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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, February 28, 2018

Legislative Chamber

Redevelopment of the QEII

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Public Accounts Committee

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[Mr. Brendan Maguire was replaced by Mr. Bill Horne.]

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

Mr. Gordon Hebb,
Chief Legislative Counsel

Ms. Nicole Arsenault,
Assistant Clerk, Office of the Speaker

WITNESSES

Department of Health and Wellness

Ms. Denise Perret -
Deputy Minister

Mr. Craig Beaton -
Executive Director, Strategic Operations

Department of Internal Services

Mr. Jeff Conrad -
Deputy Minister

Department of Transportation and Infrastructure Renewal

Mr. Paul LaFleche -
Deputy Minister

Mr. John O'Connor -
Executive Director, Major Infrastructure Projects

Mr. Brian Ward -
Director, Major Infrastructure

Mr. Gary Porter -
Executive Director, Corporate Initiatives

Nova Scotia Health Authority

Ms. Janet Knox -
President and CEO

Ms. Paula Bond -
Vice President, Integrated Health Services Program Care

Ms. Victoria van Hemert -
Senior Director, QEII Health Science Centre & QEII Redevelopment

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, FEBRUARY 28, 2018

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Gordon Wilson

MR. CHAIRMAN: Good morning, I call this meeting of the Public Accounts Committee to order, and this morning we are discussing the redevelopment of the QEII.

I'd like to remind everyone to place their phones on silent. We have a lot of people in the room today so please make sure you place your phones on silent. We'll begin with introductions, starting with Mr. MacKay.

[The committee members introduced themselves.]

We have the Auditor General with us this morning, Mr. Pickup. We have a lot of people in the room today. I usually allow for a more free flow of conversation between members and whomever is speaking, as long as there is not a change in speaker, but I may be a little more strict today because there are so many people in the room.

We will start with all our witnesses, beginning with Ms. Perret.

[The witnesses introduced themselves.]

We have a number of opening statements, I believe. We will start with Ms. Perret.

MS. DENISE PERRET: Good morning, it's good to be here. I am pleased to be with my colleagues from Transportation and Infrastructure Renewal, the Health Authority and Internal Services. The Queen Elizabeth II Health Sciences Centre redevelopment is an important part of ensuring that Nova Scotia has a highly functioning health care system. We know that system is evolving, and this initiative helps to modernize and expand system capacity for both community and highly specialized health care services.

It's good to have the opportunity to be here to address your questions and I look forward to the discussion. Thank you.

MR. CHAIRMAN: Thank you, Ms. Perret. Mr. LaFleche.

MR. PAUL LAFLECHE: Good morning, I am pleased to be here to talk about the Queen Elizabeth II Health Sciences Centre development project today and the role of our department, the Department of Transportation and Infrastructure Renewal. This redevelopment is about moving services out of the aging Victoria Building and the Centennial Building, on the Victoria General site of the Queen Elizabeth II Health Sciences Centre. But it isn't just about building bricks and mortar and a new hospital. It's an opportunity to have a look at how we deliver health care today and into the future.

Our department is a key partner in this project. We oversee all the construction, expansion, and renovations, but we are also working very closely with the Nova Scotia Health Authority and the medical community to ensure infrastructure is built to deliver the best health care services to Nova Scotians and Atlantic Canadians in a fiscally prudent way.

The Queen Elizabeth II Health Sciences Centre redevelopment project was publicly launched in the Spring of 2016, but I want to mention that actually it was probably first conceived under the previous government, in 2011, and I think the Health and Wellness Minister in charge - the former Health and Wellness Minister - is across the way there. The public website, and what the public sees, was formally launched around 2016.

It's not your average construction project. It's the largest construction project we've ever done in Nova Scotia. It's huge, it has a lot of moving parts, a lot of stakeholders, and we're not waiting for one piece to be put in place before we do another. We're working very much in parallel with all the stakeholders and all the communities to get facilities up and running as soon as possible.

A good example of this is our renovation of an underutilized operating room at the Hants Community Hospital that was opened a couple of weeks ago. In fact, when we went in and looked at it, we decided to renovate the existing room as well as build a new one, so we've got two brand-new, 2020 standard operating rooms there and they are forming part of the Queen Elizabeth II Health Sciences Centre health delivery services. We believe that

up to 800 more operations will be completed there each year, doubling the number of procedures that Hants was able to do and to contribute to the citizens of Nova Scotia.

At Dartmouth General Hospital, the third- and fourth-floor renovations are complete and if you've been by the hospital recently you'll know that the larger renovation expansion project of an addition is well under way. This work will result in 48 more in-patient beds being available and doubling the number of operating rooms from four to eight at the Dartmouth site.

At the Halifax Infirmary, detailed design is under way for the third and fifth floors for two interventional suites and a hybrid operating room and, once the bigger expansion project is done, the hospital will have about 500 in-patient beds in total, 28 operating rooms, and a new specialized outpatient centre.

We have also bought property as part of the redevelopment project, like the former CBC building and its lands next to the Infirmary and we've also bought land in Bayers Lake for the new community outpatient centre to serve the suburbs.

A critical part of this project is the master planning and programming which determines what the QEII development project will look like and where services will be delivered. The work that was awarded to Kasian Architecture, one of Canada's top architecture and design firms, will help in preparing us for the future of health care service delivery in Nova Scotia. There has been a year-long consultation working with a broad range of stakeholders including doctors, nurses, pharmacists, clinicians, non-medical staff, IT, and hospital foundations as well as the general public who are interested to contribute.

Kasian Architecture has submitted a draft master plan to the QEII redevelopment team which is made up of representatives from all of us here. We are now reviewing the plan - the team is - and it's not just as simple as reading a report and rubber stamping it. We are verifying that our year-long planning represents and adequately reflects the input we got and adequately reflects the resources that we believe we need to go into the future. It's almost 800 pages long. This is an important phase of the project and we need to take the time to get this right. Very shortly, we'll be able to put this plan in front of Cabinet and move ahead with the next stage on the Infirmary site.

We've been updating Nova Scotians on the progress of the QEII redevelopment project every step of the way whether it be on the website or through direct communication and we will continue to do so. This is a huge project, one that Nova Scotians should be very proud of. It's the biggest project in Nova Scotia's history, the biggest public project of our time. There are lots of moving parts but we are moving ahead on each one in a very systematic way. When it's all done, we hope that Nova Scotians will appreciate the rebuilt infrastructure for the health system that we are providing here.

I want to also add that the media didn't have to take all those notes. I've got a one-pager which I'm going to submit and Deborah Bayer will be available after to hand these out to the media which basically summarizes what I just said.

MR. CHAIRMAN: Thank you, Mr. LaFleche. Ms. Knox.

MS. JANET KNOX: Good morning and thank you. I welcome the opportunity as well to be here with our colleagues from the Departments of Transportation and Infrastructure Renewal, Health and Wellness, and Internal Services. I also have with me Paula Bond, our vice-president, who is the executive lead for the QEII redevelopment project and Victoria van Hemert who is our senior director of the QEII Health Sciences Centre and of this project.

I just want to talk a bit about the QEII Health Sciences Centre. It's a very busy place. On any given day, there are about 950 in-patients receiving care with another 3,800 patients visiting a clinic, 118 having surgery, and 200 seeking treatment at the emergency department. In total, we have more than 1 million visits to the QEII Health Sciences Centre every year and those are people from across Nova Scotia and, indeed, Atlantic Canada for life-changing and life-saving care.

With 10 buildings on two sites, the QEII is a leading academic research and teaching hospital which provides advanced medical care for the region's sickest patients and specialty care in almost every medical and surgical subspecialty including heart health, for example, cancer services, neurosurgery, and organ transplantation.

Today, many of those complex, highly specialized services are delivered in the aging Centennial and Victoria buildings, in less than ideal situations. This includes services that aren't available anywhere else in this province and, in some cases, anywhere else in Atlantic Canada - services like thoracic surgery and our organ and bone marrow transplant programs. That's a big worry for us, given the age and condition of these buildings. As you know, flooding in September of 2015 was a stark reminder of the potential impact on patients when aged infrastructure does fail.

While the people who work, learn, and volunteer in these buildings do their very best every day to ensure our patients and families have excellent care and good experience, moving services out of these buildings is a top priority. However, health care is changing and so are the needs of our population and we need to change as well. It would not serve anyone simply to build a replica of the current buildings and move patients, staff, and equipment into it - and doing nothing isn't an option either. So, the QEII redevelopment project is a once-in-a-generation opportunity to rethink and rebuild the way we deliver health care in this province. It is our chance to really think about the needs of the population we are serving, and organize our services and our facilities in a way that better meets the changing nature of health care and the needs of Nova Scotians today and into the future.

This project makes the best use of resources we do have within the QEII Health Sciences Centre and the surrounding communities, to ensure services are delivered safely, efficiently and, in a way, can be sustained into the future. Nova Scotians are already benefiting from this approach. We are focused on delivering better care, creating better spaces for patients and their families, and our care teams, and advancing the treatments and procedures offered here at the QEII based on evidence, best practice, and the needs of Nova Scotians. We have a monumental task ahead of us, one that is unprecedented in this province. There are more than 7, 000 staff, 700 physicians, 1, 200 volunteers, and thousands of researchers, residents, and learners who support the work of this facility.

Our team is fully committed to providing the full range of high quality, safe services with minimal disruption during the life of this project and beyond. The QEII Health Sciences Centre is a resource for all Nova Scotians and, indeed, Atlantic Canadians. In addition to providing excellent care, the QEII is our leading academic and research institution supporting the development of future health professionals, and shaping the future of health care delivery through world-class research. The QEII redevelopment project is an investment in a healthier future for our province.

MR. CHAIRMAN: Thank you. Mr. Conrad, did you have an opening statement?

MR. JEFF CONRAD: Very brief. I just want to say good morning and thank you for having us. As the department responsible for shared services like procurement and IT services, I am pleased to be here this morning to join my colleagues, and very pleased with the work that the departmental staff do to support projects of this size. Thank you for having me, and I look forward to the discussion.

MR. CHAIRMAN: Thank you. We'll start with Mr. Houston of the PC caucus for 20 minutes.

MR. TIM HOUSTON: Thank you for the opening comments. We do have a lot of people here this morning. Who is responsible for this project? Who has ultimate accountability to make sure this happens?

MR. LAFLECHE: I'll let John O'Connor go through that. There's actually quite a significant structure that has been put in place, and perhaps John should go through it.

MR. HOUSTON: Well, maybe we could just start with which department. We have some pretty influential people in the government here - a lot of salaries, quite frankly, looking back at me here. Which person in the province is ultimately responsible? For the department, and for . . .

MR. LAFLECHE: For the construction? Planning, design, and construction?

MR. HOUSTON: For the project.

MR. LAFLECHE: For the planning, design, and construction it would be Transportation and Infrastructure Renewal. For the health plan, it would be the Department of Health and Wellness and the Nova Scotia Health Authority.

MR. HOUSTON: Okay. Maybe I'll ask Ms. Knox, has the health plan been finished? I think you said we need to organize health care for changing needs. We know this project has started. Has the health part of it, that reorganization and re-visioning, been finished? Has somebody put a tick-mark in and said, that's finished, over to the construction phase?

[9:15 a.m.]

MS. KNOX: Thank you for that question. Our work, of course, is to provide the functional planning, the programming, for how we would need to use that facility. That's been part of the work, that's been a big piece of the work that we've been doing over this past year. Paula Bond leads that work on our behalf, so if you would like to hear about that, she can talk to you about that process.

MR. HOUSTON: I'd like to hear about it in the sense of, is it done? Do you know the functional needs, and has it kind of been completed, and have the functional needs been documented and passed over to TIR and said, now build this?

MS. PAULA BOND: I couldn't say that we are 100 per cent completed. We absolutely have the functional planning done to move the services out of the Victoria General and into the other facilities, such as Hants Community Hospital. As you heard earlier, our two operating rooms - the second one actually opened today. We're in the process of moving those services that are appropriate to Hants Community Hospital down to Hants Community Hospital.

Also, we have identified the services that will be going to Dartmouth General Hospital once that construction is completed. We also know the services that will need to come from the Victoria General Hospital, such as our multi-organ transplant services, our trauma services, our complicated oncology services - all of those services will have to come to the Halifax Infirmary site. Those are the most specialized, complicated services that we deliver today and into the future for Nova Scotians. We have those functional planning, to the very detail of some of the other planning, we know what we will be moving out into the community centre.

We've met with the clinical leads - physicians and staff - to identify what percentages of those services can move into the community. I would say our functional planning has been submitted for the Victoria General sites into government along with the master planning.

MR. HOUSTON: Okay. I don't want to oversimplify, but would there be a nice, succinct list somewhere that says, "currently done" on this site, "will be done" here?

MS. BOND: Yes.

MR. HOUSTON: Is that available, then?

MS. BOND: It's in for review and for approval. It has been submitted into government.

MR. HOUSTON: Okay. Is that something we could get as a committee?

MS. BOND: I would have to defer to my government friends as to where that is in the process.

MR. LAFLECHE: The full functional plan, as I said in my talk, has been submitted. We are reviewing it now, we hope to have it through some sort of a government cabinet process in the next month or two, and then it will be revealed to the public. On the other hand, for the parts we have already completed, there are plans out there.

I want to just step back for a minute - it's a very good question, but we're trying to avoid the mistakes that were done in other jurisdictions around different people not working together. Even though at the end of the day, Janet Knox, Denise Perret, and I will be fired if something goes wrong, we're all working very closely together and that's something we deliberately did from the very start of the party. Mr. Wilson would remember that under his tenure when this started, it was a joint project between the health authorities . . .

MR. HOUSTON: In the interest of time - we might be able to get into some of that history as we go through, but my specific question was about the functional plan, and how health care delivery has been envisioned and organized. What I've heard is it does exist at this point, but it's not been approved by the government. Is that something we could maybe request, Mr. Chairman? In-camera or something, just to kind of get a sense as to where services are delivered now, and how that will look in the future in a nice succinct thing, through you, Mr. Chairman - see if we could request that?

MR. CHAIRMAN: Just to clarify, so where services are delivered now that would be something that would be or could be made available? I'm hearing yes, I think, Ms. Bond?

MS. BOND: Yes.

MR. CHAIRMAN: Mr. Houston, can you clarify or restate what you're asking for?

MR. HOUSTON: So a certain service is delivered now at a certain building, and that's going to move, you mentioned some operating room movement, and some movement of services to Bayers Lake. I would envision that there would be a list that would say, these are all the things we do now, and this is where we do them, and when this is all said and done, they're not going to be there anymore, it's now going to be here, right?

MR. CHAIRMAN: Mr. LaFleche, perhaps to clarify, is that something that has been decided upon at this point, or is that something you're putting forward to Cabinet?

MR. LAFLECHE: At a high level, we know the services that will be available in the Halifax area, but if you want to know if something will be on the third floor of a new building at Bayers Lake, we're not quite there yet. What I think we can do at a very high level is give you an idea of where services will be, within a few square kilometres, but not pinpoint the exact building location. I think the exact building location will come - this is John's area - in the near future.

We'll do our best to get you what you want so that Nova Scotians fully understand, within this little geographic area, that this is where it's going to be, but we don't know the floor yet.

MR. HOUSTON: Yes, that's fine. It's just that if something's going to be in Bayers Lake, then it's going to be in Bayers Lake.

MR. LAFLECHE: Or it might be split between Bayers Lake, Cobequid, and the Infirmary.

MR. HOUSTON: That's fine. Okay, so that level of planning has been done, pretty much.

Now I want to move on to the construction and what's happening. You mentioned two or three times in your opening comments, Deputy LaFleche, that this is the biggest project in Nova Scotia's history. How much will this cost?

MR. LAFLECHE: Great question. I'm going to defer that to John.

MR. CHAIRMAN: Mr. O'Connor.

MR. JOHN O'CONNOR: I want to just take you back a little bit on the planning. To answer the question on costing, I have to take you through the process that has been worked on over the past year.

The first step is creating the program. The program requirements are basically how each program needs to function. That's what's being referred to on the "function of program" for each service and each department. All of that information drives what space

they need to function in. All of the spaces are then identified - each department, all the spaces you need for what you're working in today.

By the way, the actual spaces that currently exist are in the document that was circulated prior to Public Accounts. They're all listed, and it was provided to the Kasian group at the beginning of their work. All of the services currently in the VG site - including the Victoria and Centennial buildings - are contained in that document.

That's how you're operating today. How are you going to function into the future? That has been identified now - the space that they require for the future - and then it's how those spaces work together by each department. We have taken that further, and all of those spaces now have been created as floorplans, and then the shapes of these various floors. For example, there are 11 ORs to be added to the Halifax Infirmary site.

By the way, it is the Halifax Infirmary site where we're trying to build most of this new infrastructure, and the Bayers Lake site, besides Dartmouth and Hants. We have made provisions for a property there on the Halifax Infirmary site for this new construction.

We have now gotten to the point where all of these space requirements are formed into plans and shapes with various options of buildings - OR floorplans, what has to be on one floor, what proximity to the ICUs, what proximity to Recovery, and so on. All of that has been worked through, where the patient floors would be.

We have been costing as we go - getting to answer your question. As we're costing, we're looking at options. Could it be here? Could it be there? Could the building be shaped like this? Could we add it on this end of the Infirmary? Could we add it on over by where the gardens are currently, over by the CBC building? What's the cost?

We're costing as we're planning. That's the normal process. All the buildings that we do follow the same process, whether it's a large, large project, or whether it was - we're through all of these steps in Dartmouth General, and we're in construction. For Hants, it was the same. It's the same for all the schools.

I have been at this for 30-some years, and many, many, many projects. They all follow the same flow. The costing is done at various stages. We cost at planning. At the end of planning, we have a Class D estimate. Whether it's P3 or whether it's traditional delivery, it doesn't matter. It then moves through various stages of design, and there's costing incorporated in every stage of design.

We are costing all along. It's just premature at this point to give out numbers, because we have a number of options. We know it's driven by the fine-tuning of those options.

MR. HOUSTON: You just described a very detailed process of where things are going to be on which floor. It sounds like it exists.

MR. O'CONNOR: Yes, we have a lot of that created now. We have not brought this forward to our government.

MR. HOUSTON: I was just waiting for a drumroll, to get a number, but at the end, I got, "Well, there is no number." But there is a number . . .

MR. O'CONNOR: We have numbers. We don't do this work without costing as we go.

MR. HOUSTON: There are different classes of estimates. You referred to one, a D3 or something. There are different classes of estimates. Some of them are plus or minus 30. They just kind of fine-tune it down. You have an estimate, though, but you have one you are not willing to share, I guess, is the bottom line.

MR. O'CONNOR: For the work that I'm describing here, we are not at the point where it can be shared. For the Dartmouth General, as we got along a little further and we were at the end of design development, we promised to share that and we did share that. Then we started construction, and we keep updating those cost estimates and we're sharing those as well.

MR. HOUSTON: So you're not able to give me a number today as to how much this all costs.

MR. O'CONNOR: No, I'm not able to give you a number today.

MR. HOUSTON: Okay. Is Deputy LaFleche able to give me a number?

MR. LAFLECHE: No, I'm not, really, and there are several reasons. John described some of them. Of course, one of them is we don't want to give out too many numbers before we get tenders in because that's never a good way to bargain with the builders.

MR. HOUSTON: Maybe I'll ask a different question then, Mr. Chairman. How much have we spent so far, for the redevelopment?

MR. O'CONNOR: For the Queen Elizabeth II Health Sciences Centre redevelopment - including Dartmouth General Hospital and so on - the expenditures today, I think, are around $37 million to $40 million. That includes construction that's being built of course in Hants Community Hospital, and in the Dartmouth General.

If you're looking at numbers for the planning work, the contract for Kasian and the programmers - Agnew Peckham did the programming work, part of the Kasian team. That contract is about $1.9 million, and we're essentially at the final stages of that work.

MR. HOUSTON: So $40 million has been spent so far, and that's land purchases and construction and planning, and some element of the $40 million is on planning. I just want to make sure I'm hearing this correctly: $40 million into the redevelopment project, and we're not able to have an estimate of how much the whole thing will cost?

MR. LAFLECHE: You asked how much we spent. John, I don't know if we can add it all up today, but we can give you sort of a number of what we've announced publicly. We've announced somewhere around $138 million for Dartmouth General Hospital, we announced a number for Hants Community Hospital, we've done planning, but right back to when Minister Wilson - I don't know if I can still call him that - but the Honourable Wilson's era, we were doing planning and background work.

We can roll all of that into a number of what has been publicly out there today, if you'd like that, and that would be north of $138 million, obviously. But that's not spent, you asked what was actually spent . . .

MR. HOUSTON: No, I've got a series of questions on it. The first question I had was, how much is it going to cost in totality, and there's no willingness to share a number for that right now.

The second question was, how much have we spent so far, and that was $40 million. You've just offered another number, which is somewhere between how much we've actually spent and how much we will spend, right?

MR. LAFLECHE: That we've announced so far that we will spend.

MR. HOUSTON: So, it will be at least $138 million, because that's what's announced.

MR. LAFLECHE: John, do you have a better number than that?

MR. CHAIRMAN: Mr. O'Connor, the only reason I have to recognize you is so that we catch you on the record. Proceed.

MR. O'CONNOR: So the $138 million, just to be clear, has been publicly announced. That is for the Dartmouth General Hospital expansion and renovation project only.

MR. HOUSTON: Yes, I hear that's a $1 billion undertaking. Would anyone dispute that it's going to be $1 billion?

MR. O'CONNOR: As I've said, I'm not prepared to give out numbers today. It's premature to give numbers at this stage. We have a process we're actually involved in now, analyzing how we may deliver this work through a P3 delivery, versus traditional delivery. We want to keep that pricing under wraps because part of the overall analysis will be what's the value for the taxpayers if we deliver it one way, versus another.

Then if we do go through a P3 delivery model, then we want to keep those costs to ourselves so we can compare against submissions we get from …

MR. HOUSTON: Okay, thank you for that. I guess what I would do - through you, Mr. Chairman - is ask for the list of what has been spent to date, the actuals, so that it will come up to somewhere around $40 million, and the separate list would be the announced, which Mr. LaFleche says would be somewhere around $138 million, or it could be more. So that's up.

I do want to talk about the Kasian report; I understand that cost $2 million. It was referred to in the opening - I think at some point it was referred to as a big report, maybe 800 pages. Would it be fair to say that that is the blueprint for this whole redevelopment project?

MR. O'CONNOR: Yes, that's exactly what it is. Not including, of course, Dartmouth General Hospital. So, just as we talked about Queen Elizabeth II Health Sciences Centre, in our minds this includes all the components that we were referring to, so Hants Community Hospital and Dartmouth General Hospital, and so on.

But yes, for the work that's being planned to empty out the Centennial and Victoria Buildings into other locations, this is the blueprint, if you want to put it that way.

MR. HOUSTON: Okay, that's fair. And you have it? It exists?

MR. LAFLECHE: It does exist, and it's in final draft form under some level of review, and some additional little pieces that we're still trying to tie down with, for example, traffic studies.

MR. HOUSTON: Okay, so it's the final draft? That implies that there were earlier drafts. When did you get the first? I understand the final draft came sometime in December, a couple months ago, but presumably drafts of this started appearing earlier.

I guess I'm curious as to when can we see it? It seems like we've been talking about this project for a long time. The draft is there. When can the people of Nova Scotia reasonably expect to see what this blueprint is? Is it within the next week or something?

MR. O'CONNOR: I'm going to answer about drafts. So, yes, there are drafts all the way along, so any piece of work that we hire out to have consultants work on, we get drafts all the way along we review. So, the first, most significant draft was in around July.

MR. HOUSTON: July, okay.

MR. O'CONNOR: That finished the main programming work. It's been tweaked after that. Then you get into the master planning - where do all these spaces fit - and that's been happening since July. So to answer your question, we're very close to the final draft. We have to bring this information forward to government for direction and approval.

MR. HOUSTON: Do you have a date for that to go to government?

MR. O'CONNOR: As Deputy LaFleche said, we are focused on that now in the next month or two. We hope to be in front of government with this information and to provide the product of the last 12 months' worth of work.

MR. HOUSTON: If it's a couple of months and the first drafts would have been pretty meaningful - they probably would have been 80 or 85 percent of the way towards what the final was - that would imply that it's almost going to be a year from the time the first drafts were made available to the time it went to government. It just seems like a long time.

MR. O'CONNOR: No, we originally communicated that this work would be at least 12 months of work, and it has been about 12 months' worth of work. I mentioned earlier, one of things we're doing in parallel is to assess how we deliver on this work. The work that's being done by Deloitte to analyze the P3 versus traditional delivery could only really start once the Kasian work was complete.

MR. CHAIRMAN: Order. I'm sorry, we've run out of time. We'll move to the NDP caucus, and the Honourable David Wilson.

HON. DAVID WILSON: Thank you for being here. There is definitely a lot of interest in the province on this project. I think there's been a commitment from all three Parties who have been in government that the need is there to do this project, and Nova Scotians are just waiting to see when that will happen. I know we've heard some questions around financing and cost. What is the expected date that you have on the project, that things would be finalized - people will be moved out of those two facilities, procedures and services will be given in other locations? Do you have a date in mind?

MR. O'CONNOR: I'll try to address that. Similar to the costing answer that I gave earlier, part of the work, as we're doing the planning, is to look at time and scheduling: if we do it this way, if we do it that way, if we build the building sort of here, could you build

them together at the same time, these two buildings might have to be added to that site, or would one have to be done ahead of the other.

All that drives time, so as we're working through this, we're doing timelines on a regular basis, and then we're looking at from beyond - how long would it take during construction or during design. A lot of that is being mapped out and we have the same process we followed for all other projects. We provided timelines for Dartmouth General Hospital, we provided timelines which we already completed for Hants Community Hospital, and so on. It's no different for this work. It'll take the same approach.

At this point in time, we have estimated some timelines on the web site in May or April of 2016. We are targeting 2022 or beyond to be finished to the point where services could be completely emptied out of the Victoria and Centennial Buildings. But there will be some services, as Paula Bond had mentioned earlier, that will be moved out of those buildings as other things come on line.

Dartmouth General, for example, we're targeting the addition to be ready around 2020, then the rest of the work in Dartmouth be late 2021 and into early 2022. As all those things come online, as Hants just came online, all of that is part of the overall schedule of the - I guess we use this word "decanting" which nobody likes, but that's the one that seems to be used a lot with the emptying out of the Victoria Centennial buildings.

MR. DAVID WILSON: The biggest component to this from our position is, what options and how are you proceeding forward with the remainder of the builds? You've mentioned P3 options. It's no secret that we've advocated for a number of years now that shouldn't be the avenue that the province goes down. That's going to determine the timeline. So when would you expect a decision from the government on - the financing is going to come from the Treasury Board or the financing is going to come from some P3 model. Do you expect a clearer path forward in a month's time or a couple of weeks time when the budget is unveiled here in Nova Scotia?

MR. O'CONNOR: We haven't been able to provide the government with all the information yet, so the work that Deloitte is doing is scheduled to be completed around the end of April and into the early part of May. Then we have to again review that work and make sure it's in keeping with what we've contracted them to do, then that's part of the decision making. That together with the WoT, which is the programming, and the work from Kasian will help inform the government to make a decision.

MR. DAVID WILSON: So with that information being handed to government decision makers, are you looking at design/build or are you looking at design/build/finance or are you looking at design/ build/ finance/ and operate? Are all those options still on the table?

MR. CHAIRMAN: We'll hear from Mr. Porter.

MR. GARY PORTER: Thank you for the question. I think you're seeing a theme here. One is that process is important. We contracted with Deloitte in 2017. It really helped advise us on how to arrive at a decision on whether we go to a design/build/finance/ maintain or traditional method of delivery.

Some of the work that went into that is really critically important. First of all, we've asked them to examine projects and findings of hospital P3s elsewhere in Canada. In doing so, we wanted them to really place a lot of emphasis on Auditor General findings - process-related deficiencies, if you will - what worked really well and what could be improved or what have they found in those jurisdictions. That was an extensive piece of work.

From that, that helps us design a business case process that will really get at whether or not it's in the best interests of Nova Scotia to move forward with an alternative procurement. The range includes a traditional design/bid/build, which is usually the government approach, up through to a design/build/finance and maintain and pretty much everything in between. We'll examine those options and narrow it down to a few.

MR. DAVID WILSON: Thank you for that. I know Mr. LaFleche indicated that the group is trying to avoid past mistakes, and there have been projects in other jurisdictions that have gone severely off the rails when it comes to P3 hospital rebuilds and redevelopments. The former deputy minister of the Department of Health and Wellness in a briefing to the minister a couple of years ago indicated that. I would hope that the current deputy might hold that opinion also.

Just quickly - and I'm going to hand off to my colleague - you talked about the Hants Community Hospital and doubling the procedure capacity there. I don't know if you're aware of what's happening currently in our system around patient transfer and EMS in the province, but there are communities today that are not being covered because of the delays of transferring care over.

When I hear about this - I know paramedics in the province are going to say we're going to increase the number of transfers to Hants now. Has there been any talk on enhancing EHS, increasing transfer capacity so that emergency ambulances are not being used to transfer people from Halifax to Windsor, creating an even worse scenario down the road once the doubling of procedures happen there?

MS. BOND: Yes, we're aware of that. We're working very closely with EHS on all the transfer issues that we are facing today and the emergency department services, but the increase in Hants ORs is an increase in day surgeries. These are not patients that will be transferred from the Halifax Infirmary, Dartmouth General, or other areas. These are patients that would normally, in a lot of cases, have had to come into Halifax to have their surgeries done because they did not have the capacity in Hants. Now we're thrilled - as are the physicians and the community of Hants - that we will be able to offer double the

outpatients surgeries, omitting having to travel into downtown Halifax and all the complications that go with that.

In working with EHS and with our Department of Health and Wellness colleagues, we do not anticipate that particular situation to have an impact on the transfer services.

MR. DAVID WILSON: I wish we had a lot more time because I'd love to dive into more of what the current situation is, but I will pass my time off to my colleague here.

MR. CHAIRMAN: Ms. Roberts.

MS. LISA ROBERTS: Thank you very much. Is there utilization data available on the existing infrastructure that this project is aimed at replacing?

MS. BOND: Sorry, can you clarify the question for me? I was thinking more of the infrastructure and looking at Mr. O'Connor.

MS. ROBERTS: I'm looking at the space that is available now for all the different procedures, all the different work that happens within the QEII complex. Is it fully utilized and for what portion of the week of the hours of potential operation is it actually fully utilized?

MS. BOND: Well, we always look at efficiencies and where we can be more efficient in the system. Unfortunately, with the VG infrastructure, that's not always possible. We have continual pressures there at the VG. I do want to make a comment though, that we are very proud of the quality of service that's delivered at the VG, but certainly utilization of operating rooms, of beds - we all know that we have bed pressures within the QEII. It's a daily assessment of who is in those beds, what are the priorities for patients in beds, and the ORs, as well as the emergency services. We are constantly reviewing that.

MS. ROBERTS: I guess I'm thinking more forward looking. We know that we're at the early stage of the baby boomer population aging into a phase of life where they need more medical care in Nova Scotia. We are looking to replace spaces that are, yes, currently not as functional as they could and should be. How are we adjusting what we're building to anticipate efficient spaces that are also used efficiently through centralized scheduling, through maximizing how people work together, so that we're not building more space just because maybe two different teams don't agree on when the OR should be given to them, for example?

I am seeing some nods over there, so I don't think I'm completely off my rocker.

MS. BOND: Thank you for the clarification and an excellent question. We are absolutely looking at population growth and the aging population of Nova Scotians.

Looking at where services are delivered today and where they are best delivered, and one of the opening statements that both Ms. Knox and Deputy Minister LaFleche made, is that this cannot be about replacing the bricks and mortars of the VG. It is about where we can best plan provincially and implement locally. It's about distribution of services. It's about what's happening and is going to be happening over the next 30 or 50 years. We all know that the way services were delivered - my background is nursing - in hospitals 20 years ago are totally different than the way we deliver services today.

We know that we're doing a lot less invasive surgeries, so the operating theatres will look differently, as well as who's going to be in those different procedures and the teams that are going to be there. You're absolutely right, this is more about a collaborative model that we're looking into. It's why we are very intent on having the proper planning in order to get this right.

Over the many, many years of health care services in this province and across the country, it's been one of the issues. It's one of the reasons why we are ensuring that physicians, nurses, and other staff are involved in this planning to help us try - it's not going to be perfect by any stretch - to look at how we can bring teams together to prevent patients and families from having to come in four times for a visit when, if properly coordinated, and we had some centralized booking, they could come for one service.

Patients today rarely come in for one clinic check, with the comorbidities that we're dealing with our aging population. You're absolutely correct in that we have patients who are coming in to see a vascular surgeon, a cardiologist the next day, and possibly having bloodwork the next day. Part of this planning is the coordination of these services, where they can be delivered, and how best to meet the needs of the population of Nova Scotians.

[9:45 a.m.]

MS. ROBERTS: Earlier my colleague was asking about a plan. Can we see consultation with patients and families? Can we see a robust feedback plan from patients and families on their current experiences? Is there a report on that patient input? Is there a finalized care plan that looks forward to when this HI site will actually be built so that we can see that the best choices, the most rational and efficient choices, are being made for building the hospital that we need in the future?

MS. BOND: I think there were a couple of questions there.

MS. ROBERTS: I'm looking for two plans. Is there a document that shows how patients and families helped to shape the care plan? Is there a finalized care plan in terms of what services we actually need delivered when, and by whom and where?

MS. BOND: Yes, we actually have a patient-family advisory committee. There was a public advertisement for that committee. That has been in place. We are very fortunate

that we have very dedicated patients and families that have been part of our planning and wayfinding and giving us input into how important it is not only for distribution of services but also the coordination of services. We can certainly provide that for you.

We do have other websites that patients and families and staff and communities can go on and also offer opinions and suggestions about what would be important for this project and well into the future. We can provide you with that.

MS. ROBERTS: I'm not sure in which opening remarks I heard that there were 950 in-patients at the QEII complex right now. What number of those, on a given day, would be alternate level of care patients?

MS. BOND: I don't have the numbers for today. It does fluctuate. Throughout the QEII, we can have up to 60 to 65 patients who are alternate level of care patients. They would include patients who have been identified as alternate level of care patients and those patients also who are waiting for assessment as to what level of care they need. That could mean going to a long-term care facility, or it could be going home. So we're working with the families and the patient themselves to identify the appropriate needs for the patient to be discharged from acute care.

We understand that those are some pressures that we do see within the acute care systems across the province. We are working with our Department of Health and Wellness and our community partners to address those and to get teams in place to move patients to the appropriate care place with the right care provider, which is one of the principles of how we're developing the QEII redevelopment. That is providing care in the right place at the right time with the right care provider. We certainly all know that is not what the priority would be in an acute care setting. Our intention is to have patients treated in acute care settings or in-hospital settings when they need it and not when they don't.

MS. ROBERTS: I referred back to the Auditor General's Report from June 2016. He presented the figure that it costs $250 a day for a long-term care bed versus $1,300 a day for a hospital bed. As part of this QEII project, and again looking at where we're heading with our demographics, was there any consideration of investing in more long-term care beds in part to reduce the demand on the acute care hospital setting?

MR. LAFLECHE: There's also the question of hospices in there. Maybe at this point, it's best to let Ms. Perret address some of these questions. Not everything you referred to is part of why we're here today, which is the QEII. Some of it is part of the broader health system.

First, I would like John to talk about - you touched on utilization. I think it's important to understand the difference in approach we took when we started this project. It was not just to do a new build downtown but rather to look more broadly at utilization - what you're talking about. John can address that issue with respect to . . .

MS. ROBERTS: So was there a rationale for why we aren't building more long-term care beds in order to reduce the demands on the acute care hospital?

MS. PERRET: Thank you for the question. It's an important question and it illustrates some of the moving parts in the system. The short answer is yes, we're paying attention to that. As Deputy LaFleche said, that's not a key component of the QEII redevelopment, but just as you see a horizontal team-based approach here on QEII redevelopment, you would see that on continuing care.

In both cases we look at population data, the demographic data, the trend analysis as to aging populations, and the incidence of chronic diseases. Those plans are underway to address that. They're on different tracks, but they're absolutely happening.

MS. ROBERTS: Again, going back to the June 2016 Auditor General's Report, there was reference there to another innovation outside of the hospital that reduced demand on the hospital, which was the Care by Design program. It introduced rounds at long-term care facilities and greatly reduced transfers to hospital of residents of those long-term care beds.

The Department of Health and Wellness decided to switch away, to not pursue that program. I'm wondering if there's a rationale for that, or if there might be a return to that?

MS. PERRET: I would say that in general - because I don't know the specifics of that program - absolutely looking at how we move patients, first out of hospitals quickly so that their time in hospital is minimal, because that's important to do. We want to move them home first if possible, but we need to support caregivers in doing that, so we don't want to do that rashly. In long-term care, we want to look at continuous improvement and how the quality of care in those institutions is maintained and improved.

All of that is underway in our continuing care planning and, as I said, simultaneous to this type of work.

MR. CHAIRMAN: Thank you; the time has expired. We will move to the Liberal caucus, and Mr. Gordon Wilson.

MR. GORDON WILSON: I want to start off by thanking the - it's a very large group. We usually don't see this large a group, but I guess that does reflect the nature of the project. It's always an opportunity when anybody comes to Public Accounts to bring to Nova Scotians the work that is going on.

I do appreciate the fact that Legislative Television - hopefully we have a lot of viewers here today, but equally important are the media, to be able to let Nova Scotians know not only the importance of this project but the complexity of it and the progress of

it, where we're at, and the work that's been done and the planning of what we're doing here today.

This is an opportunity. I'll try and frame my questions around how we can best educate Nova Scotians and maybe answer some of the questions that my colleagues had asked that never had a chance to get answered.

To start off with, this is a very engaging project, to say the very least. One of the most entertaining questions that I heard asked, that I thought maybe we should give a chance to have answered, is the history of the planning and the integral work that we see amongst four different agencies here.

Mr. LaFleche or Mr. O'Connor, can you complete that answer to the question around how all of these different departments work together in ensuring this is a smooth transition in what is probably not only the largest but one of the most complex projects that we have?

MR. O'CONNOR: I'll take a stab at that. This project does go back for a number of years, as Deputy LaFleche mentioned earlier. In the 2012-13 time frame, there was planning work carried out. The primary focus at that time was emptying out Centennial Building, but part of it was the work at Dartmouth General. Some of that work has lived on and been added to and developed and performed the basis of the blueprint, if you will - what we spoke about earlier - for what happened at Dartmouth General already to date.

There has been good work developed as we go along. During that time and as we moved into the updated QEII focus in April 2016, which was rolled out, we took the same approach. So, the same approach has been a team approach.

Every project we work on - TIR manages many projects, public sector projects, and for the 30-odd years that I've been working I've been involved either directly or as a director and executive director in hundreds of project deliveries, including the Halifax Infirmary building that is there today. I was the project manager on that back in 1990 to 1996 - we follow the same approach and almost all projects involve a user group, a client department and a department that's managing delivery, so it's not unusual.

This one here is large. It has a huge reach out within the Health Authority. They have created, I think, in excess of - I don't know how many teams, but hundreds and hundreds of meetings over the last while with all these various user groups providing input - no exaggeration, more than 100 people from their end alone.

Then we have the Department of Health and Wellness, our department - we have a number of people - the Department of Finance and Treasury Board, and Department of Internal Services. We've created a governance structure. At the top of that governance

structure within our level is a group of deputy ministers of those four departments and the CEO, Janet Knox, sitting next to me, and then the VP level, Paula Bond and ADMs.

We meet regularly; there are project updates in direction. Then we have a number of other groups - I could have provided, I didn't bring that with me - quite a structure of oversight and governance. A lot of it is keeping people informed, a lot of it is working together to keep moving things along. We have various groups together for all those reasons.

Again, it's not unusual, that's the way we work to deliver most projects. It's just that this one has so many more components and some pieces are well into construction so there are groups of people who are involved that aren't here today at all, leading that. There are many, many private sector organizations now involved in these projects, design teams, planning teams. I think we mentioned Kasian, that's just one. We have large teams of local consultants and others - contractors, suppliers.

It's a far-reaching project. All of that together is the way we kind of move projects along, so when we are asked about who is leading it, it's a tough question sometimes because we don't want to answer it. We really want to do it together as a team. Yes, we have responsibilities back to the government at TIR and we all have accountabilities at different points but we are trying to build the project as a team, deliver it as a team, and I think we've been successful. The proof is sort of in the pudding, if you want to describe it that way, with the work that is already completed and well under way at Dartmouth General.

MR. GORDON WILSON: To step back even prior to that, I have a question for the Health Authority. Obviously, the stakeholder engagement is huge; this impacts across so many sectors in health care. Can you give me a bit of an idea of what work has been done on your part to make sure that we have had the voices of those people in the medical fields part of this? Can you give examples of when that started and is that ongoing?

MR. CHAIRMAN: Ms. Bond.

MS. BOND: Yes, we have had multiple stakeholder engagement, particularly with, as I said earlier, the physicians, nursing staff and other health care providers, as well as public engagement. This has been ongoing for several years now. As you recall, the previous Nycum report that we had, where at that point we were only looking at getting out of the Centennial Building.

There were hundreds and hundreds of meetings, looking at functional plans, et cetera, and it was identified by the stakeholder engagement, particularly the physicians and nursing and health care providers and administration.

[10:00 a.m.]

I was the VP in the former Capital Health that was leading that project as well. It was very obvious that the envelope that we were working with at that time was not going to get us the results that we needed if we were looking at long-term functional planning into the next 20, 30 or 40 years.

As we moved into this particular project, which was expansion of actually decanting the VG site of the Centennial Victoria and looking at distribution of services, looking at the participation of Hants and Dartmouth General, those functional plans - we have teams that are co-led by physicians. Every single team has a physician co-lead who then has responsibility to ensuring that their physician divisions and departments are involved, communicated to, get the feedback from.

We have project teams. We have functional teams. We have steering committees for all three sites that Hants has just completed with physicians and the staff of Hants - including our support staff, which would be finance and IT. The IT component is critical as we move into the next 30 or 40 years, how we're going to improve delivery of care through IT systems as well, so they're also part of it.

With food and nutrition, we often concentrate on - and rightfully so - the clinical delivery of care. We need to also be looking at how we're going to provide things like transportation, food and nutrition, IT services - what that's going to look like into the future as well.

So there are many stakeholders. We have regular meetings. We have a QEII steering committee that's made up of the department and medical department heads - of all the departments across the Central Zone, as well as administration, support staff, et cetera. We can certainly provide a list of those committees and the membership of those committees. In fact, I believe it was provided in an earlier package, but if not, I can certainly make sure that you get the scheduling of that.

MR. GORDON WILSON: So we've had a bit of a picture - I guess Hansard is going to be interesting to read on that. There is a lot in that on engagement. We've had an awful lot of testimony here on how this is all coming together as a team and the work and oversight that's going on there.

I'm curious also about what work has been done prior to even the engagement on - what is Nova Scotia going to look like in 30, 40, 50 years? You're not building something for today - you're building something for the future that's supposed to last 50 years. How do you come to that understanding and when was that work done?

MS. BOND: Yes, we are looking at population growth, as I said earlier. QEII has an academic/research/teaching mandate. We're looking at evidence-based and as we move

forward with those sorts of - the teaching academic mandates and how we can deliver quality care into the future, how that care is going to be changing into the future. We had a very strong team that was made up of our public health - the Department of Health and Wellness - and other epidemiologists - that is helping us through those scenarios and working through that.

MR. O'CONNOR: I just want to add to that. Part of the master planning work is to look out into 20, 30, 40 years. So even with the site itself - just to give some level of comfort - with the development of the site at the Halifax Infirmary, looking at all the different buildings and where we build the buildings and where they get attached now and how we deal with the boiler plants - it's all looking ahead to how that's going to evolve over the next 20, 30, 40, 50 years. That has been mapped out now as well.

It's a longer term look at all of that and how a site can get repurposed in time, because things will happen. Other buildings will age out as well over time. So I just wanted to mention that as well.

MR. GORDON WILSON: Past, present and future - I'm counting seven different individual locations. There's the Infirmary, the QEII, Centennial Building, the CBC site, the Bayers Lake site, the Dartmouth General and the Windsor hospital. Have I missed any? I don't think so - Cobequid, thank you. Eight different sites, a lot of moving parts, and a lot of progress to date also.

I'm interested in knowing - and you've touched on an awful lot of it - I think more interestingly along the progress side of where we are today, and we've come a long way, is as we're building the capacity in the system, we're reducing the capacity in these areas that we're going to decommission, I would assume.

Can somebody give me a bit of a picture of how that balance happens - how we develop a site, and then decommission a site? I'm assuming as we're doing that at most points throughout that we're actually increasing capacity to a degree for a very short window, until we actually take some away, but a lot of moving parts there.

I'm not sure if that's TIR - Mr. O'Connor.

MR. O'CONNOR: You're correct. The overall planning includes - the end goal is to empty out the Centennial and Victoria Buildings. To get there, there are a lot of steps.

For example, in Dartmouth General Hospital alone, there are like 35 different steps to finish the Dartmouth General Hospital work. The addition that's being constructed now - and the structure is finished now and we started to put the exterior cladding on - when that's open, certain things will move into that space, including the ORs. Recovery and other spaces get emptied out and they'll get renovated, some of those spaces, to create the new ICU. Then, the ICU eventually gets emptied out and so on. There are all these different

little moves within that project alone but all, again, leading to eventually the Dartmouth General having a net increase of four ORs and a net increase of 46 patient beds and other increased outpatient services and more.

As that comes online, just like Hants came online this month, it changes where services are being delivered from, and I'll let the Health Authority actually talk more about the service part. Again, it's not really about infrastructure - and that's obviously my area, that's our area that we're leading primarily - but the infrastructure and the builds of the infrastructure are really going to support the end plan of where services are needed, where services are going to be delivered from, and in what kind of spaces they're going to be delivered out of. It is a lot of moving.

To take it a little bit further, as new builds get added to the Halifax Infirmary site and to the Bayers Lake site, then, of course, that will be the bigger part of moving the services out of the existing VG buildings. Just to remind people, there are still other services at the VG. The Mackenzie Building is there. That's a lab building. It's not going to be a completely vacant site but, nevertheless, we're focused on Centennial and Victoria, primarily.

That's how it's all moving. We have a project that's out to tender fairly soon for work at the third and fifth floors in the Infirmary. When that gets completed, we hope in around 2020, that will provide additional capacity, OR capacity in the Infirmary building from what's there today. That will also start having services moved out of the Centennial Building. It's all part of the plan. It's going to take a lot of steps, but the end result will be all the services will be moved out of Centennial and Victoria.

MR. GORDON WILSON: Thank you. I just want to move on to maybe some individual, specific parts of the puzzles. The Bayers Lake Community Outpatient Centre I think is, from my understanding - and I looked at the site - it's for Nova Scotians, and I'm not sure which one of you would like to comment on it but there are a few areas that I'd like to understand fully of how that's going to fit into the overall redevelopment. I see Ms. Knox shaking her head - maybe Ms. Knox.

MS. KNOX: I'll start, and Paula will continue. As we announced the QEII redevelopment project, we said we would be using a distributive approach - really using all our resources in the local area to maximize access for people. We know that in any given year, about 62,000 people drive into Halifax or somehow get into Halifax to receive services.

Part of our work in this QEII Health Sciences Centre are ambulatory services that all Nova Scotians and Atlantic Canadians actually access. The outpatient part of it, in terms of distributing it, is making access available to those services for people so they do not all need to go downtown.

Paula can talk to you more about our thinking in terms of why we would need an outpatient centre outside.

MS. BOND: That's exactly right. Part of our functional planning with the teams looked at what services are presently being delivered at the HI and the VG and, for those services, how many patients are coming into those areas from outside to the downtown Halifax area who could be better served. There's approximately 28,000 diagnostic imaging services that we have identified that could be served in the Cobequid area, and approximately just over 40,000 medical surgical clinic visits that could also be done in an outpatient area in Cobequid.

Dialysis - we're looking at the dialysis patient population who are having to come into the HI and the VG sites right now who could easily be served much better out in a community centre.

Part of the overall patient and family input that we have been receiving is, they have said to us that one of the most upsetting things for patients and family is actually driving into downtown Halifax and finding parking, which is extremely stressful. So anywhere - including Cobequid and Dartmouth General - that we can provide those services that would alleviate those sorts of stresses is also in our guiding principles of where services should be delivered.

MR. GORDON WILSON: I guess my time is almost wrapped up. Before I do pass it on, I think Mr. O'Connor mentioned 100 people - I believe that probably more than 100 people are actually working on this file, within all the different departments. I do want to say thank you to those people. Again, sometimes we overlook the hard-working civil servants that we have out there - we appreciate the good work that they put in every day. We're very proud. Thank you.

MR. CHAIRMAN: Order. We'll move to Mr. Houston of the PC caucus for 14 minutes.

MR. HOUSTON: In December, we got the capital budget for roads. I don't think we have heard much more on the capital budget. Maybe Deputy LaFleche can give us an indication of when we can expect what I would see as the rest of the capital budget for buildings and stuff.

MR. LAFLECHE: The capital budget is really the responsibility of the Deputy Minister of Finance and Treasury Board, but I don't want to give you a non-answer like that. I can tell you that, in terms of my responsibility, we have buildings and we have roads. You have seen the road one that's out there; that hasn't changed. We do that for a reason - because we want to get the tenders out. We want to get the best price for tenders, et cetera.

Most years, the capital budgets are separate, and the road one comes quite a bit earlier. That's what you have seen. My understanding is that the capital budget for the rest of the province - including the buildings which we would have responsibility for - will be coming very shortly. I can't give you an exact date. I'm not in charge of the process.

We are working on the schools, though, and the various public buildings that are part of it, as well as the major maintenance which would be part of capital.

MR. HOUSTON: Would people reasonably expect to see something in the capital budget for this project?

MR. LAFLECHE: Well, John can speak to that. The health capital is part of the overall capital. It's just called something a little different. It's called health capital instead of tangible capital, but it's essentially the same thing. John, do you want to go into that at all?

MR. HOUSTON: Just so I'm clear, so the health capital is under your responsibility, right? Your department has responsibility for it?

[10:15 a.m.]

MR. LAFLECHE: We're part of it. Really, all capital is under the responsibility of the Deputy Minister of Finance and Treasury Board, but yes, we would be making the submissions. John would be closely involved, along with Tom Gouthro, who is the Executive Director of Design and Planning on all of the public buildings, which would include the health buildings. We would be submitting those budgets, which would include the cash flows year by year. John, do you want to say anything about the capital budget at all?

MR. HOUSTON: Maybe Mr. O'Connor can clarify. I guess what I'm trying to get at is, I was trying to find out what we have in terms of estimates. Then if we would have had a number there, then I would have tried to figure out over how many years, and this type of stuff, to figure out what we're looking at.

In the absence of that, I guess now what I'm going to try to figure out - is there going to be a big number in the capital budget this year for this project? Or are the big numbers that hit the budget still years away? I guess that's the best way I can ask it.

MR. O'CONNOR: The best way I can probably answer it is that like all public projects, we work with the Department of Finance and Treasury Board and the client departments about whether a project - at the planning stages we have certain approvals and we have approvals to do the planning. So that money is in the budget. That money is forecasted, we forecast regularly on every capital project, together with the Department of

Health and Wellness in this case, and for other projects, the Department of Education and Early Childhood Development and so on.

What we budget for and what we forecast are for projects that are approved. So, for the Dartmouth General Hospital, for example, the monies that have been approved there, they are in the capital program, they are forecasted, they are planned.

MR. HOUSTON: So, would that be fair to say - Deputy LaFleche earlier referred to $138 million as announced, or somewhere in that range, as announced. So, what we see in the budget is what we're going to see announced shortly, I guess.

MR. O'CONNOR: We would see projects like that, projects that are being approved. So, with this particular project the approvals to date are around the planning work. Then when we go to government and we seek additional approvals, then the additional commitments would get added to the capital program.

MR. HOUSTON: There's probably no big, big number this year in the capital budget for this project. More planning, maybe.

MR. O'CONNOR: Part of our work is working with Finance and Treasury Board and as we mentioned earlier about the analysis we're doing, whether we deliver it P3 or traditional, that work will also include - how does that look from a cash flow perspective, how does that look from how it is dealt with in the capital program, and so on. All those pieces will be part of the information provided to government.

MR. LAFLECHE: We are building in Dartmouth, and the numbers will ramp up fairly quickly. It's just that what you'll see in the annual capital budget of the government is just the cash flow, capital-wise, for that particular year. You don't see the whole project in that budget, and that's what's going to be somewhat deceptive, in that people will not be able to add up multiple years of numbers and say that's what the project costs. What they will see, though, is that this spending is ramping up as we ramp up the project.

As for any school, the first year is planning and then we hit construction. All buildings are like that.

MR. HOUSTON: Okay, thank you for that clarification. Deloitte came up earlier; it was mentioned briefly a little bit. Deloitte was engaged to explore public and private sector-led options. What is it that we can specifically expect Deloitte to deliver and when can we expect that delivered?

MR. CHAIRMAN: Mr. Porter.

MR. GARY PORTER: Thank you for the question. The specific deliverable that Deloitte will have for us, sometime in the April-May timeframe, which John alluded to

earlier, is a business case that would recommend a procurement model for two specific sites, the Halifax Infirmary and the Bayers Lake sites, because they are greenfield sites. They are not renovations, they are new builds, which typically lend themselves better to consideration.

In preparing that business case, they will look at a number of things. They will first, as I mentioned, rely on the work that they've learned from other jurisdictions in Ontario, Québec, B.C., Saskatchewan, the U.K., Australia, and embed some best practice into how they conduct that business case to formulate their recommendation.

At the end of the day, they'll compare two models - one being a traditional delivery, and the second an alternative procurement model which you commonly see in Ontario as design, build, finance, and maintain models. That's not to presuppose what it will look like, but it's a very common model in the country. They will also assess our capability as part of that and recommend an implementation plan.

Obviously, if you build something yourself, it requires a skill set, some of which we have within TIR in the province and readily available in the private sector. Going to a P3 is going to cause us to rely on different skill sets, with a lot more emphasis on expert procurement . . .

MR. HOUSTON: If I can stop you there, is the expectation that Deloitte will deliver a recommendation as to whether this should be a P3 or not? That's the expectation?

MR. GARY PORTER: Correct, and how we would go about doing that, yes.

MR. HOUSTON: So that report is expected in April or May, and they're going to look at things that happened in Ontario. I hear about Ontario a lot in this Chamber; a lot of different things here. Deloitte will deliver a recommendation. Will there be a commitment to make that report public?

MR. GARY PORTER: We'll have to assess that at the time. Obviously, as Paul mentioned earlier, some of the information contained in that business case will be commercially confidential, and we wouldn't want to put numbers out into the private sector in terms of what we anticipate the cost would be to keep that process meaningful for us in terms of value for money, but certainly there would be some justification for the direction that would be taken.

MR. HOUSTON: How much will Deloitte be paid?

MR. GARY PORTER: That's a little bit uncertain at the moment. It will depend very much on the amount of work that will go into the value for money. For example, part of a value-for-money assessment or business case would be a market sounding. So Deloitte . . .

MR. HOUSTON: But for the work that they're going deliver something in April or May, is there an agreement - deliver me this, and I'm going to pay X?

MR. GARY PORTER: Yes.

MR. HOUSTON: How much is that amount?

MR. GARY PORTER: The scope will change over the course of the next four to five months due to whatever off ramps might be present.

MR. HOUSTON: Wouldn't those scope changes take place after you got the initial report? You're expecting a report in in April or May; it's not that far away. They know what the scope of that work is for that report at this stage, I would presume.

MR. GARY PORTER: I can say a couple of things about that. Part of the process is a market sounding and a market sounding is where you approach financers, contractors, and facility maintenance providers, and you outline the general nature of the project and its relative value. They make a determination of whether they're interested . . .

MR. HOUSTON: Are they doing that now?

MR. GARY PORTER: They will do that in the coming months. First of all . . .

MR. HOUSTON: So that's the next phase.

MR. GARY PORTER: First of all, we need to have the master plan . . .

MR. HOUSTON: I have to move on. There's an expectation that they're going to make a recommendation in April or May. My initial understanding from this conversation was that this recommendation would basically be P3 or not. But that's not what's going to happen in April or May. They're going to deliver something in April or May that's not going to be that - what is that they're going to deliver in April or May?

MR. GARY PORTER: They will deliver a recommendation in that time frame.

MR. HOUSTON: So, the province is paying them to make a recommendation whether it should be P3 or not.

MR. GARY PORTER: Yes, with the supporting work.

MR. HOUSTON: How much are we paying them to make that?

MR. GARY PORTER: I can give you a rough estimate of that.

MR. HOUSTON: Sure, that's fine.

MR. GARY PORTER: There are things that could change between now and then. The rough estimate is around $500,000.

MR. HOUSTON: Okay. That's fine.

MR. CHAIRMAN: You have until 10:27 a.m.

MR. HOUSTON: Thank you, Mr. Chairman. After we get that recommendation, then the market studies and everything would start?

MR. GARY PORTER: The market sounding actually would be part of that process. What they will give us at the end of the day is a recommendation. They will give us an implementation plan, and they will give us an assessment of what resources and capabilities we would need to build or to perform whatever process. Even if it's a traditional build moving forward in the manner that we are, this is a very large project, and we may need to fill some gaps, which they will help identify as well through the course of that work.

MR. HOUSTON: Thank you for that. I do want to talk about Bayers Lake just a little bit. It came up earlier, about some of the services that would be in Bayers Lake and making it more user-friendly, I guess, in terms of more one-stop. I don't know when was the last time anyone was at Bayers Lake, but it can be a hard place to get into and around. There are definitely some traffic issues there.

Is there any plan to work with HRM on improving traffic flow into Bayers Lake or improving busing - are you at that level of discussions yet?

MR. O'CONNOR: The answer is yes, we are at that level of discussion. We've had discussions all along with HRM around transportation and busing.

What you see at Bayers Lake now is not what you're going to see when the work is complete. A number of new roads are going to be built into that area that's being developed. That's about a 175-acre parcel of land; we're dealing with about 15 acres out of that.

The new road network system, for example, I think most people know the streets - Susie Lake Crescent is going to move out and be expanded out into that site. Hopkins, which comes in on the backside of Access Nova Scotia, will be extended through into that area as well, another road up from the Burger King side of Chain Lake Drive. There will be a number of different streets, roads, that will lead into that whole development.

The access will be much different than what you see there now. Access now through Washmill . . .

MR. HOUSTON: Who would pay for that road development?

MR. O'CONNOR: That's all part of the private sector development approved by HRM.

MR. HOUSTON: Okay, the province won't be paying.

MR. O'CONNOR: No.

MR. HOUSTON: The private sector will be paying for those.

MR. O'CONNOR: That's correct.

MR. HOUSTON: Okay. Are you in any discussions with HRM on busing? I think at the time when the purchase was announced, I thought HRM was surprised. They spoke out against that location a little bit at the time. Has that been soothed over?

MR. O'CONNOR: I would say it's been soothed over and yes, we're in conversations with them, and we've committed to further conversations and we're all in favour of them increasing buses and we're encouraging them to look into doing that.

MR. HOUSTON: Thank you.

MR. CHAIRMAN: Time has expired, we'll move to the NDP, and the honourable David Wilson.

MR. DAVID WILSON: I just want to go back to the decision that will be made in April or around that time around the recommendations that government will be presented either through a P3 model of redevelopment or a traditional build that we've seen in the past.

I guess it would be up to government, but I'll ask anyway. Do you anticipate a timeline on getting an answer from government once that report lands on the table of a number of ministers, the Premier, I assume, and ultimately the Treasury Board?

MR. GARY PORTER: The question and the timing around when government makes a decision I'll leave, but I would like to comment that when we talk April-May - I think it's likely May - there are some things along the way that would, and could, influence the timing around that.

Some of those things could be whether or not the Bayers Lake site and the Halifax Infirmary site are seen together or separately, and the amount of due diligence that goes into collecting the empirical data necessary to make a true comparison between a traditional

approach versus an alternative delivery approach. Our plan right now has us into May in terms of the recommendation.

I will add also that market sounding - determining if there's a market interest in a project like this - is an important part of the process that happens earlier than that. If we find there's no market interest, then the business case comes to a conclusion fairly quickly.

MR. DAVID WILSON: So how is that timeline set, providing the government with recommendations? To me, when I hear this, I predict it's going to be at least another year before funding would be allocated. The budget preparation for this year has taken place, we're going to be debating the budget in this Chamber in a couple of weeks, so I anticipate the money won't be there in this budget. There's another year delay.

How was that timeline set? Why are we not seeing January as a timeline of a recommendation going to government so they could change the budget, or implement recommendations? Where did that come up? Who made that decision to have a recommendation go to government in May after the fiscal budget will be debated in the House?

[10:30 a.m.]

MR. GARY PORTER: Just on the first part, in terms of the significance of the timing around May, a recommendation at that point - I mean, it's not as linear a process. There's still a lot of work that would need to be done, regardless of which procurement method would be undertaken - output specifications being developed, tender documents being developed. So there's a lot of work that would go into whatever method is recommended at that point, without the commitment of funds at that point, necessarily. I'll turn it to others to . . .

MR. DAVID WILSON: I'm satisfied with that. Would you anticipate then that the government would have enough time to include it in their budget preparations, which usually start around August or September, when departments are asked to start looking at what they want to see in the next year's budget? Would you anticipate there being enough time from the report in May to the early Fall, so in that next year's budget, we may see a decision? I don't know if that's a question.

MR. CHAIRMAN: Mr. LaFleche.

MR. LAFLECHE: I think the government is committed to proceeding with this project. It knows that it's a project with specific timing, that Nova Scotians need to see the closure of the Victoria and the Centennial buildings, and they want to see this project operational. I doubt they're going to worry about the niceties of the budget cycle.

I will point out that this is a capital budget, not an operating, so it's not tied to the operating budget except through the depreciated amounts, which come post-construction many years down the road. I think the government will consider this in whatever timing it comes in, and will act expeditiously to ensure that Nova Scotians get the services they want when they want them.

I do want to point out that Mr. Porter has let something slip there, but that's fine - he's allowed to do these things - that we're only looking at those two sites for a P3. So we're not looking at any other sites. You might also notice that the last time we were here, we explained we didn't do a P3 on the Dartmouth General, even though it was of sufficient scale to possibly do a P3.

We're looking very, very carefully at P3s. We know there is debate around them in the public. There are misconceptions, but there's a lot of use of them throughout Canada, and it behooves us to ensure that Nova Scotians get the best value possible. Other provinces are doing lots of P3s. We need to look at P3s. We are probably at the bottom end of the scale in terms of size for interesting - and Gary referred quite appropriately to market interest. We're at the bottom end.

MR. DAVID WILSON: I get it, that you're all in for P3s. We have differences of opinion . . .

MR. LAFLECHE: No, no, we're not all in for P3s.

MR. DAVID WILSON: I'll share my time with my colleague.

MR. CHAIRMAN: Ms. Roberts.

MS. ROBERTS: I want to go back for a moment to the Bayers Lake site for the outpatient clinic. There was an access to information release that came out and was reported on last May that noted that the Highway 102 and the Lacewood interchange near that site is nearing capacity, in that there are limited options for further improvements.

I imagine TIR would be on the hook if there needed to be additional work done to add new interchanges if that large block of land that you're describing is actually to be developed. Is that not correct?

MR. LAFLECHE: You probably know that we are replacing the Highway No. 102-103 interchange. That was announced about a year ago. It's a federal-provincial project, quite large, to replace and modernize and change the radius of curvature on that interchange. In fact, we're building the new interchange around the old one, much like they're building the Champlain Bridge in Montreal.

We respond, as we do everywhere in the province, to capacity issues in terms of highway prioritization. We will be looking closely at any capacity issues, not only there but anywhere in Nova Scotia, particularly in the growth areas around Halifax. When we have capacity issues, we bring forward projects.

MS. ROBERTS: I would just like to make the point that, by committing through the purchase of land and the announcement of that outpatient clinic to an anchor development on a currently undeveloped parcel of land, you're basically ensuring that there will be additional capacity needs. So to some extent here, the provincial government is driving an urban development agenda that HRM had not bought into.

MR. LAFLECHE: Can I respond to that? I'd rather my chief engineer pronounce on whether or not we are driving any capacity changes there. I wouldn't take that as a fait accompli.

No, we are being very careful to work closely with HRM. Their concerns were over bike access and there is a bike trail there to that facility, a paved bike trail that HRM has already paved, so there's no new expense there.

Their other concern was on transit. We had extensive discussions with them on transit. They have not mentioned to us, to my knowledge, John, any road access issues, have they?

MR. O'CONNOR: Just quickly, HRM approved the development; that entire development is approved by them. All we're doing is buying a parcel of land in a development that they approved. All these roads I mentioned earlier, that's part of the development that has been approved. That developer has requested approval and got approval. We had nothing to do with that process. We were just out searching for property and we searched for all properties that were available of a size in certain areas outside the downtown core. We didn't create the development; we are just buying a piece of land in it.

MS. ROBERTS: Okay, thank you. Since that outpatient clinic was announced, the Premier has said to the media that people who are currently living on the peninsula and are concerned about accessing outpatient services for whom a bus trip to that location would be in the realm of one and a half to two hours, that that site will not be the only location for those services. At the same time, today I've heard that the Halifax Infirmary site - the new development there is going to be oriented towards those very complex specialist services like oncology and organ transplantation.

Where is this other outpatient site where residents who would rely on public transit, for example - where else would they access those services? Where is that anticipated?

MR. CHAIRMAN: Ms. Bond.

MS. BOND: Thank you for that question. For a point of clarification, the services that I referred to which were multi-organ transplant and those specialized services that are required only at the Halifax Infirmary for Nova Scotians - those are only portions of the services that we deliver. The QEII is also a community hospital for patients and families on the peninsula. We do deliver clinics at the QEII and will continue to deliver clinics at the QEII.

The functional planning work that was done was to identify of the services such as medical, surgical clinics, nephrology, diagnostic imaging, laboratory services - of the services that are delivered in downtown Halifax, which portion of those could we actually deliver outside of HRM, in particular for patients who are travelling into the HRM? That is not in any way to say - there will be a new ambulatory centre also on the QEII site of the Halifax Infirmary to continue to provide those services.

There won't be any service - just like we have at Cobequid right now, we deliver multiple services at Cobequid. They are not services that are unique to Cobequid nor will they be services that are uniquely at the community centre.

MS. ROBERTS: Okay, thank you.

In terms of the ER capacity at the Halifax Infirmary, my understanding is, as was talked about earlier, every sub-specialty is available at the Halifax Infirmary site and it's also a site of training. Is there planning going forward to allow ER usage that is appropriate in terms of the level of specialist services provided, that is appropriate to also the needs of a general ER visit that you would see at any spot in the province?

There are people coming in with relatively simple health issues that still require an ER visit but don't need specialist attention. Is there any planning going forward to ensure that the fact that all the bells and whistles are available does not mean that all the bells and whistles get used when somebody comes in with COPD, for example?

MS. BOND: So there is planning of a provincial emergency program of care, so we have planning provincially for the emergency services. You are absolutely correct, not every visit to an emergency department - we have different levels of emergency departments throughout this province. In terms of the community centre, we are planning for an urgent access clinic in that centre so that there is availability in the community centre, so the patients don't have to go into emergency rooms.

MS. ROBERTS: I'm sorry, what community centre are you referring to?

MS. BOND: Bayers Lake community centre.

MS. ROBERTS: Is there going to be a community centre of that nature at the Halifax Infirmary site for people who are in the downtown core?

MS. BOND: Yes, we are working with primary care - there's also a provincial primary care plan to look at the needs of patients and families that do not need to come into the emergency department.

I do want to clarify some myths that are out there that you may not need to go into an emergency department, that you could go to a family physician. That is absolutely true, however, there are also situations where you do need to go to an emergency department. It may not a life-or-limb situation, but you may need to have suturing that may not be offered in your family physician's office. There are many situations that we are working . . .

MR. CHAIRMAN: Order. Sorry, time has expired. We'll move to the Liberal caucus, and Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: I'll let you finish that line of questioning.

MS. BOND: Thank you, member. We are identifying across the province on the provincial program of care, which is emergency services, primary health care services, where the services are required and at what levels. Emergency departments have levelling of everything from Level 1, which is a trauma centre at the QEII, and Levels 2, 3, and 4.

Levels 3 and 4 are more what we consider urgent care, access care for individuals who need that appropriate level and the appropriate individuals who would be required. At a Level 1 emergency department, the standards for both nurses, paramedics, physicians, and others is a different level of education that is required than if you were looking at what we would call a Level 4 emergency department or an urgent care centre, where we could have nurse practitioners, advanced care nurses, or advanced care paramedics working in those areas and delivering services.

MS. LOHNES-CROFT: And that will be at the Infirmary site?

MS. BOND: We're looking at all sites across the province, but certainly at the Infirmary site we are looking at how we can complement the emergency department with the appropriate services so that we are not having the patients go in and wait to be triaged in the emergency department. If we can divert, for lack of a better word at the moment, patients to an area that would be rapidly - we actually do that in the emergency department at the moment. We have different pods where depending on how you are triaged - how sick you are - you are triaged off to some of those pods in the Halifax Infirmary. Some of those, what we call less urgent pods, are already staffed by advanced care paramedics. Not everybody's waiting to come into the direct emergency department even at the QEII.

MS. LOHNES-CROFT: And there are walk-in clinics, are there not, in the central area of Halifax?

MS. BOND: There are walk-in clinics, but not at the Halifax Infirmary.

MS. LOHNES-CROFT: And they will remain - they are run by the Nova Scotia Health Authority? (Interruption) No, they're not? They're private. Okay.

Mr. LaFleche, you said that this is your largest construction project ever taken on by TIR?

MR. LAFLECHE: Yes, directly. I mean we've had a few large projects. Of course, we had the Sydney tar ponds, which was about $420 million. We just had the Nova Centre, although we didn't have to supervise all the construction; in fact, John's going to run out of here to try to achieve substantial completion shortly, and that's a fairly large project.

At the end of the day, when we determine the final scope - and that's one of the reasons we can't give final numbers is because since Mr. Wilson's day, the scope has changed. It's a much broader scope than it was before, so there are more things included which means more cost, more square footage, et cetera. When we determine and finalize the final scope after we see the Kasian study and see where it gets approved, then we will have a fairly large project here, probably the largest in Nova Scotia. I can't speak to inflation and whether there was a larger project inflation adjusted in 1852 or not, but it's the largest certainly in our memory.

[10:45 a.m.]

MS. LOHNES-CROFT: This is happening in HRM. This redevelopment is for all Nova Scotians, it's not just for people who live in HRM, which . . .

MR. LAFLECHE: In some cases, for all Atlantic Canadians. We are a unique service centre for Atlantic Canada, in some instances.

MS. LOHNES-CROFT: I'm a rural MLA, so how is this going to benefit my people, other than those who come up for cardiac care and what not that are specializations, how are we in rural Nova Scotia going to get better use of this facility overall?

MR. LAFLECHE: I'm going to turn that over to Janet, who can probably talk about the province in general.

MR. CHAIRMAN: Ms. Knox.

MS. JANET KNOX: Thank you for that question. I think that's a very important question. The Queen Elizabeth II Health Sciences Centre is our centre where the most advanced acute care occurs for the people of this province and, as Mr. LaFleche is saying, occurs for many Atlantic Canadians. It is also our centre which is affiliated directly with our medical school, and our faculty of health professions at Dalhousie. It is also the centre where we have 1,200 research projects. It is Nova Scotians' advanced care centre available to all Nova Scotians.

How do people in your local area see this? I hope they see this as an integrated part of the fabric of the health system for Nova Scotians. We have built in this province, started many years ago, an integrated, community-based system. We say the focus is on supporting people in their local communities and a network of emergency rooms and hospital system around them.

In your constituency, if your members need to go to the QEII, they should be able to be referred to the advanced care at the QEII, and be returned home to be supported by their local community providers. That's how we are positioning this very important resource. It's a resource for all Nova Scotians.

MS. LOHNES-CROFT: At this complex that will be in Bayers Lake, is it going to be like the Cobequid Community Health Centre, emergency care and outpatient services that people in rural Nova Scotia - I mean they come to Costco once or twice a week, why not go there for care?

MS. KNOX: I'm going to ask Paula, because Paula is our lead for the planning of this work. I want to say to you that when we plan, we look at the province in terms of who the people are and what their needs are, where they live, and how do they access services.

I can tell you that even in our planning around where collaborative care centres should be in this province, in our drive - the royal our - when our team drove Nova Scotia and met with care providers in local communities, they also asked community members where they shop, where they worship, and how they travel around their communities. We think about those things as we are planning, and try to make our services accessible to people in the way they like to access them.

I'll let Paula, if I could, talk about how we see that Bayers Lake Centre.

MR. CHAIRMAN: Ms. Bond.

MS. BOND: Just to clarify, Cobequid Community Health Centre is an emergency department. We have the Emergency Health Services that actually takes people to the Cobequid Community Health Centre. A lot of people often are transferred from Cobequid Community Health Centre - depending on the acuity, how sick they are - to the Dartmouth General Hospital or the Halifax Infirmary.

The community centre at Bayers Lake will not have an emergency department. It will have an urgent access clinic. It will be available for patients as a drop-in. There will be drop-in appointments that are open for patients, as well as booked appointments. We will have medical and surgical clinics there so that we're hoping to be able to better coordinate.

Somebody, and I apologize that I don't recall who, mentioned COPD as a perfect example. If you had somebody come in through the urgent care centre with COPD and we had clinics available, we're going to try to coordinate so that there's open appointments there in some of those specialty clinics that you can be referred directly to that clinic that day, in hope to prevent patients from having to come back.

It really is about where the best services for the appropriate care, the appropriate time, and the appropriate caregiver. What we are really stressing as clinicians, because we hear it all the time, and certainly in my past life as a clinical nurse - we saw it on multiple occasions. So it will be an urgent care access clinic and hopefully be able to have the coordination, where necessary, to those clinics that are going to be at Bayers Lake.

MS. LOHNES-CROFT: So can children access care there, or do they have to go to the IWK?

MS. BOND: No, the IWK remains the emergency department for children for this province. To determine what populations come in would determine, that's still part of the functional planning. We are working with our IWK partners to look at it, because as you know, many other emergency and urgent care centres across the province do see children. Children are not just seen at the IWK, so we're in the process of looking at what resources would be required if we were to have the pediatric population. As I said, we're working with our colleagues at IWK to determine where the best fit for that would be.

MS. LOHNES-CROFT: I want to talk about the chemo prep project that's happening. Would that be under the Health Authority? Okay, we'll continue.

I see the design is portable. Do you want to explain the design and how it being portable is going to be beneficial during this transition?

MS. BOND: I might have to ask for some help from my TIR colleagues about the actual design, but I will tell you that the chemo prep room has been identified over the last couple of years now as an area where we really could not wait to do the renovations that are required for that prep room. It is the only chemo area where we provide that service, at the VG site. Should it go down, it would be detrimental to the citizens of Nova Scotia. It is why the oncology program brought it forward to the senior team, and we brought it forward to government to expedite.

One of the questions - and rightfully so - that we asked was, how much is that going to cost to renovate? Should we change that in the near future? What are the risks and the pros and cons of doing that now? Part of the design work was - and again, I think I'll hand this part to John - there are lots of things happening today which are modular. ORs are being built as modular - you're having walls that can be opened and closed to make multiple OR rooms, or very large operating theatres to accommodate the more complex surgeries.

From the work that we have been doing and our research, we know that there are lots of opportunities where we can look at those different designs in order to ensure that we can change and have flexibilities in our designs as services change, whether it's the infrastructure of services or whether it's the services themselves.

I'll pass to John on the actual design, if I may.

MR. CHAIRMAN: Mr. O'Connor.

MR. O'CONNOR: I really can't add a lot. You answered that one well, Paula. It's flexibility and design. The flexibility that's being built into the chemo prep design work - and it's at the early stages - is really around the same as what Ms. Bond referred to. It's about looking ahead. If changes get made in the future, the way that the infrastructure gets built, some of the equipment that is brought in has some flexibility to be moved around for things to change and adapt in the future without extensive renovation. All that is sort of being kept in mind and then flexibility with building systems that lend themselves better to changes. Health care systems and health care services, as we all know, change as time goes on.

MS. LOHNES-CROFT: Mr. LaFleche, you said that that there are lots of misconceptions around P3 builds. Can you further explain what those misconceptions are?

MR. LAFLECHE: I think a lot of people take just an ideological view of P3. P3 has been applied to many different types of builds. In fact, right now, John is trying to finish up today a P3 build which was approved by the Dexter Government. Mr. Wilson, I don't think you were in Cabinet at that time. It probably started before you got in Cabinet.

Anyway, that's a P3 build, the new trade centre, part of the Nova Centre. We feel that has been very beneficial for us, in that we got a fixed price. The schedule did slip, but the price didn't, which was very good, and we got what we want.

We have had a P3 at the Cobequid. We were in here talking about the Cobequid Pass highway - we talked about that a couple of months ago.

I think in every major project, $1 million-plus, like our neighbors do, for Nova Scotians, we must examine whether it could be P3 or not. We looked at it for the Dartmouth General, $138-odd million, and we decided it wasn't really that suitable, that the benefits were not there. We're looking at it for the two other sites Mr. Porter described.

In answer to Mr. Houston's question - Mr. Porter couldn't really answer it - we will be revealing all the information we can when we can on those P3 analyses. We think it needs to get out there in the public and whether we go P3 or not for those two - or one of the two or none of the two - we'll be getting valuable information from those studies that can allow us to get possibly a better deal for Nova Scotians in terms of the build, P3 or not.

Once we get that better deal and we can reveal some of the information, we will be putting it out in the public to the extent we can.

MR. CHAIRMAN: Order, time has expired for questions. I did let you go beyond a bit. We have just about a minute left for each entity to provide a closing statement if you wish. It's not necessary. Would anybody like to provide a closing statement? Ms. Knox.

MS. KNOX: I just want to say thank you for your interest in this project, and I want to say again how pleased we are to have this collaborative effort. We've put a lot of effort into creating how we work well together. We are very committed to managing this project together, on time and on budget. It is so important to the fabric of the health system of Nova Scotia and, as I said, Atlantic Canadians. So, thank you for your very considered interest. This a very important project as we go forward together.

MR. CHAIRMAN: Thank you, Ms. Knox. Mr. LaFleche.

MR. LAFLECHE: Thank you also. We've got a serious mandate from the government to deliver the best value for Nova Scotians expeditiously, and to ensure that this project serves the future needs of future generations of Nova Scotians. So we're working very hard on it.

I did create a slight a little bit earlier when Mr. Houston asked me who was responsible. I neglected to say that Jeff Conrad would also be fired if we screwed up. So, I just want to make that correction and make sure that he doesn't feel he's left out. (Laughter)

MR. CHAIRMAN: Thank you. If there are no further statements, I would like to thank all of you for being here today. This is, I think, one of the largest meetings we've ever had in terms of people, which shows the size of this project. Thank you for being here. Thank you for answering our questions.

We have no committee business unless somebody wishes to bring something forward. Hearing nothing, our next meeting is on March 7th, where we will have the Department of Agriculture as a witness to discuss wine development. That's on March 7th.

This meeting is adjourned.

[The committee adjourned at 10:58 a.m.]