HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, November 4, 2020

Legislative Chamber

QEII New Generation Project-Halifax Infirmary Expansion and Community Outpatient Centre, Phase 2 - July 14, 2020 Report of the Auditor General

Printed and Published by Nova Scotia Hansard Reporting Services

Public Accounts Committee

Keith Bain (Chair)
Keith Irving (Vice-Chair)
Brendan Maguire
Hon. Margaret Miller
Ben Jessome
Rafah DiCostanzo
Tim Halman
Lisa Roberts
Susan Leblanc

In Attendance:

Kim Langille
Legislative Committee Clerk

Karen Kinley
Legislative Counsel

Terry Spicer
Acting Auditor General

Robert Jewer
Audit Principal

WITNESSES

Department of Health and Wellness

Jeannine Lagassé,
Associate Deputy Minister

David Benoit,
Senior Executive Director - Strategic Infrastructure Planning

Department of Transportation and Infrastructure Renewal

Paul LaFleche,
Deputy Minister

Nova Scotia Lands Inc.

John O'Connor,
Vice President - Healthcare Infrastructure Projects Division
(Lead - QEII New Generation Project)

Dr. Alex Mitchell,
Senior Medical Director, Nova Scotia Health Authority
(QEII New Generation Project)

Gary Porter,
Senior Director of Procurement and Finance

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, NOVEMBER 4, 2020

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIR
Keith Bain

VICE-CHAIR
Keith Irving

THE CHAIR: I will call the Standing Committee on Public Accounts to order. First of all, I want to welcome everyone here this morning. Anybody who has their phones with them, please place them on either silent or vibrate.

We're going to begin with the committee members introducing themselves. We'll start with Ms. Roberts.

[The committee members introduced themselves.]

THE CHAIR: Just a couple of reminders before we start. You're asked to keep your mask on during the meeting, unless you are speaking. I make myself an exception because I'm over here to allow the free flow of conversation to go back and forth. I think we have our distancing done anyway.

In an effort to limit the movement within the Chamber, we just ask everybody to remain in their seat as much as possible. To accommodate this, we're going to take a short break after the first hour for about 15 minutes. In order to do that, I'd have to ask the committee members for agreement to extend the meeting by 15 minutes at the end.

Is it agreed?

It is agreed.

Finally, when leaving the Chamber, please use the side exits and re-enter through the Chamber doors. I think that pretty much covers all the lead-up to today's meeting.

On today's agenda, we have officials from the Department of Health and Wellness, the Department of Transportation and Infrastructure Renewal, and Nova Scotia Lands to discuss the QEII New Generation Project, Halifax Infirmary Expansion, and Community Outpatient Centre Phase II from the July 14, 2020 Report of the Auditor General. We'll ask the witnesses to introduce themselves.

[The witnesses introduced themselves.]

With that, we'll ask the witnesses to begin their opening remarks. Mr. O'Connor.

JOHN O'CONNOR: Good morning, Mr. Chair and members of the committee. On behalf of myself, the deputy minister and my fellow witnesses, thank you for the opportunity to return to the committee to discuss the QEII New Generation Project. My name is John O'Connor. I'm the Vice President of the Health Care Infrastructure Projects Division at Nova Scotia Lands and the lead for the provincial government for the new QEII New Generation Project.

I'm joined today by Deputy Minister Paul LaFleche, Gary Porter to my right, and Dr. Mitchell behind me. In addition to addressing your questions, we are here today to respond to the Auditor General's most recent report on our project.

The redevelopment of the QEII Health Sciences Centre is a once-in-a-generation opportunity to rethink and rebuild the way we deliver health care. This isn't just a construction project: it is the foundation of our next 50 years of health care. As the largest infrastructure project ever undertaken in Nova Scotia, the QEII New Generation Project is complex and ambitious.

Two significant pieces in this important redevelopment are the expansion of the Halifax Infirmary and the construction of the Bayers Lake Community Outpatient Centre. These two projects were highlighted in the Auditor General's July report. The report noted that our approach in selecting a Design, Build, Finance and Maintain delivery model for the two projects, as well as our methodology for developing a master plan for the two projects, were both reasonable and appropriate.

This endorsement supports a great deal of work that has taken place since January 2020, particularly in regard to the Bayers Lake project, which we are pleased to say is under way and getting closer to reality. In August 2020, EllisDon Infrastructure Healthcare was awarded the contract to design, build, finance, and maintain the new community outpatient centre, and we are eagerly looking forward to a planned construction start later this month.

This is an exciting milestone. Breaking ground on the Bayers Lake project is a huge step towards our goal of providing Nova Scotians with easier access to modern, high-quality supports and care closer to home. In addition to the planned construction start, we also recently received an updated value for money, or VFM, analysis for the Bayers Lake Outpatient Centre project. The results of the value-for-money analysis confirm that the Province should expect overall lifetime risk-adjusted costs of the Bayers Lake project to be over $35 million less through the DBFM arrangement as compared to a traditional model. That is a reduction of nearly 15 per cent.

Supported by this analysis, we are confident that our selected delivery model and our project approach will realize the maximum benefits possible for all Nova Scotians. I want to assure this committee that our team is working diligently to advance the QEII New Generation Project efficiently and in accordance with best practices. We are engaging experienced and qualified partners. We are working closely in collaboration with the Nova Scotia Health Authority colleagues, the Department of Health and Wellness, and other government departments, and we are advancing the Auditor General's recommendations to ensure appropriate oversight and governance.

In closing, I want to thank the Auditor General and his staff for the work they have done in evaluating our project. Mr. Chair, thank you very much for this time. My colleagues and I look forward to your questions.

THE CHAIR: Mr. LaFleche.

PAUL LAFLECHE: I know I'm not allowed to officially hand this to anyone like we usually do, but this is the project development report for the Bayers Lake Community Outpatient Centre. We have promised that we would deliver this type of report in the future, and the future has arrived. I'm officially tabling it. It is available immediately on the website healthredevelopmentnovascotia.ca, and we will ensure that the Clerk gets sufficient access to it to produce it with the documents.

THE CHAIR: I was going to suggest you give it to the Clerk.

PAUL LAFLECHE: We're not allowed. Apparently my hands are germy.

THE CHAIR: Just leave it on your desk. Ms. Lagassé.

JEANNINE LAGASSÉ: Good morning, committee members. Thank you for inviting the Department of Health and Wellness to join our colleagues from the Department of Transportation and Infrastructure Renewal and Nova Scotia Lands to meet with you today. We are happy to be here today to discuss the Auditor General's most recent report on the QEII New Generation Project.

As Mr. O'Connor noted, the QEII New Generation Project is the largest health care project in Nova Scotia's history. This once-in-a-generation initiative will see new and renovated operating rooms, relocated cancer care services, the construction of a new community outpatient centre, and much more. This project will transform how some of the province's most specialized health services are delivered and ensure we will continue to provide outstanding health care to Nova Scotians.

As you would expect with a project of this size and scope, there are many people and stakeholders connected and contributing in various ways. We continue to work closely with the Nova Scotia Health Authority, Nova Scotia Lands, the Department of Transportation and Infrastructure Renewal and others to ensure proper oversight for the project is in place. We appreciate the recommendations that the Auditor General has made to strengthen the governance and project management as the project moves forward.

To further support the Department of Health and Wellness in its oversight role, we recently established a new branch - led by Mr. Benoit, who is with me here today - to work collaboratively with our partners to better coordinate the significant health care infrastructure projects we have under way across the province. These projects include: the QEII New Generation Project, the CBRM Health Care Redevelopment Project, the South Shore Redevelopment Project, emergency department renovations, and new dialysis sites.

The effects of the COVID-19 pandemic have been felt in all parts of our health care system, including our infrastructure and construction projects. We continue to respond in a rapidly changing and uncertain situation. As we learn more about the virus, we have adapted our approach. We will continue to monitor the costs of goods and services, delivery dates, and productivity across all infrastructure projects. COVID-19 will continue to be a key consideration in our health care delivery and in our infrastructure projects moving forward.

In our recent infrastructure projects, we have been exploring ways to innovate and do things differently, and we have seen some success. The New Waterford Community Hub will see a school, health centre, and long-term care home located together in the same area. This approach is unique to our province and will create learning opportunities for students and bring community resources together in one place. We look forward to the continued work with our partners to find innovative approaches to new health care infrastructure.

In closing, I want the committee members to know that we are working diligently with our partners here today and others across government to move forward the QEII New Generation Project. As the Auditor General noted in his most recent report, the project is progressing well, and we continue to implement his recommendations to improve and strengthen our oversight and governance. Thank you very much for the opportunity to appear here today.

THE CHAIR: Thank you. We'll begin now with the first round of questioning, with 20 minutes per caucus for the first round, beginning with the PC Caucus. Mr. Halman.

TIM HALMAN: Thank you very much for your opening remarks. Thank you to all officials here for the ongoing work you do on behalf of the residents of Nova Scotia. It is certainly appreciated.

That being said, Mr. O'Connor, you made a statement that was very profound. It captures what this project is all about: This is the foundation for the next 50 years of health care. Certainly, I know members of the committee here - this project, they don't take lightly. This is a project of great importance to the vitality of Nova Scotia. As someone who lived with a sick partner at the QEII Health Sciences Centre's Centennial Building for a month's time, I know how critical it is that this project gets going.

It seems obvious to me, though, that before we build something new, we need to know what we already have before we build more. Maybe this question is more appropriate for Ms. Lagassé. What are the current utilization rates of the beds at the Halifax Infirmary at the moment?

JEANNINE LAGASSÉ: At the Halifax Infirmary specifically, I cannot answer that specific a question. I do know their bed utilization rates are quite high right now across the province.

TIM HALMAN: Does the department keep statistics on how many beds are being utilized? Do we keep data on that?

JEANNINE LAGASSÉ: The data would be kept with the Nova Scotia Health Authority. I'm not sure if Dr. Mitchell may be able to help us to answer that question, but we do receive information from the NSHA on bed utilization, yes.

TIM HALMAN: Is that information you can get to the committee, please? I think Nova Scotians would want to know how we're utilizing existing infrastructure at the moment. As we add something new, I think we obviously need to know how we're using the existing infrastructure to maximize health care outcomes. Again, is there any data you can provide on utilization rates?

JEANNINE LAGASSÉ: Overall utilization right now, I believe, is over 80 per cent across the province.

TIM HALMAN: Would you be able to provide some information on how many beds are occupied by patients that are ready for discharge as a percentage of number of beds?

[9:15 a.m.]

JEANNINE LAGASSÉ: I do not that specific data here with me today. But I would be able to check on that.

TIM HALMAN: Again, as I was saying, as we expand this, this is the largest capital investment in the history of our province. I think obviously in terms of transparency, I think Nova Scotians want to know how it is we're utilizing the existing infrastructure.

After work is completed with the Halifax Infirmary with the rebuild, how many critical care rooms will be added from the current numbers?

THE CHAIR: Mr. Mitchell.

ALEX MITCHELL: The critical care numbers, I'll have to probably get back to you with the exact number. I believe we're at 24 currently with an expansion to 36 critical care beds, plus an additional 12 IMC beds.

TIM HALMAN: With the statement you just made, are you stating that from a place of certainty? Again, these are massive investments we're putting in. What you just stated, you're quite certain? I sense a bit of vagueness.

ALEX MITCHELL: If I could have a moment, I will get the exact numbers for you.

TIM HALMAN: How many additional rooms for the medical and surgical unit will be added from the current numbers?

ALEX MITCHELL: I do not have the exact number, and I apologize, while looking for that I did not hear your second question, sir.

TIM HALMAN: The question is how many additional rooms for the medical and surgical unit will be added from the current numbers?

ALEX MITCHELL: We'll have to get back to you. I think one thing to emphasize is there are a few places with expansion of capacity, but that the ultimate first goal of this is to replace the capacity of the existing VG. But the exact number of the bed delta, I believe is what you're asking, is not rooms but number of beds, that is an adjustment from the current state, we can get you that exact number.

PAUL LAFLECHE: It's important to realize too that the question is a moving target in that we've already completed some expansion. Probably we will look back to where we were with beds before we started any expansion at all, and where are going to end up in beds after we've finished all the expansion. I'm including things like Hants, Dartmouth, et

cetera. We have to understand our base before we give you the answer, so that will take a little bit of calculation.

TIM HALMAN: Mr. LaFleche, that's my exact point. The expectation is that we understand our base at this point. By understanding the base, we have a clear picture of where we're moving forward. Is it correct to say that it's unknown the total increase of rooms for the expanded inpatient centre from current numbers? Is that a correct statement?

JOHN O'CONNOR: Just to clarify, we have all this information; we just didn't come prepared with it today. It's in the master planning documents, it's work that we've completed over the last number of years, it's just that we don't have it at our fingertips here today.

We definitely have a program that was being replaced from the VG. Some of the program has gone to Dartmouth General as part of the renovations and additions at Dartmouth General; some of the program is going to the Bayers Lake Community Outpatient Centre. Some of the program is going to the Hants Community Hospital. Then the remainder of the program is going to be housed in the new construction and renovations at the Halifax Infirmary.

We definitely have all of the data. It's just that we didn't come prepared with all of that data today. I want to assure the committee that all of that data is well-known. It's well-established. I think it's something like 36 or 38 additional beds. I'm just going by memory, so it's a bit dangerous, but there is some increase in the total bed count overall. We can get you those numbers, for sure.

THE CHAIR: Mr. Mitchell.

ALEX MITCHELL: I'm sorry - I can confirm it is 38 beds.

THE CHAIR: Thank you. Mr. Halman.

TIM HALMAN: Thank you. Surely, since this is the foundation of our health care system for the next 50 years, it's obviously the hope of Nova Scotians that straightforward questions such as this could be answered and clarified here at the Public Accounts Committee.

Just another quick question. Of the new rooms, how many of those new rooms will be cohabited?

ALEX MITCHELL: Again, it's limited. The majority of the new rooms are private rooms, but there is a limited capacity of, I believe, two-person rooms in the new build. The exact number, again, is not at my fingertips, but we can provide that to you.

TIM HALMAN: Thank you. Obviously, that's a relevant question, given everything that has transpired in the last few months here in Nova Scotia. That is a question that is on the minds of Nova Scotians. Will different genders be placed in the same rooms?

ALEX MITCHELL: Recognizing that currently I sit and work on the redevelopment side of the Health Authority and not on the operations side, I am well aware that over the last number of years, in order to efficiently utilize beds, there has been a move to cohabitate male and female patients in the same room where sometimes necessary. It's not preferred. In terms of what their active procedure is with that today and in the last several weeks, I'm not sure where they're at with that, but I can certainly get an updated statement from the Health Authority for you.

TIM HALMAN: That would be greatly appreciated. Can you outline what demographic projections and studies were used to design this building?

ALEX MITCHELL: A sizeable amount of effort and work was conducted by a variety of different professionals to assess the current state to see what existing service utilization was, to see what demographic trends were there. There were both clinical planners and functional planners, as well as professional epidemiologists that were engaged to look at the current state as they were looking at this to also project what the patterns would be in HRM, what the disease patterns would be in terms of particular disease states related to various specialties, the change in our age demographics, among other things. A thorough and deep exercise was done to assess that to the best of everybody's ability at that time.

TIM HALMAN: Will those analyses be made public?

ALEX MITCHELL: I would defer that to my colleague, John O'Connor.

JOHN O'CONNOR: I could stand corrected, but the documents that we posted on the website - all the master plan versions - give a lot of the background of the assumptions that were made in all aspects, from the health care requirements of the future compared to the programs that exist today. Then, as well, is the infrastructure itself and its conditions and decisions that were made and that support the master planning decisions. All of that is included in the master planning documents.

Again, we didn't come fully prepared for that today because a lot of that we did during 2016 to 2018. It forms the base or the foundation of the work as we are advancing since 2018. A lot of that information is why it's not as fresh in our minds. It was all documented and put together, but it's included in the master plan, which forms the foundation of our move forward to the next levels of design and construction.

ALEX MITCHELL: The previous question about the number of double rooms - I have the exact number, which is 15 double rooms, one per pod, at the present time in the current plan design.

TIM HALMAN: With respect to the demographic studies, you indicated that you looked at some patterns in HRM in terms of health outcomes. Just as a Dartmouth MLA, I'm curious, what were some of the patterns in HRM that were observed in that demographic study?

ALEX MITCHELL: The specific details in that report with regard to disease prevalence or otherwise would be the kind of details I would not have at my fingertips, but certainly we can work to obtain that information for you.

TIM HALMAN: Just going back to the projections, were departments asked what they wanted or what they needed with respect to this rebuild? That internal consultation - what was indicated to you by departments in terms of what their wish list?

ALEX MITCHELL: Let's talk about the structure of how that all unfolds. The planning of all this occurs over many years, to reassure the committee. That would involve a number of different layers of the organization, starting with those at the front lines, so those right at the coal face are engaged representatives identified from different clinical units to participate in the previous processes, also during the design processes. That want list that you discuss is the functional programs, so that would have engaged some representation from front-line clinical care - both physicians and nurses and sometimes other allied health professionals.

The next layer up would be leadership and other management - director-level individuals within those portfolios contributing to that, working in conjunction with the functional programmers, experts in looking at this information, asking people what they want in the context of the hospital build with the appropriate layer of filter to make sure that those wants are appropriate.

Then above and beyond that a redevelopment team of folks like myself and the rest of our teams who are tasked with gluing that all together, making sure that we're listening, making sure that we're rationalizing those wants and asks, making sure that we're checking those against what the epidemiology and what the numbers say, and so that process has been ongoing for many years, and those layers that I discussed still continue today through the design processes.

TIM HALMAN: Thank you for the response. Have we revisited any of these plans since the onset of COVID-19?

ALEX MITCHELL: This question has come up in just about every forum in every room that I've entered in the last several months. COVID-19 has been a significant event

for everyone across the planet. Thankfully in the health care and medicine concept, it's a novel virus, but its behaviour is similar to things that we've seen at a lower rate previously. SARS and H1N1 gave everybody a real good scare a while back. They gave a scare to the architects, the planners - the kind of people who think about hospital construction.

SARS and H1N1 was in the room as we were thinking about our designs. Things like airborne isolation rooms, that's a negative-pressure room where you make sure that the air in that room is not getting out of that room. In the current designs, there are negative-pressure rooms distributed throughout the new facility under the expectation that there may be an airborne illness. We didn't know COVID-19 was coming, but we'd seen H1N1 and we'd seen SARS before, so these were already in the room.

What I'll confidently say is that we did do a lessons-learned and look back to our Bayers Lake design, which was pretty much completed. The financial close on Bayers Lake and the proposed design for the COC was there as COVID-19 essentially hit. It was pretty much done, and then assessing that facility for what that facility would have looked like during a COVID-19 outbreak. It would have functioned very well, with the right seating capacity, hallway sizes, the right ability to put in plexiglass barriers, the right ability to separate people and scale back the volume of people in the building, the right air handlers and other things.

That facility would have functioned quite well in part because we had already begun to think about what it would look like to function in an environment with an airborne pandemic. COVID-19 is not an airborne illness, it's a droplet illness, but in a similar type of virus.

TIM HALMAN: With this rebuild, what can Nova Scotians expect in terms of reduction in wait times for diagnostic imaging. In my time as an MLA, I've certainly heard concerns from residents about those wait times. What are the projections on that? What can we anticipate those reductions in wait times to be for that critical service?

ALEX MITCHELL: The specifics in how this facility will by the numbers reduce diagnostic imaging wait times, I don't have that specific number. What I can say is that there is a number of efficiencies that are gained by the way that these new buildings are created. The technology that goes into the building allows for better processing of patients through the building, so you can more efficiently move people, you can make much better sense and use of the day and the day's work.

As most diagnostic imaging technology advances, the speed with which it takes a picture, transmits that picture and somebody is able to read that starts to improve. There are a lot of technologies coming that allow for faster reporting to occur. Certainly, the expectation is that the throughput and efficiency that is gained by a modern building with modern supporting technology should significantly improve their business, but the exact numbers and how that will play out, I can't tell you today.

TIM HALMAN: What's the timeline when Nova Scotians will know the exact numbers and how this will play out? I think we're now at the point where if this is the foundation of our health care system for the next 50 years, it's a reasonable expectation on the part of Nova Scotians to know answers to essentially simple questions like this.

Am I correct to say that at this point we don't know what the reduction of wait times will be for diagnostic imaging? That was great in explaining the rationale, but is it correct to say we don't know what those reductions will be?

THE CHAIR: Mr. Mitchell, can we get a response within about 35 seconds?

ALEX MITCHELL: From where I sit, I would be unable to answer that question today.

THE CHAIR: That was good timing. That is the time for the PC Caucus. Now we'll move to the NDP caucus for 20 minutes. We'll start with Ms. Leblanc.

SUSAN LEBLANC: Thank you to everyone for coming today. I just wanted to clarify Mr. O'Connor's remarks about the $35 million savings of the Bayers Lake project through the Design, Build, Finance and Maintain model, according to the new value-for-money analysis. Is the report that Mr. LaFleche referred to - that beautiful report that no one is allowed to touch - is that the value-for-money report? That has the value for money in there?

JOHN O'CONNOR: It does.

SUSAN LEBLANC: Well, what do you know? Thank you for bringing it today. I have to say that I really wish we could have seen it before this meeting. We don't get to see you very often, as you know, because of the democratic deficit that has occurred in the last six months because of the pandemic and the government's response to not allowing committees to meet safely. It's too bad that we weren't able to see the report before this meeting, because we would have loved to ask you some questions about that. I will let that go for now, but I'm happy that I'm on the record saying that.

The last time we were together, however, I asked about the release of the business case that explains the government's choice to use a P3 model over a traditional build. So far, we have not been able to see this analysis. Before I ask all of these questions, I want to clarify that that report does not include the value-for-money analysis for the Halifax Infirmary site.

JOHN O'CONNOR: The value-for-money for Bayers Lake has been redone with the actual bid numbers, results from the procurement, and the award of the contract to EllisDon. We'll do the same when it gets to the HI project - the new builds at the HI. The Value For Money analysis will be updated again and reported on.

SUSAN LEBLANC: So you'll report on it after all the bidding is done and after all the procurement is done?

JOHN O'CONNOR: Yes, that's the plan.

SUSAN LEBLANC: I've been saying for the last several months and possibly years that Nova Scotians should really see the value-for-money analysis before the bidding is done to make sure that we don't get ourselves into a situation that we don't want to be in.

PAUL LAFLECHE: I think I explained before why we wouldn't do that, because some Nova Scotians may actually show it to the bidders, so that would be not in our interest. We do believe in transparency, we do want to put these reports out, and we've done that in the past P3s we've done in recent history.

I can't speak to the P3s that were done 30 years ago, so we will be putting out the value-for-money analyses as each P3 is done. The next P3 will be the Infirmary, and in the same sort of time scale, when we get to the appropriate point and we feel we've gotten the best deal we can get for Nova Scotians, we'll put out the value-for-money report.

I realize that doesn't satisfy those who want to know every detail up front and want to be in on the game, but I think what you should console yourself with is that we're doing the very best we can to make sure these projects are in the interest of Nova Scotians and do deliver the very best value. We had a situation in Cape Breton where we started out down one road, and after we did some of that work we actually reversed ourselves.

We do carefully study this and ensure we're going down the right road. What I would say to the member across, Ms. Leblanc - I can't remember what I'm supposed to call them - is to look at the two previous value-for-money analyses we've put out and study those and you'll see the type of path we're on. That's the best we can do today, but I appreciate your concern and willingness to see more.

SUSAN LEBLANC: Thank you, Mr. LaFleche. I don't really want to be in the game, as you say, but I do want to make sure Nova Scotians are getting the best deal for their money. I want to make sure Nova Scotians for the next 50 years - for this entirely amazing, great project that we're going to have - that we're going to have the best one possible. We're going to leave that alone.

As I was saying before, we don't have the value-for-money analysis for that part of the report. In the AG report, it was pointed out that we're in a very different global situation presently with COVID-19, et cetera, and there are key steps that we need to make sure are taken so that this project is steered clear of the massive issues we know that plague the P3 model.

I have a couple of questions based on that. Can you tell us how was the public engaged in the development of the business case, and consulted on the question of which project procurement model to use?

JOHN O'CONNOR: I'd like to have Gary Porter take that question, please.

GARY PORTER: Could you ask that question again?

SUSAN LEBLANC: How was the public engaged in the development of the business case, and how was the public consulted on the question of which project procurement model to use?

GARY PORTER: This information is covered in the project development report that was released today, and there was limited broad public consultation on the selection of the model. As standard practice, there is a component early on in the business case where there's a market-sounding initiative that's taken. This is where we consult with industry, designers, constructors, facility maintenance providers, other large and small local and national - in this case, we consulted with 20 of those groups.

We look for their interest in the project, we look for them to identify any issues or barriers they see with implementing the project like labour availability, and it helps inform us in terms of how much market interest there is on the project that we put to market.

SUSAN LEBLANC: How are organizations representing health care workers and clinicians - like labour unions or Doctors Nova Scotia, for instance - consulted in the development of the business case, and consulted on the question of which project procurement to use?

GARY PORTER: There were several points in the process where we had direct consultation with representative members that would help inform decision making. Specifically when we looked at the question of whether or not we bundle these two projects together in a single procurement or separate them out in distinctly different procurements, which we ended up doing, we would have consulted with the facility maintenance staff and the financial staff within the Health Authority.

We would have included the Department of Health and Wellness. We would have included the Department of Finance and Treasury Board, along with our internal Department of Transportation and Infrastructure Renewal resources that would help inform some of the questions.

It was a fairly limited consultation process. Much of the consultation with clinicians and Health Authority staff really was around the engagement in the master planning process, so defining what the facility needed to include.

SUSAN LEBLANC: That makes sense to me. I do think that consulting unions, maintenance staff and that kind of thing - did you consult with any labour unions that are present in the hospitals currently?

GARY PORTER: Not directly in this process.

THE CHAIR: Mr. LaFleche.

PAUL LAFLECHE: I can't answer the question of who exactly we consulted with on every project. The NSHA staff - Ms. Bond is unfortunately ill today, but she could tell you that. We'll try to get you an answer.

I can tell you that the workers themselves were critical in the input on whether we went ahead with a P3 or not in Cape Breton. Their input about how it would function on a P3 or not a P3 was key to that decision to not do a P3 in Cape Breton, and to really crystallize for us that in Cape Breton, the P3 benefits - unlike in Halifax - would have been very marginal.

We do take into account those views. Ms. Bond, who is not here, could tell you up front who exactly we consulted with and at what level. I can't, but I know we did consult.

SUSAN LEBLANC: That seems to go against what Mr. Porter said. I appreciate that the workers were consulted in Cape Breton. I think that's excellent. I think they're obviously an important voice. I also do understand that they would be more consulted during the master planning process, but in terms of a business case, they do have input. Can you clarify between the two of you, were the labour unions consulted?

GARY PORTER: I can clarify. My answer was directly related to the Bayers Lake and Halifax Infirmary expansion. I don't have involvement in the Cape Breton projects, other than supporting some furniture and equipment procurement.

One thing that's really important here - when you have a chance to look at the value-for-money report, you'll see the span of options that were reviewed for consideration in a P3. On the far side of the spectrum of a P3, we selected a DBFM - Design, Build, Finance and Maintain.

Right next to that is the DBFMO or OM, which includes the operating of parts of the facility. We do not have in scope operating aspects of the hospital within the scope of the P3, so portering, laundry, food services - all of the staffing that directly interacts with patients are not in scope of the contract with EllisDon. Those are still to be delivered directly by NSHA.

SUSAN LEBLANC: Thank you for that clarification. Can you talk about what terms will be negotiated with contractors about transparency and public access to

information about how the health facilities will be managed during the 30-year maintenance contract?

GARY PORTER: That right now is a work in progress. As you know, we recently closed the Bayers Lake project agreement, which then initiates a number of activities. There are several committees that are struck that focus on specific things that need to advance as part of the development: the works committee, which is really focused on construction; we've got an equipment committee; a facility management committee that has some sub-committees around utilities; and all of that sort of thing.

Then there's an entire reporting regime around how progress is being made by each of those committees relative to construction and plans leading up to the operating portion, which is the facility operation's performance expectations or performance objectives.

There are a few other things that really guide around how communications occur that are actively being done right now. There is a portion of the project agreement that addresses apprenticeship and community benefits, so it's really EllisDon's response to how they're going to engage apprentices in the province and how they're going to engage the workforce.

To complement that, there's a crisis communication plan. If there was an event to occur on the site that requires a crisis response, there is a plan that addresses that in terms of how we respond, how EllisDon responds and how we transition that to that process.

Importantly, there's a communications plan that's developed jointly between the province and EllisDon that addresses a number of things: broad communication, the current landscape, internal and external stakeholder identification, specific communication strategies internally and externally. That's currently being developed. In fact, it's in the later stages now. I expect within the next month we'll be finalizing that communications plan.

The crisis communication plan is now complete, and the apprenticeship and community benefits program will be ongoing over the next several months. There is really an active responsibility on both parties to address communications proactively as we move through the period.

SUSAN LEBLANC: You have already said that you will not release the value-for-money report for the HI site until all of the bidding and procurement is finished. Would you consider releasing a version of the business case or the value-for-money report scrubbed of information that you would feel would negatively impact the procurement process, with the goal of informing Nova Scotians how you are so sure that the approach will be a good deal for the province?

PAUL LAFLECHE: Yes, I think we can take a look at something like that. What we don't want to do is affect the benefits that Nova Scotians might accrue by getting a good deal. We have to be very careful in what we do. That's the real issue here. I think Gary will take a look at that. Do you want to say something, Gary?

GARY PORTER: I would actually like to refer back to the Auditor General's report. This was an area that we discussed with the Auditor General and the Auditor General had a look at. I think they concluded, and I could probably find the direct statement - they opined that they believe that it's not in our interest or they support our decision to not release the business case data, as it would have a negative impact on the procurement process.

SUSAN LEBLANC: I understand that rationale, but I'm just wondering if there's a possibility of having at least a shell of it, scrubbed of information so that we could get a sense. It's okay, I won't continue on that point.

I just want to move over to risk transfer. One of the ideas behind the rationale that a P3 model could provide a good deal for the province is that the province pays a premium in return for the private sector assuming the lion's share of the risk of the project.

First of all, could you explain exactly what the risk transfer equation is in the business case? Explain the idea that the private sector assumes risk for a premium price. Can you give some examples of risks that a contractor might assume? I understand the risk transfer idea. I just want to know some examples of the risks.

GARY PORTER: The top three that probably account for the majority of the benefit that we've realized in this contract with EllisDon are construction budget - cost certainty, in other words - and the asset residual value at the end of 30 years. The value-for-money statement is a comparison to if we were to do those things ourselves.

The fundamental difference is when we would do this ourselves, we would separately contract for the design, we would separately contract for the constructor, we would separately contract for the facility maintenance over the period of time, and we would finance it on our own.

The evidence would suggest that when we do that, we face risks ourselves. We face design risks: when we change a design, it impacts our design-related cost, which correspondingly impacts the construction-related cost. If we're in construction and we find change orders are prevalent, then that leads back to design changes, leads to construction changes, scope increase, and that's where you see the risk retained by the province. You start to lose the value.

We took a very empirical approach to evaluating our performance in the construction management on our own compared to a DBFM, and we were able to provide,

I think, a solid rationale for the Value-for-money that you see. Construction risk and asset residual value account for close to 90 per cent of the benefit of the $35 million.

THE CHAIR: Ms. Leblanc, you have a minute and a half left.

SUSAN LEBLANC: I'm going to speed through this. In the last number of months, we've seen many ways that risk calculations can get turned upside down because of COVID-19, obviously. Supply chain disruptions, work force stoppages, and liability loggerheads have thrown into question the typical assumptions that can be made around the kinds of risk encountered by large, complex projects. What exactly are the necessary changes to the risk transfer assumptions in the business case as a result of COVID-19?

GARY PORTER: I don't know if I have time to answer that question - I desperately want to. COVID, in relation to our process, happened - well, March was the pandemic. Our submission deadlines were the following April, May. We had the opportunity to ask the proponents to forget COVID happened and submit their bids as if it didn't. We created a $5 million cash allowance and a negotiations process to address COVID-related impacts to their project costs, and we asked them to submit with their technical submission the types of things that they would see as impacting their cost to the project.

That allowed us to enter into negotiations on those things. We focused on only costs that were known, direct, and able to be quantified, and that helped inform the process. I would also say that I think we did very well in that process, and one of the reasons, I think, is that in the nine months preceding that - that was the open period - we created a really collaborative process with the proponents and actively engaged them in solution-focused discussions around this.

When we got to COVID, we already had good relationships established in terms of how we would address that, and we had some really productive discussions that allowed us to focus on the item, put a box around it and actually close on time. One of the few projects I think that was able to do that in mid-stream.

THE CHAIR: The time for the NDP caucus has expired. We'll go now to the Liberal caucus. Mr. Irving.

KEITH IRVING: Thank you to all of our guests here who are spending the morning with us to review the Auditor General's report. As has been said before by my colleagues, this is an extremely important project for the province, the biggest in its history, and does influence health care delivery now for the next half a century or so.

We can certainly understand the public's interest and the Opposition's interest in ensuring that good decisions are being made throughout the process, and this Auditor General's report is really that first hard, objective look at the decisions being made by

government, and I do want to underscore the conclusion by the Auditor General, and I'll quote from the summary document:

> "The Department of Transportation and Infrastructure Renewal conducted a reasonable and appropriate analysis to select a project delivery model for the Halifax Infirmary Expansion and the Community Outpatient Centre."

Those are very reassuring words, I think, for all members of the Legislature. Our independent Auditor General, who is tasked with looking for gaps in decisions and financial decisions for the province, has given, I think, a strong endorsement of the work to date. As they have said, there's lots of work to go, but we have a reasonable and appropriate analysis.

I was wondering if our witnesses can expand on the methodology used with respect to choose this delivery model.

GARY PORTER: Thank you for that question. Maybe I could just provide a little bit of a summary of what's included in the value-for-money report just by way of how the process was followed to arrive at that decision, and ultimately what that led to.

The business case itself focused on a number of things. Obviously, the scope of development, we needed to make sure we understood the size and complexity of the development - both Bayers Lake and the Halifax Infirmary. That was largely informed by the master planning work that had been undertaken.

Then we went into what's called a bundling assessment. That was a specific area of work that we wanted to understand in terms of should we procure these projects together? Should we procure them separately, regardless of what method we used. So that was informed by a number of things in terms of which model best suited the case.

What we found is that it was marginally a better case to actually do them together, but when we conducted the next step, which was the market sounding - which involved both local and national constructors, designers, and facility maintenance providers - we found that there were some benefits to separating them - most of which were really around early delivery. Proceeding with Bayers Lake ahead of time allowed us to construct that facility sooner than if we had engaged both of them together.

Secondly, we concluded that there would be increased competition through separating those projects. Bayers Lake is of a size that would attract local and national partners. Halifax Infirmary or combined site - Halifax Infirmary alone, there are only a few groups that could actually take on a project of that size. I think we see them now in our short list for Halifax Infirmary: Plenary and EllisDon.

Following that, we did a qualitative assessment. That really is where we focused on how to select the model that we selected. That was done through a lot of consultation internally around the benefits of proceeding with - or looking at the various models that we looked at. The focus of that really was around which model best suits us in terms of ownership and control, managing against a project schedule, achieving cost certainty and cash flow management, market in interest and availability, ease of management, flexibility, risk mitigation and innovation.

After all that analysis, it really pointed us directly to the DBFM or the Design Build Finance Maintain model. From there, we conducted the quantitative analysis. That's where we compared the risk cost comparison to doing it ourselves: construction management as an agent compared to DBFM and the associated costs.

In the earlier question, I talked about the risk transfer. This is where we see big benefits in terms of being able to transfer construction budget, construction schedule and facility asset residual value at the end of the day. That was, as I said to you earlier, done with supporting empirical evidence that looked at our history of project completion. It looked at the current state of the assets within the health sector and where they are - particularly if you look at the Halifax Infirmary, which is almost around 30 years old. It provided a good comparison to what a building could look like, based on current practices with facility management.

So we had some really good data that allowed us to conduct that analysis and provide a fair comparison. Ultimately, that led to and supported the decision to proceed with a Design Build Finance Maintain model. Hopefully that answers your question.

KEITH IRVING: Thank you, that was very helpful. I do want to note the comments from the deputy minister in that a similar process was done with respect to Cape Breton. A decision was made not to use the P3 model for that particular project, based on the evidence of that project relative to this. I think it's important for Nova Scotians to know that these are not philosophical decisions that we're for or against P3s, but it's based on the evidence and how we get the best value for money for Nova Scotians.

My follow-up question here is: we've got two projects which are underway, but one is ahead of the other, so we're further down the road on the community outpatient centre. Are there any lessons or takeaways from getting to the stage that we've gotten with the smaller budget, the outpatient centre, that can help us enhance the next larger project?

JOHN O'CONNOR: We'll turn it over to Gary as well for some detail, but absolutely one of the better decisions that was made was to advance one ahead of the other. Given that the Bayers Lake project is a smaller project, we were able to manage through it very well, and all of the experience that we have gained, and the experience with our advisors - they were experienced anyway, as we brought them on as advisors - but our experience in working with them, learning from them, all of the lessons learned from the

process that we have gone from A to Z on for Bayers Lake are being embedded into our work for the HI project.

The HI project - we're very close now to request for proposal release. We have some governance discussions to have with some of our oversight committees to get the final okay to have that RFP release, but we're just at the very early stages now of putting that out to those two shortlisted bidders, and a year later we'll be in a position that we were in during July and August for Bayers Lake.

Absolutely, many lessons were learned, and I know Gary has conducted a number of lesson-learned feedback loops there to really capture from all different aspects what was good, what was bad, what worked and what didn't work. I think we're in a good position now, and we've embedded a lot of that in the RFP documents already that are being prepared and are ready to release.

THE CHAIR: We'll go to Mr. Porter first and then we'll go to Mr. LaFleche.

GARY PORTER: To John's point, in hindsight I think the separation of these two projects into individual procurements has proven very, very beneficial. We learned a lot through Bayers Lake. We took a really deliberate approach after Bayers Lake to really try to understand what worked well that we should build on, what were we challenged with through the process that we should brace ourselves for the next time, and how might we modify the process to support what we've learned through Bayers Lake. I would say overall there's a few key things that I would point out.

I obviously can't talk a lot about what we're going to do with Halifax Infirmary until the proponents actually see the documents so they don't hear it today versus when we officially give it to them, but I think some of the observations are important.

We engaged in a really collaborative process. During the open period, there are several consultations that occur. We're really negotiating the project agreement over that course of time, and there are several commercially confidential meetings where proponents engage us in trying to understand and clarify some of the contractual language, maybe pushing back on some things that they don't like in it. We try to embed some things in there that we'd like to see within the contract.

The second process that is under way at the same time is that there's a series of design presentation meetings, which is really clarifying our requirements to bidders and what we want to see in the facility, what's essential and what can't change, what has room for modification that might enhance clinical care or cost efficiency.

Engaging those discussions in a really collaborative way, I think, was really beneficial. We had three great proponents that were really solution-focused. When we encountered issues or items that we wanted to discuss, it was done so in a really

collaborative way. That really helped us in addressing COVID so having had established those relationships, it really allowed us to establish a trusting dialogue around that.

The second thing I would say is that the open period for Bayers Lake was challenging in the sense of the amount of time we had. We have modified the Halifax Infirmary open period slightly so that the time that we set - which we will release as part of our RFP - was really very much informed on what we learned from Bayers Lake: the amount of time we need to engage proponents on design-related items, allowing the right amount of innovation, discussing that kind of innovation.

The one benefit that we have, a real technical piece, is that all of the work that we did on the project agreement and all the language and all the adaptations to the language and the various schedules - our starting point for Halifax Infirmary is where we ended off in Bayers Lake, so we won't have to replicate all of those discussions over again. The proponents are already familiar with the language. They've already opined on the language. They've accepted it.

I think if there is an area that we'll continue to work towards, it is the ongoing impact of COVID and how that may change in time. That's a dialogue that I assume we'll enter into with proponents, and we have the benefit of what we've done with Bayers Lake to help inform that.

I think the other thing is that, just as we're saying it goes to some of our governance and capabilities, we've built our capability quite significantly since we embarked in the beginning on Bayers Lake. So our strength in entering into this process in terms of our clinicians and their understanding of the requirements, their ability to talk about what was intended by what we're saying we need, the ability to push back on some stuff we don't want any change to, the ability to engage in things that we'd like to see some innovation around - I think we're so much better positioned in this process now that that will really pay off as part of the process.

PAUL LAFLECHE: Gary and John have gone over the continuum between Bayers Lake and the Infirmary and what lessons we learned. But it's important to understand that we and others have been in P3 projects and conventional projects for a long, long time. Nova Scotia is one of the leaders in Canada in P3 projects. In fact, if you go to any of the conferences, they still talk about what a breakthrough it was when Nova Scotia launched the schools project in the mid-90s. That's viewed to be a success. It's not viewed to be a success in some political or media venues, but in terms of P3s and government construction, they're viewed to be successes.

We then went into a bit of a lull. We did those projects in the schools for different reasons and different accounting reasons in different times. We went into a bit of a lull, but then we relaunched P3s in the MacDonald government, continued in the Dexter government, and went through to the McNeil government. We've done a number of P3s

now. They're mentioned in some of the reports by the Auditor General. A lot of people don't even know they were P3s.

Every single one of those P3s we have learned lessons from which are translated to these things we're doing today. In fact, the one right before Bayers Lake, Highway 104, which is under construction now - we learned from lessons there in negotiating that contract that we've used in Bayers Lake and that are now going to the Infirmary.

We've also done extensive work across Canada in looking at others. When we went into a lull in the early 2000s in P3s and others passed us and did a lot of them based on our first experiences, we learned from them. We went to visit. What do they do in BC? What do they do in Ontario? What do they do in Alberta? So we've had a lot of learning, and every P3 is situational, but you can learn from the past. Every conventional build is situational.

There's not really anything that's P3 or conventional. If you look at the Auditor General's reports and you like letters of the alphabet, you can find there's about 10 different types of builds one can do along the spectrum. I encourage you to go look at that. It's a really good report and it's got really good definitions of what they are.

We've done almost all of those builds. Each one is good for some situation, and you learn when you do them, so you do better in the future. Conventional builds - if I say strictly conventional, they actually don't exist because government doesn't have workers that actually build the facility. But if we get near-conventional, they have their risks. We've seen that in the Colchester Hospital.

P3s have their risks. Everything in between has a risk. We learn. We do our best. What is our objective? Our objective is to deliver value for money for Nova Scotians. Our objective here is to have a really good health care facility that addresses some of the questions that were asked by Mr. Halman earlier regarding wait times, what we are getting in terms of beds, how we're delivering better health services to Nova Scotians. That's the real objective. The building is just a means to get there.

My colleague here on the left, Jeannine Lagassé, and Dr. Mitchell - they're more familiar with that. They could tell you more about that. But we want to make sure that we get the best building for them and we've consulted vastly and widely with clinicians, with unions. I've heard from Ms. Bond and she will speak to you, Susan Leblanc. We have a council of unions we consult with along the way, so there's a much bigger process than was elaborated on here. Ms. Bond will get back to you on that.

That's our objective. It's about health care facilities. Sometimes we talk a lot about the building, but it's about health care and health care for Nova Scotians and the best health care.

THE CHAIR: Mr. Irving has a minute and a half left.

KEITH IRVING: I was going to pass that on to my colleague.

THE CHAIR: Mr. Jessome.

BEN JESSOME: Thanks for that minute and a half, coach. Does anybody have a short snapper? Rafah's going to go.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: Maybe it's part of the comment that I was going to start with. There was nobody who was more excited when I heard about the Bayers Lake location, just because the three biggest ridings - that area has grown so much. As a worker who drove to the parking lot downtown, I know how hard it was for patients, and for myself, to find parking downtown. This development of moving all the health services or the ambulatory health services to where people live was really visionary and a wonderful thing that will be used.

I do actually think that Bayers Lake offers so much more than has been said because of the highway access. I actually feel that it may be too small for the demand that's going to come on to Bayers Lake because of the highway access, because of this increased population and the three - Bedford, Clayton Park and Fairview area - and the rest that will be serviced in that location. We are all so excited for that one and I hope it goes on time.

The quick question is: is it big enough for the demand or how did you assemble the demand for that location?

THE CHAIR: The time for the Liberal caucus has expired. Maybe we can get an answer to that on the second round of questioning.

What we're going to do now is take a 15-minute break. Again, I want to remind everybody you exit through the two side doors, have your mask on, and when you come back, you come in through the main door. We will resume again at 10:30 a.m.

[10:13 a.m. The committee recessed.]

[10:30 a.m. The committee reconvened.]

THE CHAIR: Order, please. We'll call the committee back to order. We'll begin now with the second round of questioning and will be eight minutes for each caucus, beginning with the PC caucus - Mr. Halman.

TIM HALMAN: I'd like to turn our attention to the Bayers Lake Community Outpatient Centre. At this outpatient centre, how many additional Nova Scotians will be able to receive physiotherapy, occupational therapy - essentially rehab services? Could you provide us some commentary on that?

ALEX MITCHELL: I do have specific numbers on a number of volumes that visit the COC. The total number of visits to the COC will be 207,000 and change. Of that, the OAC and rehab numbers are projected currently at approximately 36,000 visits. It is our expectation that will service in the manner that was described earlier in that it will provide service to the local community, but most importantly, it provides a really great point of entry for patients coming to access those services from outside HRM or from outlying areas.

TIM HALMAN: I know we'd all acknowledge how critical access to mental health services is to Nova Scotians. Certainly, COVID-19 has amplified the need for that. Based on that, how many additional people will be able to be treated for mental health services at the Bayers Lake facility?

ALEX MITCHELL: Two layers to the answer on that question. First, there is not specifically a mental health or psychiatry services footprint at the COC in its current clinical service plan. However, it is important to recognize that a sizeable component of mental health services is provided by primary care, and there is a primary care footprint that is significant at that site with the ability to be utilized thoroughly.

In terms of the clinical service plan for mental care in conjunction with this, I can't speak to today, but there is not a specific mental health footprint at this site.

TIM HALMAN: How will it play out then? Once this is built and operational and a Nova Scotian arrives at Bayers Lake to access mental health services, what does the footprint look like? What will be the protocols? What services will they receive? If not there, where are they sent?

ALEX MITCHELL: If somebody in a mental health crisis turns up at the Bayers Lake Community Outpatient Centre, we can provide for them, but there would be facility-based policies and protocols for the management of a mental health crisis individual. That would direct that patient, depending on the circumstances to the appropriate level of care, the location of care, among other things.

That's something that we do or the organization has to do every single day, depending on what comes through the doors at various sites, and that would be no different than at the COC. Those standard policies and procedures would be followed.

TIM HALMAN: With respect to administrative offices, how much space is being allocated for administration offices at the Halifax Infirmary?

ALEX MITCHELL: The specific square footage allocated to administrative office space would be a number that I would be unable to provide you immediately at this time. What I can tell you is that the principles behind the project were to maximize the placement of clinical activity - mission critical patient-centric activities - into the new buildings, which were being purpose-built to be efficient, to meet a modern and future standard, and subject to the M portion of this contract.

The beauty of this thing is that there is an outside third party who is contracted to make sure that the lights in that building work and is perfect every day for providing patient care. We want to make sure that we have patient care in those new buildings, and then direct the administrative, non-clinical care functions as much as possible into other components of the project in our existing buildings, et cetera, so that we maximize the utilization of this investment in front-line clinical care.

TIM HALMAN: I appreciate that, Dr. Mitchell. I ask because someone very close to me used to work on 7.3, the division of neurosurgery. That's one thing that struck me when I would visit - not specific to that floor, but just overall - the amount of administrative offices.

That being said, with respect to Bayers Lake, how much space is being allocated to administrative offices at Bayers Lake?

ALEX MITCHELL: Again, I can't tell you the exact square footage. I can close my eyes and I can picture the exact district where the administrative functions are in that building. It is on the ground or basement floor in that building in the back left corner and it is a very small, insignificant component of that building's function. The rest of that building is dedicated to the clients, to the patients, to the community and for the things they will do in that building.

TIM HALMAN: An article that fairly recently struck me was an article by Dr. Bernie Badley in the Chronicle Herald, and that was published on February 5th of 2020. I'd like to take a quote from that Chronicle Herald article: "The proposed consolidation of all cancer services in Halifax . . . would involve destruction of the existing structures that have not outlived their usefulness . . ."

The doctor, of course, as you know, is talking about the Dickson Building, which was opened in 1982. How has his concerns and those of the Friends of the Halifax Common been taken into consideration in the development of this plan?

ALEX MITCHELL: I think there are three layers there. Let's start with Dr. Badley's comments about the cancer centre and its pre-existing capacity or ability to provide care well into the future. I think any and all of us that are involved in creating these facilities would challenge that assumption.

The Dickson Building is not a building that is built to survive the next 30 years, and significant analysis before my time was done to decide whether or not that building should be replaced, and whether cancer care should be located concurrent with other things. I would challenge us all to ask patients and our clients whether or not they want to have their cancer care in a variety of different locations or have their clinicians co-located, discussing collaboratively and providing care that is centred really around the patient experience.

A lot of those factors, along with building condition and the cost involved with maintaining, upgrading, and keeping that Dickson Building were all entertained. The end result was that the best for all, including finances, was probably to move that cancer centre up the road.

Part 2 of your question is on the Friends of the Halifax Common issue, and I believe you'll see in our upgraded master plan diagrams or other things that a lot of that has been addressed. There were concerns about the way that we needed to move the cancer centre up and the ambulatory care building, which required some element of our structures to be across the road or on Common land, among other things.

What you'll see in the updated design plans is an accommodation of that - some significant innovation in moving the buildings together and maximizing the use of the existing campus and capacity so that we do get that wonderful dream of having cancer care co-located with everything else. We know that will be highly celebrated by both patients and is currently being celebrated by the clinical staff involved in cancer care.

THE CHAIR: The time for the PC caucus has expired. I'm going to add an extra 30 seconds on to the NDP caucus. Ms. Roberts.

LISA ROBERTS: Glad to be here and to have this opportunity to ask some questions. I'm going to start with one building on the HI campus that isn't being touched by this project, which is the Abbie J. Lane Memorial Building for psychiatric care, which is outdated and in need of something major. I don't know if renovation or replacement is the right language, but I understand that it has needed that for some significant time. That's been well-known.

What are the plans to update the building, and what is the timeline for that? Why wasn't it contemplated in the scope of this project?

JOHN O'CONNOR: I'll take that question. The focus of this project was to move the services from the Victoria General site elsewhere. Most of the new construction will be at the Halifax Infirmary site, as we all now know, and, of course, the Bayers Lake site and Dartmouth General.

This project did not include scope to do many other things. There are many other health care projects underway in Nova Scotia and in this area as well that are not necessarily

part of the scope of the QEII Regeneration Project. However, they're being planned separately but together. There are many other projects like the dialysis projects and others that are currently under way.

The Abbie J. Lane Memorial, I specifically do not know. I know we have some spill-over between this project and Abbie J. Lane around some changes around loading docks and things of that nature because the loading docks are tucked in behind the Abbie J. Lane. We're moving those to a different location - or some of them - in the redevelopment project. Inside the building on the various floors, I'm not familiar with what is planned for those floors.

LISA ROBERTS: I want to go back to Dr. Mitchell's comment early on about planning at the coal face with actual health care staff and support staff who are working in the current facilities.

I had a recent conversation with a psychiatrist about the number of people who are actually in-patients at the Abbie J. Lane who actually need the support of housing in the community, but there isn't adequate support of housing in the community and so they are in-patients. Of course, at the VG site, we have wards of in-patients who actually need long term care beds, but they are currently ALC patients in an acute care setting.

In both of those cases, we are providing very expensive housing or very expensive care that is actually inappropriate for the individuals who are in those beds. So when I look at the health redevelopment site and I see that there are going to be 626 beds - an increase of 180, 36 of which are new, 144 relocated from the VG site - is the starting assumption for planning that we are going to continue to have significant numbers of alternate level care patients in an acute care hospital? Or are we going to start doing better in these other parts of the system that touch and impact on the acute care hospital setting?

ALEX MITCHELL: Recognizing that I represent the redevelopment, I'll speak as a physician and representative of the organization. What you describe is actively a daily, really complicated issue. Alternate level care patients, long term care capacity - the number of things that contribute to a patient still existing in an alternate level care in our existing facilities or mental health patients in the wrong bed in the wrong place is a really complex issue. It requires the co-operation and collaboration of a variety of different levels to solve that issue and is quite a bit beyond what we are currently planning in terms of acute care beds.

In any given context, our plan around acute care beds when we create them is, we're not creating them with the lens on that we'd like to create this and create alternative level of care bed space or that this is what we really want to do. The active reality is that is an ongoing pressure for the system, but the new acute care capacity in the new buildings was not envisaged to be alternative level care beds or to house long-term mental health patients or otherwise it was to service the acute care needs of the facilities. The needs of mental

health inpatients - alternative level of care or otherwise - is a much larger issue that is beyond our scope. It is certainly one that is very important to the Health Authority to manage.

[10:45 a.m.]

LISA ROBERTS: Maybe in writing perhaps, because of my short time, I would be curious to know if the 144 beds being relocated from the VG site, if those are currently ALC or if those are acute care and cancer care beds.

ALEX MITCHELL: Those are predominately acute care beds. Those are not planned alternative level care beds presently.

LISA ROBERTS: The AG Report points out that the public will only see the value and that is suggested or purported to come from a Design Build Finance Maintain model, if contract management is significantly improved. This has been a major weakness in the past with spotty enforcement of terms and deliverables.

Administering and managing contracts is a complex task which will need to continue long past many of your stays in the public service. How much are the departments anticipating spending on managing and administering the QEII redevelopment contracts?

GARY PORTER: I'm not sure I can place a dollar value on it. We built capability within Nova Scotia Lands, within our team to actively manage the contracts as they come to be, so in Bayers Lake we have assigned specific responsibilities within the three divisions that we have. In procurement and finance, there are some responsibilities in contract management. Our infrastructure group has some responsibilities through the work stage and in the construction management realm, and the clinical team also in terms of advancing the design.

The project agreement spells out all the obligations that are on the Province and project company. We've taken those obligations and we've built a project implementation plan or contract management manual. We've created the right committee structures, we've put the right people on them, we have accountability assigned for those obligations within our organization, and we will be actively managing and monitoring the contract through the construction period.

We still have a little bit more work to do to define our contract management approach in the operating period, but that's also well-defined in the project agreement. It's really taking those obligations that we're contracted to perform and embedding them into our organization.

THE CHAIR: I apologize - I'm going to have to cut that discussion off because the time for the NDP caucus has expired. We'll go now to the Liberal caucus for eight minutes, beginning with Mr. Jessome.

BEN JESSOME: The AG's report acknowledged a couple of different variances between a couple of different programs that had less space provided than was outlined in the master plan. Mr. Porter alluded to some of the back-and-forth, the lessons learned that have taken place since Bayers Lake to the Infirmary, with respect to the engagement of the medical community.

I'd like our medical director to weigh in on that relationship - the medical director's capacity to be involved, to okay and give feedback - and additionally, on top of that, the protocol that's been realized. Reassure us that the Bayers Lake project was not a burnt first pancake, please and thank you.

ALEX MITCHELL: This was a journey and a learning exercise, no question, but we did learn quickly. Our teams have developed significant proficiency - when I say our teams, both on the infrastructure side but also on the clinical side. It is about being able to understand how each other thinks and speaks, understanding the language between the two groups. As we got through the COC process, we began to get to that place - because Gary and I work extremely closely - where I understand what Gary is saying and Gary understands what I am saying.

I will reassure both everybody here and the public that the clinical voice and folks like myself have had a significant seat and voice in the design meetings, in the open period with the proponents. What we have through the P3 process with the COC is yes, lessons learned, and we learned some really good ones: what to do, what not do to in the HI open period.

During the process of the COC with the collaboration that Mr. Porter described, we got a really great product. We took the things that we asked for and we asked the market to solve a bunch of our problems. What we ended up with was a building that was actually more efficient, had everything in it that we had asked for at a very affordable price, that we are going to be absolutely thrilled with. We've shown those at the coal face some of those updated designs that have been built out of the open period, and they are thrilled. It does capture what they asked for and we do think it was a real success.

We didn't burn that pancake. We learned a lot while we made it, but we didn't burn it.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICONSTAZO: I was hoping that he would be able to finish up the question about the volume that is expected for Bayers Lake, but I also wanted to bring one other item when I was speaking.

Most people don't know the wilderness that is so close right now to your new hospital - I actually lived in Clayton Park area for 35 years, and I didn't know. This is a huge advantage for the employees, for the staff that will be working at the hospital, and for the visitors.

There's an actual access point that is right next to the hospital, I'm told. Has this been looked at as an advantage of the location, and is there any signage, any opportunity to make sure that both the staff and the visitors know about this and take advantage of it?

ALEX MITCHELL: Absolutely. Briefly, back to your volume question: 207,000 visits at the COC site annually is the overall volume expected to go there, and a facility that – as to your question, is it big enough? The answer is yes. It is well-sized to accommodate the kind of volumes and the activities we need to do there. Absolutely. I have a lot of confidence in that.

In terms of the outside, absolutely. We've spent many hours during the open period discussing gardens and paths and lighting and access to nature and where staff might eat their lunches outside, where patients might go, how do we get - you know, there's things in the contract about bike trails, access to the bus station, among other things. Like you, I lived in Clayton Park for many years and used to mountain bike up behind all those areas, so I'm very familiar with it.

There is absolutely lots of nature trail access there and it does represent a great location for those kinds of activities and the people attending that facility can experience that should they wish.

THE CHAIR: Mr. LaFleche.

PAUL LAFLECHE: I want to thank you for that question. There's been a lot of misinformation around the bike trails and not having a bike trail at the Bayers Lake Community Outpatient Clinic. In fact, that's one of the few sites that does have a bike trail, so that is really a bad piece of information that somehow got out there.

In fact, at the end of September, beginning of October, the Ride for Cancer for leukemia and lymphoma started from that new site on to the HRM bike trail that goes out down the South Shore. It's very well serviced and it's one of the reasons why that site was very advantageous.

THE CHAIR: Ms. DiCostanzo, two minutes left.

RAFAH DISOCSTANZO: I hope people will hear about it and some signage and some work between the Friends of Blue Mountain-Birch Cove Lakes society and the hospital, because that's an access point that is really wonderful and hopefully people can use the parking lot to use that access point as well. I'm not sure how big the parking lot is and where it is, but these are two things that can work well together. I pass it on to my colleague Brendan Maguire.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: We've had a lot of questions here today about this development and how much of an impact that it's going to have on Nova Scotians. To say that it's long overdue is an understatement. I think all of us at some point have frequented the medical facilities here in Nova Scotia. We have fantastic staff that are working at those facilities, but the truth is that we need to upgrade that and to modernize it.

What kind of impact, in your opinions, is this going to have on recruitment of staff? I just turned around and looked at Dr. Mitchell.

THE CHAIR: Dr. Mitchell, you have one minute to answer that question.

ALEX MITCHELL: Recognizing that I grew up visiting the old Dartmouth General, and my mom worked there for 23 years, and I watched it convert into what it is today, so you can go see that. It's beautiful. Facilities have a huge impact on nursing staff and clinicians in where they decide to work. People do not want to come to antiquated facilities; they want to graduate and come to the newest, best buildings with the newest, best technologies in them, and that's where they want to work. These buildings will absolutely contribute to the recruitment of quality future health care providers.

THE CHAIR: The time for the second round of questioning has expired. Now what we'll do is open the floor. If witnesses want to make closing remarks, you're welcome to do so. I'll start with Mr. LaFleche.

PAUL LAFLECHE: I think you're going to start and finish with me, actually. There's no one else. I want to thank the committee. we've been here several times to talk about the redevelopment of health care facilities in Nova Scotia - I say in Nova Scotia because we have a lot of facilities where we are redeveloping. The QEII is part of them. They're all interlinked, they're all part of a plan, as Dr. Mitchell outlined.

I can mention some in Cape Breton, Pugwash, Yarmouth - these are all recent announcements that we have made, good announcements that will provide great service for Nova Scotians. It is not about the facility; it's about the service and health care they're going to get.

I want to thank you. Every time we come here you ask insightful questions. There were some good ones today. I want to finish on two thoughts. The first thought is the ongoing contract monitoring. That was brought up by Ms. Roberts, and that is a key point that's brought up in the Auditor General report. I think it's important the people read that report.

Ongoing monitoring and relationship management with P3 is critical to achieving the benefits that Gary Porter talked about. In the past, that's been maybe a spotty record for various governments around Canada and North America. We have to do a very good job of that. The job doesn't end with the build. The job goes on for 35 years.

As we've seen with the schools, where maybe things over the last 25 years might have been a bit lax in the monitoring area, monitoring delivers you a great result at the end if you do it properly. We will endeavour to have a group that specifically works on that. Gary mentioned that.

The other thing I want to mention is that we're public servants. We want to do the best job we can for you. We want to make sure you get a good build and good health care. We take risks on behalf of the public, but they're managed risks, they're calculated, and we try to do the best things we can to build these facilities. Sometimes mistakes are made and sometimes we hit a home run, so to speak.

For the last 35 years in health care in Nova Scotia, John O'Connor has been involved in virtually every build, and he will probably not appear here again. He's going off into the sunset, but slowly. He'll be with us for another year - he doesn't know that yet - in a part-time role, and we'll be hiring a replacement who will appear in the near future.

I think it's important that we acknowledge that whether it's an infirmary, a hospital in Amherst, in Yarmouth - wherever it is in Nova Scotia, John O'Connor has been involved in those facilities, he's put his hand on it, he's had experience. He could have earned a lot more money, multiple times more money, working in the private sector for different consultants, but he chose to have a career in public service, and that's what's important. I want to just go out thanking John for his long career in public service. (Applause)

THE CHAIR: Thank you very much. I think Mr. O'Connor wants to have a response. Maybe he's not going now. (Laughing)

JOHN O'CONNOR: I won't take much time, I'll just say thank you very much, Paul, for those remarks. I guess that really means I have to leave. I've been thinking about it.

THE CHAIR: On behalf of the committee to you, Mr. O'Connor, thank you for your service to the province of Nova Scotia and we look forward to a happy retirement for you.

That concludes our presentation today. There is just one thing I'd like to bring up if I could. At the start of discussion, there were questions about numbers, and we have received some of those numbers, but the commitment was made that the committee would be provided these numbers, and I would ask if you would please forward those numbers to the Clerk and we can go from there. Mr. LaFleche.

PAUL LAFLECHE: Two follow-ups I have: one is the one you just mentioned, and I think many of those are already on the website, but we will endeavour to follow up. The second is Ms. Leblanc mentioned the union consultations, so Ms. Bond is going to follow up with Ms. Leblanc on the union counsel.

[11:00 a.m.]

THE CHAIR: Again, that concludes our witnesses for this morning. We'll give the witnesses the opportunity to leave the room, and then we'll finish off with our committee business.

Mr. Halman.

TIM HALMAN: I'd like to put forward a motion, Mr. Chair.

THE CHAIR: Go ahead.

TIM HALMAN: By my count, as of today, it's been 239 days since the Legislature sat. We know that this is a government that struggles with accountability and transparency. We know that this is a government that finds it very challenging to answer questions of the opposition, of the media. Fairly recently, the Premier indicated to a reporter that "I'm not your research team."

Here we are at Public Accounts, the mandated Public Accounts Committee meeting, despite the alterations made by the Liberal Caucus in the Fall of 2018. The purpose of the committee is to question government spending. Therefore, I'd like to put a motion forward that is the following:

Recently, the federal government gave the Province of Nova Scotia $228 million in COVID-19 stimulus funding. The Province has been unable or unwilling to give details about how that taxpayer money will be spent. The government is not disclosing this information. Therefore, I move that this committee invite the Department of Transportation and Infrastructure Renewal and appropriate staff to this committee at the earliest possible date to explain how this $228 million will be used in Nova Scotia.

THE CHAIR: The motion has been called for a vote and a recorded vote has been requested. I'll call according to the way people are seated.

YEAS	NAYS
Lisa Roberts	Keith Irving
Tim Halman	Margaret Miller
Susan Leblanc	Ben Jessome
Keith Bain	Rafah DiCostanzo
	Brendan Maguire

THE CHAIR: The motion has been defeated.

Mr. Halman.

TIM HALMAN: One final motion to put forward. This is a motion endorsing the Auditor General recommendations. I move that the Public Accounts Committee formally accept and endorse recommendations contained in the following reports: the June 2020 report of the Auditor General: Nova Scotia Liquor Commission Phase 1; July 14, 2020 report of the Auditor General: QEII New Generation Project Halifax Infirmary Expansion and Community Outpatient Centre Phase II; and the July 28, 2020 report of the Auditor General: Government-Wide Contaminated Sites.

We move that this be accepted by the audited departments or agencies and ask that those departments and agencies commit to and take responsibility for full and timely implementation of the recommendations accepted by those departments and agencies.

THE CHAIR: We have a motion on the floor. Is there any discussion? Mr. Jessome.

BEN JESSOME: Just to clarify, this is a lengthy way of saying we accept the report of the Auditor General? Okay, thank you.

THE CHAIR: It's a little lengthy too because there is some direction in the motion.

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

The motion is carried.

Just a few more items if I could. There is some correspondence that the committee members have received and we'd just like to get this on the public record. The first piece of correspondence was from the Department of Environment: the response to the committee correspondence requesting an update on the implementation of recommendations from the November 1st Auditor General report.

The second, from the Department of Municipal Affairs and Housing: response to the committee correspondence requesting an update on the implementation from the November 2016 report.

Thirdly, the Office of Aboriginal Affairs: response to the committee correspondence requesting an update on the implementation of recommendations from the June 2015 Auditor General report. Those are received for the committee at this point.

Is there any further business to come before the meeting today? I have to apologize. I expected with so many witnesses here today that the closing remarks would be actually longer than they were. I was surprised that Mr. LaFleche was as short as he was. (Laughter)

If there's no further business coming before the meeting, our next meeting is on December 9th here in the Chamber, where there will be an in camera briefing from 8:30 a.m. to 9:00 a.m. The public meeting will be from 9:00 a.m. to 11:00 a.m., and the witnesses are from the Office of the Auditor General of Nova Scotia and the Department of Finance and Treasury Board, concerning the December 2020 Annual Financial Report of the Auditor General.

If there is no further business, the meeting stands adjourned.

[The committee adjourned at 11:06 a.m.]