tell us when and how the costs will appear on the books in Nova Scotia for the whole project?

JOHN O'CONNOR: It already appears on the books. The work that we are doing now is in budgets - it has been in the past year's and currently this year there is money in the budget that had been approved by government for doing the work that we are currently doing.

The current plan on the DBFM work is to have a substantial completion payment at substantial completion and the rest of the costs would be paid to the project co. over a 30-year period. Somebody else probably can exactly tell you about the accounting of all of that, but that's generally the payment approach that is going to be.

THE CHAIR: Mr. LaFleche.

PAUL LAFLECHE: I just want to ensure that all the members understand that when we talk about not putting out the Deloitte report, we're talking about today. So once the bids are in and we've evaluated them and made a decision, we will put out all that information. So it's not long in the future that in fact all that information will be out. It's just while the bidding process is on that we will not put it out.

Also, we do put out rough numbers, as John said, and there's a good reason for that. We want to ensure that we get the best bids possible and don't affect the bidding process. But once we do get a successful tender winner, we do put out those numbers and once we do the construction, we do put out the numbers. So numbers have already flowed out on some of the project work we've done like at Hants, and I think we've got some Dartmouth General numbers out.

These numbers are all becoming public, but they're becoming public and in a timing such that they don't affect the value that Nova Scotians are getting.

SUSAN LEBLANC: You mentioned that there are up front costs and there are billed costs and all that but then there will be more costs that are sort of amortized over the 30-year period. Can you tell us what portion of the total value of the contract will be made in those payments, like what are we talking about that's going to be over the 30 years?

PAUL LAFLECHE: Well maybe I'll just talk about a general capital project; whether it's P3 or not P3 is not really material to this. We are going to incur a capital cost each year and we've put together with the Department of Finance and Treasury Board - I'm sorry, do you want to cut me off?

SUSAN LEBLANC: Yes, sorry . . .

PAUL LAFLECHE: Good, because I was about to go into government accounting which I thought you wanted. We can do government accounting, maybe someone else there wants to hear about government accounting.

SUSAN LEBLANC: I'm really conscious that I'm short on time so with respect, I'd like to move on. Investors in P3 deals tend to expect real rates of return, between 14 per cent and 25 per cent. Are we looking at something comparable to that with this project, with the private profits?

JOHN O'CONNOR: Just to get back to your other question as well - what's in the bid that's going out? The RFP will include design, construction, financing and maintenance for 30 years, so the total cost that we'll see when we receive the bids at the end of the RFP period will include all of those components. That will be measured against our value for money overall.

The entire deal, including the financing, is being measured against traditional delivery. Then if we enter into a contract, there's a substantial completion payment made and the rest of the monies are paid over the 30 years.

SUSAN LEBLANC: So assuming that we are expecting that the project will generate profits between 14 per cent and 25 per cent for investors, even though we don't know yet but we will soon, would it be accurate to say that Nova Scotians should expect to generate at least $280 million in corporate profits with this deal?

PAUL LAFLECHE: We don't have any idea about the investors. They could lose 14 per cent to 25 per cent a year, for all we know. What we know is, as John says, we're trying to get the best value for Nova Scotians. At the end of this result, if we find that the Deloitte numbers that we're expecting don't show up . . .

THE CHAIR: Order. Time has elapsed for the NDP. We'll move to the Liberal caucus. Mr. Rankin.

HON. IAIN RANKIN: Thank you to the witnesses for coming in today. This $2 billion is an exciting amount of money to be spent on the next generation of health care not only for Halifax but outside of Halifax. Some of that money has, I think, quite rightly been targeted at a community outpatient centre in Bayers Lake. That will be the focus of my discussion.

I know that both Opposition Parties have been against this project since the announcement came out and have preferred either to look at downtown or expanding out in Sackville. I think it's important - I certainly hear excitement across not only Beechville-Lakeside-Timberlea and the urban communities that are on the doorstep, but down through Tantallon and Hubbards and some of the rural areas of HRM and Terence Bay and some of these areas where actually most of rural Nova Scotians live. Not everyone recognizes that they are in rural HRM, and they don't have access to any transit at all.

I do want to mention transit, though, to start with. Quite rightly, I think it should be discussed when any kind of new development is brought forward. I know it was, and I fully expected it to be, with the Canada Games Centre. That's a very successful building right on the other side of Bayers Lake. They are virtually next door to the Lacewood terminal, but even they have a lot of people who drive to their facility. I know part of the reason that terminal was put there is because of that crush point. There are always modifications being made, notwithstanding that people in the areas that I am representing can take a bus to Bayers Lake in about 15 minutes, I recognize that folks have to get transfers and such.

I just would like to see a bit of an update from any of the witnesses, if possible, of any discussion that has happened with Halifax Regional Municipality in terms of their plan to modify transit to the area.

JOHN O'CONNOR: I should probably get Brian to speak to this one because Brian has been conducting the meetings; we have had regular meetings with the HRM. If it's okay, I might have Brian Ward speak to it, please.

BRIAN WARD: We have had around eight or nine different meetings with Halifax Regional Municipality, and we continue to talk to them about the transit situation in Bayers Lake. I think there are currently two or three routes in Bayers Lake that touch down in the area. We've expressed our opinion that we would like to have the community centre be accessible by transit. We have had numerous conversations with them on that. We're still waiting for them to make their final decision. I would assume that as we get closer to the project being completed, they will probably make some decisions then.

IAIN RANKIN: I appreciate the update, and I fully expect that we'll continue to get updates on that. The alternate sites that were mentioned, when they were under review - I know the list started at something like 15, and you mentioned they were narrowed down.

I want to try to get some insight on parking. I mentioned parking briefly. As I said, people will continue to drive, and a significant amount of people who come from rural HRM drive to the facility as well as outside of Halifax. We have people coming from the South Shore and all the communities along Highway Nos. 102 and 103 who frequent in. Was parking part of that criteria? Can you give me a sense of how many parking spots we're going to be able to have in this complex?

JOHN O'CONNOR: Parking was part of the criteria when we established the initial estimate of 15 acres or 16 acres. Initially, it was based on how much space we have at Cobequid, how much parking is at Cobequid, and how big the building is. We used that as a bit of a reference for us to establish the initial requirement for a property that we would need to focus on. Part of the master planning team included specialists in parking and traffic engineering. The parking component of the planning has been an integral part of the overall thinking of what needs to get built at Bayers Lake. So, included in the current plan and as we go forward into the output specifications is a large parking component at the site. Possibly somebody else might remember how many. I don't remember how many, but definitely based on projections of parking needs and looking at Cobequid and other similar facilities and what is needed there for parking - maybe Victoria or David could give a more accurate number.

DAVID KIRKPATRICK: I think first of all, I would like to say that in our planning for this outpatient facility, part of the motivation was that we knew that when we combined part of the consolidation of the Victoria General site and the Halifax Infirmary site it would result in a fair bit of congestion on whichever site we chose to land on, but in this case it's the Halifax Infirmary.

If you take all of the 400,000 visits that come to the VG and transpose them on top of the 400,000 that are coming now, it's going to be a pretty busy spot. Certainly traffic management and parking at that site is something that's being looked at quite intensely. We also thought that having something outside the peninsula would help decompress some of that congestion on the peninsula.

The main reason for looking at a community outpatient centre was the numerous patients who come in from outside peninsular Halifax - mainly from outside HRM, in fact – who say, I don't mind driving five hours from Cape Breton, but I sure as hell hate driving on the peninsula, so if there is something you could do to relieve that, that would be great. That's the reason we decided to do something about it.

IAIN RANKIN: I just wanted to get confirmation - I think I heard you say that most people who were visiting, out of the 400,000, come from outside of HRM. Also, do you have any metrics at all on the population catchment area? I would be confident that the - I don't know if it's a 5-kilometre radius, but I've seen numbers before around the Bayers Lake site, if it's comparable to what we would have at the Cobequid Centre. So that would take in Beechville-Lakeside-Timberlea, and Fairview-Clayton Park-Rockingham. Are they comparable or do you have any specifics on those population numbers?

VICTORIA VAN HEMERT: The location of the Bayers Lake community outpatient centre was partly in response to the expected growth in those immediately adjacent communities, but partly - as Dr. Kirkpatrick said - just to serve generally those who do not live in the Halifax Regional Municipality and are driving a considerable distance. So, in response to your question, it's actually a bit of both in terms of meeting the needs of those who are coming to Halifax for care.

I would like to also follow up on the specific questions about parking and the site circulation. We are planning - as Mr. O'Connor said - for staff and visitor parking, there is a consultant who is doing very specialized analysis of that. They take into consideration the staff and visit volumes. They do use Cobequid as a benchmark but look at this centre specifically to say how many spaces are required, depending on the length of the visits.

There are considerations for how to expand should the volumes expand. There are considerations on the site in terms of being able to accommodate transit - both the handy transit and the regular transit on the site should those decisions be made at a later time.

IAIN RANKIN: I can certainly appreciate that. I know there is a lot of work happening. Even today the Highway No. 102/103 interchange is a massive project that's improving that traffic flow. Two years ago - or maybe it was last year - the St. Margaret's Bay entrance had some improvements in terms of how you come off the highway and extending the right turn lane out. So that's all good to see and it's great to hear that there is more work being put into more modifications.

In terms of other advantages to the site itself and the sheer size of the 15-acre site, is there an opportunity to provide more of a park space/green space relative to the type of benefits that patients and visitors will have - how it relates to good mental health and that type of welcoming nature? Is there any thought being put into how that may be a benefit with the site?

[2:00 p.m.]

VICTORIA VAN HEMERT: Yes, there's considerable emphasis on the wellness aspects of the design of the building - orienting the building to enable maximum natural light penetration. There's considerable green space around the entire building. It is on the top of a hill and has vistas - I think it's called the Black Duck Ponds. So yes, those are some of the basic principles that we have included in the design of the building as we confirm the output specifications.

IAIN RANKIN: I'll try to share my time. I just wanted to ask another detail question, if possible. You mentioned private care - that would be something like primary care in the site. We've had pretty good success in the area in terms of recruiting nurse practitioners and doctors and getting a lot of people off the 811 list in Timberlea and those areas.

This to me is another opportunity to provide a world class modern facility for attracting more doctors and what they're looking to practise. I don't know if there's anything that we could add in terms of the opportunity for new primary care providers operating out of that space.

PAULA BOND: Yes, we're looking at a collaborative care model of multidisciplinary teams that will be out at the community centre as well as what sort of after-hour access that we could also be providing.

Again, if you look at some of the reasons why patients and families still have to come to the emergency department with what we call low acuity - for an example, if your GP retires tomorrow and you don't have a GP and you have a prescription refilled, right now you have to go to a walk-in clinic or to an emergency department until you can get a new GP. So those are some of the things we are looking at in the community centres to help alleviate some of those pressures with nurse practitioners, advanced care nurses, and primary care teams.

What we're hearing from the provincial primary care planning is that physicians, nurse practitioners, dieticians, and others want to work in a collaborative practice. One of the principles that we're also using at the QEII redevelopment is really looking at the right care by the right provider at the right time, in the right location. It's really looking at scopes of practice - we know that our paramedics have expanded scopes of practice that are working in different areas right now outside of hospitals and ambulances, and certainly the primary care teams have been very successful in recruiting multidisciplinary teams. We're looking at expanding that.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: My questions are about the Bayers Lake outpatient centre as well because my riding has Bayers Lake in it. You have no idea how exciting it is for me and for my constituents. I have over 100 apartment buildings - I think it's the densest population - and a lot of seniors are moving to my riding and this is huge for them.

I worked in hospitals for 20 years as a medical interpreter and I hated parking downtown and my patients hated parking downtown. It was very expensive - $20 a day sometimes for me. So this is huge for the seniors, for a lot of the population that is really concentrated. Between Bedford, Clayton Park West, and Fairview, we have the highest population. To have that centre there, I think, is very smart. It's a very well-thought-out idea to have it there and I thank you for it.

I keep trying to tell my constituents what's going there, so if you can help me. Some of the conversation that I heard today and from other things, I know it's going to be a centre that will have ambulatory care - which is in and out - so we will have no beds overnight. No day surgery, I don't think. No. So what do I tell my constituents what's going in that centre? I heard there would be some beds for dialysis, but if you can give me some more

ideas of what I can inform them of this very exciting place and what is there for seniors especially.

PAULA BOND: Yes, actually we are extremely excited. There have been multiple meetings and investment in what we should be putting out in Bayers Lake. All of the specialty services, as well as primary care, have been working together. We have teams that are made up of a physician lead and a clinical lead and multidisciplinary advice into this.

There will be medical/surgical clinics out there. We looked at, of the medical/surgical clinics coming into Halifax Infirmary, how many were coming from outside Halifax, to help indicate how much of a volume we would be determining out at Bayers Lake. Orthopaedic clinics will be out there. We are putting 24 dialysis stations there. We worked with our dialysis colleagues. Dr. Soroka, who is the planning lead for dialysis for the province, looked at where and what acuity of patients could be seen out in Bayers Lake, of patients coming into Halifax or other areas for dialysis. That determined the number of dialysis clinics that are out there.

We are looking at rehab, lab, and blood collections being there. One of the principles we are really trying to focus in on, one of the benefits of this QEII redevelopment, is really looking at better coordination as well.

My office is at the Halifax Infirmary. I speak to paramedics and nurses and other people all the time. One of the things that has been very loud and clear - my background is nursing, and you know, we shake our heads when we see a patient being brought in for one clinic visit one day and another clinic visit another day and blood work another day - really working with adjacencies in the services that we're providing there so that we can have a coordinated effort, so that we'll have a coordinator that if you are coming in for one visit, we'll be able to talk to you about, do you have any more visits planned, coming in for the next sort of close-knit, close together - so that we can help coordinate that and get patients and family in at one visit as best as possible.

There's an array of services that will be delivered there. We're also making it very flexible. The whole idea about planning for Nova Scotians' health care into the future is that we need to have flexibility here. I always say that if I'd told my mother 40 years ago that she would be able to go to Shoppers Drug Mart and have her blood pressure taken, she would think Mars was coming.

Health care is changing, and in this redevelopment, we need to make sure that we plan provincially and implement locally as best we can. That's what we're doing. We're trying to implement locally and trying to make the flexibility spaces so that we can expand services as required.

RAFAH DICOSTANZO: Thank you again. So if I understand it well, you are still in the process of deciding what services are going in there? That hasn't been decided, correct?

PAULA BOND: It has been decided. It's about 95 per cent completed. I could certainly give you a list of the different services that will be located out there. It was part of the clinical planning, as well as the functional planning that we've been doing for the last 18 months with all the services.

RAFAH DICOSTANZO: That would be wonderful. One other small question that I get from a lot of the seniors as well, when I say no, I don't think there will be an emergency department - a lot of them ask me if you will have one. What was the decision behind that, and why? I know at Cobequid they have one. I try and explain to them that it's going to be similar to Cobequid, so they get very excited about the emergency, but we aren't having that there. If you can just explain why.

VICTORIA VAN HEMERT: There will not be an emergency department there. One of the principles was how many locations is it efficient to deliver services in, and the emergency department is a very high-acuity area. It requires a lot of specialized medical and nursing human resources, equipment, and response times. So the decision was taken very early on that there would be primary care services and there may be unscheduled primary care, but not to the level of an emergency department where you would be responding to traumas, having to potentially receive ambulances and helicopters, that those resources should be improved at the existing emergency departments, such as the Halifax Infirmary or Dartmouth General or Cobequid.

RAFAH DICOSTANZO: It's wonderful, and really my third question, my colleague already asked, but if we can have collaborative care there that would be wonderful. I think you're on that as well, so I thank you all and I'm very excited. If I could have some date of approximately when I can tell my constituents, I would love that too.

PAULA BOND: There will not be an emergency department, but we will have availability for small things like minor procedures. So, if somebody came in there would be the possibility of having a suture or a dressing change, things like that.

THE CHAIR: Order - the time has elapsed for the Liberal caucus. We will turn it over to the PC caucus.

Ms. Adams.

BARBARA ADAMS: I'm very happy to have you here this afternoon. As somebody who has worked in those hospitals and has walked down the corridor between the VG and the Rehab Centre when there is water running down the hallway tunnel, this is long overdue.

I guess I'm not quite as excited as my colleague to my right because to me this is a replacement of things that should have happened a long time ago. I realize that it's an opportunity to do things better, but the people that I'm representing and as a health professional, what I'm still struggling with are a couple of things. The first - is the one in Bayers Lake going to be open 24 hours a day, the clinic out there? What are the hours going to be?

VICTORIA VAN HEMERT: No, there will be standard outpatient operating hours - probably from 8:00 a.m. or 9:00 a.m. until 4:00 p.m. or 5:00 p.m. At the present time for opening day, we'll take a look at the demand and re-evaluate after the centre has been open.

BARBARA ADAMS: So, there are not going to be any in-patient beds and it's only going to be open until 4:00 p.m. or 5:00 p.m. and there's no ER - it's not even replacing what Cobequid Centre has because that has an ER.

I guess what I'm left wondering is the current problems that we have - and we know the hospital has to come down because you can't even have a shower there - is we have 25 per cent of our acute care beds taken up by long-term care wait patients. Is this new development going to change that? We've got 2,100 people waiting for home care who are home waiting for long-term care. We don't have enough home care in the homes, so people are stuck being delayed being discharged because they don't have home care or supports in place. Is this redevelopment going to change that?

We don't have a sufficient number of family doctors or access to specialists. They can't get into surgeries for months on end, and we have a ridiculously long wait time for almost all of our surgeries. I'm wondering, how is any of this going to change that?

I specifically want to go back to the initial introduction of the fact that at the QEII, which is what we're replacing, on an average day there are 950 in-patients. If 20 per cent of them are going to the Dartmouth General, where are the other 80 per cent going?

DAVID KIRKPATRICK: The other 80 per cent will go to the Halifax Infirmary site. There will be capacity to accommodate them, with some extra capacity as well. This will help alleviate wait times.

Also, superimposed on this project has been the government's arthroplasty expansion project, which has brought four additional orthopaedic surgeons into the province - two are here in the central zone, along with all the resources to support them.

When we move four of the operating rooms to the Dartmouth General Hospital, that will give us 20 additional operating rooms every week - 11 of those will be used by orthopaedics. So one of the long wait-lists that we hear about over and over again in the press are the long wait-lists for hip and knee joint replacement surgery, and so there is a big plan in all of this to really get a handle on all of that wait-list. We do have the resources

all lined up to look after that. In those 11 beds, we'll have a primary joint replacement centre and that will be able to look after a significant volume.

BARBARA ADAMS: Thank you for that. We are getting bits of information. What would be really helpful is if we had a comparison now to say we have 950 in-patients, and this is how many we're going to be able to have once this is all done. We have 4,000 clinic visits now. Once all this is finished, we'll have X-number of clinic visits. We have 270 cancer treatments, and we'll be able to do this many. We have 130 surgeries and 200 ER visits a day. This is how many we'll be able to handle.

[2:15 p.m.]

You mentioned that you know what's going to be out in Bayers Lake and that you could give us those details. I would have hoped that would have been today when we got the summary of those details.

What people want to know at the end of all of this is, are more people going to get more treatment in a faster way? We don't have that answer yet. If there's 270 cancer treatments now offered at the QEII, and we tear it down, and you build all these other buildings, will there be more cancer treatments? Will there in fact be more surgeries? I know for orthopaedic surgery, there will be more surgeries because that's one of our biggest wait-lists. What I don't know is, if you're going to have surgeons doing that, are we cutting back on surgeries that are being offered for something else?

I'm asking somebody on that side: Is it possible to have a breakdown of procedures and in-patients and outpatients and wait-lists, what it looks like now, and what it's going to look like whenever the building is finished? That would be another question. When are you starting all of this, and when is the actual finish date? Is it possible? Do you already know if we're going to have increased capacity for all of these in-patient and outpatient beds and procedures? Or are we simply moving them from the QEII, and we're going to end up with exactly the same number of in-patient and outpatient beds and procedures?

PAULA BOND: There were a few questions there. I'll take a stab at a couple of them.

I certainly do have all of the details with me today of the services that will go to Bayers Lake. We can certainly provide that.

The second thing is that, as we all know, it's very complex. The inefficiencies of running the VG site and the Halifax Infirmary site right now are part of the reasons why we have increased lengths of stay. As was mentioned earlier, there are 3,446 transfers between the VG and HI alone. That's getting patients back and forth for tests. It's if we don't have a bed. If you come in with a fractured rib and have to be operated on tonight at the HI, you come in through the emergency department, and you're then transferred over to the VG.

Bringing everything together is part of this QEII redevelopment. It will help with these inefficiencies and decrease lengths of stays that we're seeing. We know that we have lengths of stays that are above what we should have as the average length of stay. We know that this will be improved upon, which will turn our beds over, so we'll be able to utilize those beds better.

We're increasing three operating rooms at the HI above the capacity we have today for future growth. Right now, many times, we have elective cases that get cancelled if we have a transplant come in. That can take up two operating rooms. The increase of three operating rooms at the HI site will eliminate that. It will eliminate your ordinary traumas coming in having to cancel elective surgery. That will be eliminated. We're increasing two ophthalmology ORs. We know that we have an aging population. We know that there is an increase in cataract surgeries. We look at projections out for the next 15 to 20 years. We know that's a concern. We've worked with ophthalmology departments. We are increasing those two operating rooms to be able to help deal with that.

We're adding an additional 36 in-patient beds to the Halifax Infirmary above what we have today. They will be flexible to help with future growth.

We know we're over capacity everywhere in this province. Particularly at the HI, we're over capacity. We know taking those ambulances that are going back and forth and putting them back on the road is going to help with the off-load in the Halifax Infirmary.

We're also increasing intermediate care beds both here and at Dartmouth General. Right now, Dartmouth General has a critical care unit. It does not have intermediate care beds, so we're often holding patients in those critical care units waiting for in-patient beds. The increase in the IMCUs will help alleviate that, as well as the increase in critical care beds at the Halifax Infirmary.

We are building capacity with the QEII redevelopment.

BARBARA ADAMS: I'm writing down all of those things. I guess it's the net gain that I'm looking for. What people want to know, and I specifically want to know is, how many hospital beds are at the VG, and where are they going to be distributed in the future? Is that an increase gain? I want to know the number of beds that we have now and how many we're going to have. Obviously you can't do it today.

When we talk about how we're going to be increasing beds here, we have to talk about how many we are chopping down when we destroy the VG building and how many surgeries we are doing here. Frankly, increasing the number of surgery ORs to three - I mean, as you said, we have to look 20 to 50 years down the road. Well, the number of seniors is going to double, from 16 per cent of the population to 32 per cent.

The increase in the orthopaedic surgeries in the Dartmouth General isn't what we need 10 years from now. It's what we needed 10 years ago. Where is the building capacity

for 10 years from now and 20 years from now? I know those OR wait times for orthopaedic hip and knee surgeries. We are way behind where we should be, unless you happen to fall and break your hip, in which case you get in on time.

The expansion that's going on at the Dartmouth General is going to catch us up, but we have one of the oldest populations in this country. Is there a possibility that somebody could prepare for us: This is how many of each thing we have now, and at the end of the construction of all of these buildings, this is how many beds, this is how many OR times? Is that possible, and to put it out to all Nova Scotians, not just us, because we want to be able to give it to people? Is that possible?

THE CHAIR: Order. Time has elapsed for the PC caucus.

We'll turn it over to the NDP. Ms. Martin.

TAMMY MARTIN: I believe it was Mr. O'Connor who said the costs would be fixed for the next 30 years. I'm wondering how you can fix the maintenance costs going forward for 30 years.

JOHN O'CONNOR: You are correct. When I did mention the maintenance costs, most of them will be fixed on the maintenance, but there may be a few variables, like energy costs and so on that might not be fixed. We're still working through the details of that costing regime. But the overall bricks and mortar maintenance, the hard FM - the hard facilities and maintenance - will be a fixed price. There will be certain parts of it that will be variable, possibly the energy costs and so on. There might be certain costing that won't be at risk.

We can put everything in the risk bucket, but we might pay too much for it, so we're getting the advice on what typically goes out, what is typically fixed, and what is typically left to be variable. Some of them might be fixed for five years and then reset again, these sorts of things. We're taking advice on that and preparing with the help of the folks who have written those documents many times before. They are helping us write those now.

TAMMY MARTIN: That begs the question, then, how do you fix the staffing cost over the next 30 years? We have no idea what's going to come. But to that end, I notice in the description it's private - it's designed, financed, built, and maintained by a private company. What happens to those union jobs that are currently in the facilities? Will you be guaranteeing that those remain union positions?

JOHN O'CONNOR: Well, I'll just clarify something. I can't speak to certain union positions, maybe, but the maintenance we're talking about is just the building maintenance. The cleaning is not being contracted out to the private consortium. The portering is not being contracted out to the private consortium. The Health Authority will still operate the facility, so as a patient, as a person working in the facility, you probably shouldn't know whether it's a P3 facility or a non-P3 facility. It's the behind the scenes, like the heating

systems, the electrical systems, the maintenance of the building, that we're going to include. Even when it comes to snow removal on the HI site, we may just leave it all in the one contract that the Health Authority has. It's just too complicated to break it in two, because they are on the same site.

We're working through those details now, but again, it's not any services that touch the patients or inside the building in that way.

TAMMY MARTIN: Thank you, but to be clear, the maintenance positions - the electrical and the bricks and mortar - are union positions right now. I would hope that by saying that, you are guaranteeing that those union positions remain, because they are the ones who are doing the electrical and the boiler-making and those jobs currently.

I will move on. While the deal will not privatize direct clinical relationships, there are still reasons to be concerned about the impact that privatization will have on the health of patients in the facilities. As you said - and I'm glad to hear that cleaning will not be part of contracting out, but the Auditor General has found that in the past, Nova Scotia has been extremely poor at ensuring developers are held accountable as per their contractual responsibilities on P3 contracts.

Throughout the process of the roll-out of this development, we've heard several times that neither the Department of Transportation and Infrastructure Renewal nor the Department of Health and Wellness have the in-house expertise or capacity to manage these kinds of projects. Is the new health care division within the Nova Scotia Lands meant to rectify this problem?

JOHN O'CONNOR: I'll address some of that. The creation of the contract is the stage we're in now, and we do understand fully that a very good contract is important to start with. So you're correct that overseeing that contract for the next 30 years is equally as important. We're surrounding ourselves with folks who have created those contracts many times over in the past, helping us create them. Obviously we have our input into all the output specs, and all the clinical requirements are clearly being laid out with our involvement and the Health Authority.

We do contract out construction now. We contract out the design now typically on every public facility that we build. We contract out some maintenance around Nova Scotia. We contract out some snow removals and cleaning. We do contract out to the private sector. Government doesn't have all of the capacity to deliver design and construction. We contract out the majority of it.

All this is doing is assembling it together under one contract to get some real advantages - the balance between making design decisions and construction decisions that will cause you grief in the future. Well they don't want the grief in the future if they're responsible for maintenance and the cost of maintenance, so they try to strike the right

balance to design and build a good quality building - one that's easy to maintain, with longevity and durability and so on for 30 years.

That's all we're really doing - assembling together under one contract arrangement a lot of things that we would do separately - separate contracts.

TAMMY MARTIN: I would respectfully disagree. We've seen many problems with P3 contracts over the years. Would the representatives from TIR be able to provide the committee with a more detailed breakdown of the health care division's budget? I understand that we're allocating $6 million a year until these health care redevelopment projects are finished.

JOHN O'CONNOR: Currently the budget approval is for $6 million. It was half of that the last fiscal year and this year it's at $6 million. That money is to cover the cost of resources that are working on the project at the Health Authority, at TIR and some possibly at the Department of Health and Wellness. There are a few positions that aren't in place yet, but generally that's for the overall resources from the governments and grouped together under this health infrastructure division of Nova Scotia Lands. That's what that $6 million is for.

TAMMY MARTIN: I'll ask my final question and then pass it back to my colleague. Given that this contract will span 30 years and that health care technology is changing very quickly, how will new requirements and costs that come up over the course of the next 30 years be managed?

JOHN O'CONNOR: Again, built into the contract that we're preparing now that's going to go out through the RFP, is contemplating language and provisions around how those things get handled. As most contracts that are in place for 25 or 30 years, quite typical for P3 hospitals, there are provisions built into those contracts that address how changes are addressed over time.

If there are changes initiated by the owner - by the way, we will own this facility. The government will still own the property, own the facility. The folks here that we're talking about contracting with will do what they're required to do under the contract for the 30 years - the province will still own the facility. We'll have provisions in the contract that will give us some opportunity to make changes at our own or have them help us make some changes.

TAMMY MARTIN: My final, final question is: You mentioned there will be a short list that the RFP will go to - will SNC-Lavalin be included in that short list?

[2:30 p.m.]

JOHN O'CONNOR: I'm fortunate enough to be in a position where I don't even know who bid on it. I'm not part of the evaluation team so I can't answer that question if they are on one of the teams or not at this point.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: I just wanted to go back to Bayers Lake, the choice to put that facility in Bayers Lake for a moment. A couple of weeks ago, I don't know when, the last time we sat with the Community Services Committee and Gerry Post was there, the Director of the Accessibility Office, and he talked about how Access Nova Scotia in Bayers Lake is not actually accessible to him. As you know, he uses a wheelchair and in the winter months he cannot actually get from the bus to the building.

This makes me think about the new facility out there. We've talked a little bit about the road access, but my question is: Have the departments been working with HRM and the transportation unit at HRM to develop a real, workable transportation plan that includes bus and active transportation to get to the facility?

PAUL LAFLECHE: The answer is yes. Yesterday in fact I was speaking with Gerry Post. I don't know if many of you know, but Gerry Post actually hired me here in Nova Scotia 25 years ago and I always appreciated his tremendous contribution to this province.

We've had many meetings with Gerald as we build new facilities. As you know, we have a standard that we've worked very hard and we're very proud of. Our architects are proud of what we have, a dedicated team of architects in-house who specialize in accommodating disabilities and making sure the buildings accommodate them.

I'll hand it over to Brian Ward in a minute to talk about our discussions with HRM but I want to talk about - there was a lot of talk early on about no bike trails there. In fact, I've driven by those sites many times on my bike so that was sort of a rumour that got out and I don't think people actually . . .

THE CHAIR: Order. Time has elapsed for the NDP. We'll move to the Liberal caucus.

Mr. Irving.

KEITH IRVING: Thank you all for being here this afternoon. First of all, I want to say that I come at looking at this project as an architect, so I have a bit of insight into the complexity you are dealing with here. I think it's important that Nova Scotians get some insight into the challenge of this project.

I do want to say that I am delighted to hear that you are bringing in external expertise to this project given its complexity, and the staging of the buildings I think is a very wise decision with respect to breaking it down into more manageable pieces. As has been stated by our witnesses today, the key to this project will be a good contract.

As an architect I understand the complexities of this building type. Hospitals are the most complex building type that we deal with in construction. On top of that, where I need to get more understanding and I hope someone can shed some light on this for all Nova Scotians, is the complexity from the health care side of this. With the technological changes that we're dealing with, the demographic changes as we try to look out 50 years on what is happening, the new medical techniques with less invasive procedures coming online, so less space needed after surgery, that kind of thing, the changing of standards.

There were a few comments made about 360 meetings with users. That's a little bit of an insight, I guess, for Nova Scotians in the amount of work that is involved here. It's so important that very solid planning goes into this, this will save Nova Scotians money in the end. It's a lot more difficult to make those changes in the midst of construction, as I think most people know.

I'm wondering if there's anybody on the Health Authority's side, Ms. Bond or Dr. Kirkpatrick or Ms. van Hemert, are there any examples that you can give Nova Scotians on how complex this is? What are the tender documents going to look like with respect to this project? I don't know who to best direct that to.

DAVID KIRKPATRICK: Just in terms of the process of planning and trying to future-proof this, it's not a very advanced objective to try to bring everything up to date, but we would like to go beyond that and actually plan for the future. There's a lot of emerging technology, and we know that some of it never comes to fruition.

In our planning process, we meet with clinical groups, and I'll say to them that we shouldn't invest in this technology because what's coming down the pipes is some new technology that, 10 years from now, will completely outdate all of the stuff we're currently thinking about buying. We can't really plan that far ahead, so we have to do what we can do and make for a reasonable ability to make the adjustments as time goes on. We will invest in the most up-to-date technology. We'll try to anticipate the future and also have the kind of spaces that will have the ability to expand for the kinds of things we might be able to anticipate.

One of the things that's happening in the middle of all of this to the new orthopaedic surgeons that we recruited is that they have been trained to do knee replacements as outpatients. This is something that hasn't been done in Nova Scotia. It has only been done in a few places in Canada, they have been doing trials on this technique and it seems to be working. That will have a significant impact on creating an efficiency in our system if we're able to apply this to a large number of the patients who are currently waiting for knee replacements.

KEITH IRVING: What I heard from that last comment is that more modern facilities are going to be integral for us to create an efficient, cost-effective health care system. Underlying all of this work is something that will deliver health care better for Nova Scotians in a more cost-effective manner and as well create better working conditions for our doctors and nurses in the work that they do every day. Any comments on that?

DAVID KIRKPATRICK: One of the questions asked was about how much extra capacity this new facility is going to create. The easy list to come up with is the exact number of additional beds and the exact list of the size and type of additional operating rooms that will be in existence. That physical infrastructure is easy to list. What's a little harder to actually quantify is how much extra capacity we're going to get from some of the obvious efficiencies.

In decanting some of the secondary care from the Halifax side over to the Dartmouth side, the patients who will be treated over there will be mostly categorized as low risk for anaesthetic. When you have a facility that deals mainly with low-risk patients, you can be much more efficient. You can move them through the system much more quickly than if you have a mixture - as we do now on the Halifax side - of very sick high-risk patients mixed in with low-risk patients. There's that efficiency that we anticipate from that, but it's very difficult to put a number on.

THE CHAIR: Mr. Jessome.

BEN JESSOME: Referring back to Dr. Kirkpatrick's opening remarks, I quote, "During recruitment interviews, candidates ask about this project with great anticipation." Could our chief of surgery please elaborate on how this infrastructure redevelopment lends itself favourably to doctor recruitment?

DAVID KIRKPATRICK: Unlike some disciplines in the province, like primary care, if we have an opening in surgery, we usually don't have any difficulty attracting candidates. In fact, we may have as many as 10 applicants for a position. When we look at the applicants, like any employer, you want to choose the very best one. It turns out the very best ones often have lots of offers. They want to work in a place that's modern and has the equipment they're going to need as they think about their future over the next 30 or 35 years. They need to be in a facility that's not going to crumble and disappear out from underneath them.

BEN JESSOME: Thank you for that. Again back to Dr. Kirkpatrick's opening remarks, "Renovations at Hants Community Hospital were completed last year, and we exceeded our first-year target of doubling the number of surgeries performed compared to the previous year." That's a definitive piece of evidence that improvements to health care infrastructure can have a significant impact on the quality of health care in Nova Scotia.

Dr. Kirkpatrick, through the Chair, you go on to say, "By consolidating the QEII functions at one site, we will be eliminating 3,500 patient transfers . . ." Can you elaborate on that, in the context of how that lends itself to quality improvement in Nova Scotia?

DAVID KIRKPATRICK: If one of you had a bowel obstruction tonight, you wound up in the emergency room and you had to have surgery, you'd go upstairs to the operating room at the Halifax Infirmary, you'd have your operation. Then probably within 12 hours you'd be put in an ambulance and sent to the Victoria General Hospital. That's because the general surgery service is spread across two different sites. There's just simply not enough room at the Halifax Infirmary to have all of what they do at that site. That's very inconvenient for patients, it's not very comfortable after surgery to be put in an ambulance and sent down the road. They wind up in a different environment with different caregivers and it tends to delay their processing overall. It's a very inefficient model.

In addition to that, the surgeon who comes to operate on you might be working at the VG and have commitments there. You're waiting in the emergency room, it may take several hours for them to get over to see you, to assess you. It's not a very efficient model having services spread across two sites. Many of us have worn out an awful lot of shoes walking that 0.5 kilometres between the two sites.

THE CHAIR: You have one minute.

BEN JESSOME: One minute, okay. I guess I'll just surmise to say that there are definitive examples of how improvements to the infrastructure in our province can lend themselves favourably to the overall initiative to improve the quality of health care in Nova Scotia, and I'm proud to be part of a government that's endeavouring to make that a priority. Thank you.

THE CHAIR: Order, that concludes our questioning time. I would ask that we have closing remarks. Mr. LaFleche.

PAUL LAFLECHE: I'm the only one with closing remarks here so I first want to touch on a few points that were made here today to demonstrate that we've listened and understood the need to look at this.

These facilities have to service all Nova Scotians. I appreciate that many Nova Scotians look at it from their own particular lens or their geography. Ms. Leblanc talked about accessibility. The facilities have to be truly accessible in more than one way to everybody and we've worked very hard to plan that with our colleagues at the Department of Health and Wellness and the Health Authority to make sure that at the end of the day, Nova Scotians will see that these facilities have a greatly enhanced degree of accessibility, both in terms of what Gerry Post would call accessibility but also in terms of transit or geographic accessibility for all Nova Scotians.

We do hear that, and Mr. Ward unfortunately didn't get to talk about that, but we are working on that with HRM.

Another point brought up was the adaptability - I think Ms. Adams brought it up - of the facilities to the future. One of the things we're being very careful of, some of the reasons we can't renew our old facilities in several locations in Nova Scotia is because they are not adaptable. These facilities have to be adaptable to changes in medical technology, medical instrumentation, medical practices and procedures. We're trying to work both here and in Cape Breton, which we talked about a few weeks ago, to ensure that the facilities will be - if they last 50 years as buildings, they will last 50 years in terms of their ability to accept new innovations in the field of medicine and serve the patients well. That's another point that I think was a good point that was brought up.

[2:45 p.m.]

Communications - I take the point from Ms. MacFarlane that we can communicate all we want, but if there's no reception on the other end we have to do a better job. We have to get out there and do a better job. To that end, I was speaking with the new CEO of the Cape Breton Partnership. I hope I have secured an invite to go up there and meet with the partnership members and deliver in a very different way - if we have to go right to the site, if we have to go to Pictou and New Glasgow, if we have to go to Yarmouth - talk to the people as opposed to just putting up websites. They serve a purpose for a certain generation but maybe not for everybody. We have to go communicate directly to the people; we have to do a better job of that.

There were a lot of questions about the design, build, finance, maintain P3. Of course, we have done a lot, as John said, of design, build. That's something we're very familiar with. We have done a number of design, build, finance and a number of design, build, finance, maintain.

There was talk about expertise. We do have an expertise, but we're putting out - someone said $2 billion here, half a billion in Cape Breton. We have art galleries; we have schools; we have other museums, et cetera. We're doing a lot of work, so we do need a lot of extra expertise brought in. It's not that we lack basic expertise. I know my staff are very proud of the expertise they have, but we have to bring in more.

We talked the last time we were here about the potential shortage of construction workers in Cape Breton. We are challenged in Nova Scotia in terms of the population and our ability to do these projects in a timely fashion so we can deliver these services for Nova Scotians.

The design, build, finance, maintain is an option that we feel will deliver potentially a quicker result and a better fiscal result. If it turns out that they don't, we're not ideologically wed to things. We have done a lot of work, as John said, in the background to ensure that we have the right numbers. When we get the answers to the RFSQs and then

short-list and then get the RFPs out and we get the results in, we'll find out whether that's true or not. Hopefully, we can move ahead as quickly as possible.

Where a design, build, finance, maintain is not appropriate, we haven't done them. You'll notice we have done a mix, as John said, of both. In the $2 billion here in Halifax, some is traditional build and some is design, build, finance, maintain. We have tried to do the mix such that we get the best values and the quickest results for Nova Scotians.

I want to thank the committee very much for inviting us here today. We would be willing to brief any of the committee members in person at any time - or any of the other 42 MLAs. Did I get that right? Oh, 41, because we have a vacancy.

THE CHAIR: Thank you. We look forward to updates and communication about the progress of the build. You may leave the Chamber. We'll give you a few minutes.

We'll do committee business.

Mr. Irving.

KEITH IRVING: Madam Chair, I have learned that our witnesses for the June 11th meeting are no longer available. I would like to put an idea on the table here for the committee's consideration.

Most recently, just on May 2nd, a report was issued. The Nurses' Union contracted a report entitled *Nursing Potential: Optimizing Nursing and Primary Healthcare in Nova Scotia*. The nurses have brought forward a number of good ideas. I think it's worthwhile for the committee to take a look at those and learn more about the ideas. The nurses are on the front lines, and we can learn considerably from their work and what they have found in this report. So with that potential opening on June 11th, if these folks are available, I'd like to put forward a motion that the topic of the meeting for June 11th be *Nursing Potential: Optimizing Nursing and Primary Healthcare in Nova Scotia,* and ask the following witnesses to appear if available: Ms. Janet Hazelton, President of the Nova Scotia Nurses' Union; Coleen Logan, Nova Scotia Nurses' Union; and the authors of the report, Paul Curry, Justin Hiltz, and Ashley Buckle.

TAMMY MARTIN: First off, if I could ask what was initially scheduled for June 11th?

THE CHAIR: It was Dr. David Anderson, Dean of Medicine at Dalhousie. It has been moved to August 13th. He wasn't available.

TAMMY MARTIN: What was the topic?

THE CHAIR: I don't have the topic here. Ms. Kavanagh?

JUDY KAVANAGH (Legislative Committee Clerk): From memory, I believe it was Dalhousie Medical School and its role in sustainable health care. They approached me late last week and said that he had a time conflict and asked if he could come later in the summer.

TAMMY MARTIN: As well, I'm wondering if this report that my colleague speaks of is the NSGEU survey that was put out to nurses.

THE CHAIR: No, this is the report that was released last week by Ms. Hazelton. Is that correct, Ms. MacFarlane? You had sent a letter.

You would have received a letter from Ms. MacFarlane.

We have a motion on the floor.

Ms. MacFarlane.

KARLA MACFARLANE: I just want to say that I'm very pleased to hear this. We had hoped that perhaps we could get them in sooner, but given the timelines, I'm in favour of the next meeting calling in the three witnesses that my colleague has just mentioned, as indicated in the letter of May 8th that I wrote, identifying that I felt that it was extremely important to have them in here.

I think that our committee, collectively - it's part of our responsibility to have them come in and for us to understand the 35 recommendations. Perhaps there are one or two out of those recommendations that we as a committee will all agree are a no-brainer and make common sense to put forward to send off to Minister Delorey, and that perhaps could be implemented immediately to make health care better in Nova Scotia.

I just want to say thank you so much for identifying my request of May 8th.

TAMMY MARTIN: Can I amend the motion?

THE CHAIR: We'll have to vote.

TAMMY MARTIN: I would like to ask then if we could include the NSGEU and their report from the nurses in this.

THE CHAIR: I don't know what report you're speaking of.

TAMMY MARTIN: We spoke about it in detail in the House - the survey that the nurses did.

THE CHAIR: A survey?

TAMMY MARTIN: Yes, that the NSGEU put out.

KARLA MACFARLANE: I just want to comment on that. I think that is a fabulous idea to bring them in at a later date.

I just feel that these 35 recommendations need to be dealt with. We only have two hours. We know, given today as an example, that we just can't get all of our questions in. I would love to be able to see that next meeting dedicated solely to the report on the 35 recommendations, so that hopefully we can have an action plan that we can actually put forward. No disrespect. I agree that at some point they should be brought in too.

THE CHAIR: There may be some overlap, you'll learn with the report. It would probably be the same people surveyed in both reports.

Ms. Leblanc.

SUSAN LEBLANC: Just to be clear, I don't think it's possible to make an action plan. I think this is a great idea, by the way, but I don't think an action plan can actually be made for the province if we don't include all of the nurses. So NSGEU represents some nurses and NSNU represents the other nurses, and so we need to hear from them all. If the point of the meeting is to develop an action plan going forward, then we should be able to hear from all nurses at the same time.

THE CHAIR: I don't know if this committee's mandate is to develop action plans. Our motion on the floor is to have the nurses' report brought forward to the committee. At a next agenda-setting meeting you could add the NSGEU for it and they would have the floor to themselves or something.

SUSAN LEBLANC: Could we have clarification on how that works with amendments? If there is a motion on the floor, can we put forth an amendment and then we vote on the amendment, and then we go back to the original motion?

THE CHAIR: Maybe we can have unanimous consent to extend the meeting. Do we have unanimous consent? It is agreed. Thank you.

JUDY KAVANAGH: If there is a motion on the floor and somebody proposes an amendment, first you agree on whether or not to amend the motion, and then if it passes, you vote on the amended motion. If you don't agree to accept the amendment, then you just vote on the original motion.

THE CHAIR: So, we agree to allow the amendment and then we vote on that amendment? No? We have to agree to the amendment.

SUSAN LEBLANC: I would like to propose an amendment to the motion, which is to add a representative from the NSGEU to be included in the witnesses for that meeting.

THE CHAIR: There is a motion on the floor to amend the original motion to include the NSGEU nurse survey?

SUSAN LEBLANC: No, just a representative from the NSGEU.

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

The motion is defeated.

The original motion is on the floor. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Our next meeting will be the nurses' report. We have two pieces of correspondence - I don't know if they were in your package or not. One was from the Department of Transportation and Infrastructure Renewal; that has been circulated. Also, correspondence from Mr. Mark LeCouter from the Nova Scotia Health Authority that was requested.

Ms. Martin.

TAMMY MARTIN: To be clear, what was sent from Mr. LeCouter is not what was requested in the meeting. It was asked in the meeting that all members of the group making decisions for health care in Cape Breton, whether that be community members, politicians, facility staff, just regular everyday people, be included in that list. We've only gotten the physician leads. We've asked for everybody on any committee for the health care redevelopment in Cape Breton.

THE CHAIR: Could we ask the clerk to contact Mr. LeCouter and ask for that other information?

TAMMY MARTIN: And he agreed.

THE CHAIR: He agreed. Okay. Thank you. Is there any other business?

Being there is no other business, we will have our next meeting on Tuesday, June 11th from 1:00 p.m. until 3:00 p.m. Our topic will be the nursing report.

This meeting is now adjourned.

[The meeting adjourned at 2:59 p.m.]