HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, February 16, 2022

VIDEO CONFERENCE

Emergency Health Services Contract and Service Delivery

Printed and Published by Nova Scotia Hansard Reporting Services

Public Accounts Committee

Hon. Kelly Regan (Chair)
Nolan Young (Vice-Chair)
Dave Ritcey
John A. MacDonald
Melissa Sheehy-Richard
Trevor Boudreau
Hon. Brendan Maguire
Claudia Chender
Susan Leblanc

In Attendance:

Kim Langille
Legislative Committee Clerk

Gordon Hebb
Chief Legislative Counsel

Kim Adair,
Auditor General

WITNESSES

Department of Health and Wellness

Craig Beaton,
Associate Deputy Minister

Dr. Andrew Travers,
Provincial Medical Director for EHS

Emergency Medical Care Inc.

Charbel Daniel,
Executive Director, Provincial Operations

Jan Jensen,
Executive Director - Medical Communications, Patient Flow & System Performance

International Union of Operating Engineers Local 727

Kevin MacMullin,
Business Manager/CEO

Michael Nickerson,
Business Agent

Samantha Hamilton,
President, Executive Board

Nova Scotia Health Authority

Victoria L. Sullivan, BN, RN, MHS,
Interim Vice President of Operations - Central Zone

HALIFAX, WEDNESDAY, FEBRUARY 16, 2022

STANDING COMMITTEE ON PUBLIC ACCOUNTS

IN CAMERA

9:00 A.M.

CHAIR
Hon. Kelly Regan

VICE CHAIR
Nolan Young

THE CHAIR: Order. I now call the meeting to order. This is the Standing Committee on Public Accounts. My name is Kelly Regan, I'm the Chair of this committee.

Just some reminders before we start. Please keep your video on during the meeting. Keep your mics muted until you are called upon to speak and wait until after the Chair recognizes you to unmute your mic. This is one of the hard parts: do please wait to be recognized before you begin to speak, and indicate your wish to speak by raising your hand. I want to remind everyone to place their phones on vibrate or silent before we begin.

I'll ask committee members now to introduce themselves, beginning with Mr. Young.

[The committee members introduced themselves.]

THE CHAIR: On today's agenda we have officials with us from the Department of Health and Wellness, Emergency Medical Care Incorporated, the International Union of Operating Engineers Local 727, and the Nova Scotia Health Authority to discuss emergency health services contract and service delivery.

I'm going to ask the witnesses to introduce themselves, beginning with Associate Deputy Minister Beaton.

[The witnesses introduced themselves.]

THE CHAIR: At this time, I will invite Associate Deputy Minister Beaton to make his remarks.

CRAIG BEATON: Good morning, everyone. Appreciate the opportunity to be here this morning to discuss the Emergency Health Services contract and service delivery. I want to thank you and our guests for joining us today. Each witness brings to the table a different role and perspective to some of the challenges facing our emergency health system, but we are all committed to ensuring better care for Nova Scotians, and we are committed to working together to bring forward improvements.

We know there are significant challenges, and certainly the pandemic has put even more pressure on the system. Many of these challenges are long-standing, complex issues that not only our counterparts in provinces across the country are facing, but around the globe as well. Our system needs to be more responsive, modern and efficient.

Through the department's most recent contract with EMC, we made bold and significant changes to enable redesign of emergency response system to provide the right resource to the right person at the right time, for the right reason. These changes were validated and informed by global best practices outlined in the Fitch report the department released last year.

The report outlined 68 recommendations, of which the department committed to accepting 64. Some of these 64 recommendations were already implemented when the report was released, and as noted earlier, some were included in the new contract with EMC. Some needed to be evaluated further on how to implement, and many are currently under way, such as installing power stretchers and loaders to improve patient safety and paramedic injury prevention.

I want to acknowledge the excellent care paramedics and all EHS staff provide to Nova Scotians. They've been at the forefront of caring for patients throughout the pandemic and have adapted to changing rules and processes when COVID-19 called for it over the last two years. I think everyone here will agree that paramedics are one of the most collaborative health professionals out there. It's that teamwork and collaboration that has helped us, and will continue to help us, while working with the Nova Scotia Health Authority, EMC, and the paramedics union to address some of these long-standing, complex problems.

I want to take a minute to speak directly to paramedics working on the front lines. We know at times you've worked harder than anticipated, and longer. You've missed

tucking in your loved ones at night or seeing them before they leave for school and work. You're giving the best of yourselves when Nova Scotians need you the most, and you've done all of this and more to help those in need of emergency care. I want you to know that, together with our partners, we are working to increase the provincial supply of paramedics and to get you the support you need. It's been an incredibly challenging time for the entire health system, so thank you for all that you've done and continue to do.

I also want to thank all of my colleagues from the IUOE 727, EMC, and the NSHA for their hard work, dedication, and efforts to work collaboratively to find innovative solutions for our current challenges, and to keep our communities safe. Thank you.

THE CHAIR: Mr. Daniel.

CHARBEL DANIEL: Thank you for the opportunity to be here today. I'd like to start off by acknowledging the loss of a number of long-standing Nova Scotian paramedics since the start of the pandemic. This includes the most recent loss of Yarmouth paramedic, Terry Muise, who along with others, was a great mentor, leader, and clinician.

For over two decades, EMC has worked closely as a health system partner with EHS and the Department of Health and Wellness, Nova Scotia Health Authority, the IWK, medical first responder agencies, employee unions, and others to provide emergency pre-hospital care as part of Nova Scotia's health and emergency response systems. EMC is very proud and thankful for our team of more than 1,500 clinicians. These are highly trained paramedics, nurses, and communication officers who work closely with leaders and support staff and over 3,500 medical first responders to provide emergency care for Nova Scotians.

The EHS system has long been the safety net for Nova Scotia's health care system, providing care for patients in the community, as well as setting up collaborative and innovative programs to fill gaps in the system. Today, EHS faces unprecedented challenges - both health system and human resource strains. We no longer have that same ability to flex and fill these gaps. This has impacted our service delivery to the public and our employees. We know Nova Scotians and our team members are concerned about our ability to respond in a timely manner, and we're listening.

We know paramedics are not getting their lunches and are missing time with their families due to shift overruns, causing hardship on the job and at home. We continue to work with our partners on immediate solutions. Never has there been a more important time for a collaborative approach among all stakeholders and a willingness to work together to implement solutions. We know this challenge is not unique to Nova Scotia or even Canada. We are, however, optimistic about the steps government has taken to improve communication, collaboration, and accountability in the health care system.

One of the guiding principles of our relationship with EHS is providing the right resource for the right patient at the right time. This principle has led to the development of several innovative programs, such as the extended care paramedics in Halifax caring for seniors in nursing homes - paramedics who have been trained to provide palliative care in the comfort of a patient's own home, if that's their wish. Also, our community-based paramedic program in Cape Breton that supports patients recently discharged from their regional hospital to recover at home, and has also recently expanded into long-term care facilities.

We're also making operational changes to enhance coverage in all communities across Nova Scotia while focusing on improving the work environment for our employees. We continue to add more EHS unit hours and are currently having our deployment system reviewed. We continue to expand on our patient-transfer side with increasing patient-transfer hours and a new delivery service called the Medical Transport Service that provides patients with a different method of transport, and further collaboration and integration with our health system and the Nova Scotia Health Authority to ease offload delays and increase patient flow.

We've also introduced a position into our medical communication centre and will be adding a nurse to help navigate low-acuity calls and identify appropriate alternative care pathways. We've redesigned our internal leadership model. We continue to listen to the valuable feedback we receive from our teams, employee unions, and others as we build our employee advisory group to help navigate the future of EMS.

The EHS ground, critical care, and medical communications programs have all been accredited and re-accredited for many years. These independent accreditations provide external validation of the high-quality care provided by our EHS clinicians. However, the EHS system is under-resourced and strained right now. We are working on solutions.

On behalf of our entire team, I want Nova Scotians to know that the EHS operations team is laser-focused on providing and ensuring the right resource for the right patient at the right time.

Thank you to all our employees for their work. They provide excellent pre-hospital care and critical care to Nova Scotians.

THE CHAIR: Now, from IUOE, Mr. MacMullin.

KEVIN MACMULLIN: Thank you, Kelly. First of all, good morning, and thank you for inviting me here today on behalf of Nova Scotia's paramedics and LifeFlight RNs. I worked as a paramedic in the field for 42 years before moving into my new role this past December 2021.

As the union representing this critical workforce, we're concerned. Working conditions continue to deteriorate with constant missed meals, shift overruns, denied vacations, extended response times, and so much more. They're mentally, physically, and emotionally exhausted. For years, we have been calling for change and ringing alarm bells on a system in crisis. I reviewed a video on Monday that was taken three years ago. It's a repeat of what we're doing today, and that's three years later. Today, the system is nearing the point of failure.

We became paramedics to help Nova Scotians. When we see calls in the queue with no units available to respond or we are dispatched from the CBRM to calls in Truro and Dartmouth - like was reported to us on December 30, 2021 - that takes a serious mental and emotional toll on our members and puts Nova Scotians at risk. How many more news articles do we need to see of stories from Nova Scotians who waited and waited and waited for an ambulance while their loved one suffered in front of them? Nova Scotians are struggling. It's time that we all work together to put an end to it.

We believe Premier Houston and this government were elected on one particular promise: a promise to fix health care. We were happy to see this government take a very important step towards that promise with the offering of a 20- to 25-per-cent raise to CCAs. That's very important to them, and well deserved. A similar increase for paramedics would do a lot to alleviate staffing pressures, in turn helping to improve working conditions. Our paramedics are some of the most highly-skilled and -trained in North America, and yet they're some of the lowest paid. It's easy to see why we are bleeding paramedics to other professions and other jurisdictions.

The time for action is now, before it's too late. Nova Scotians and our paramedics deserve better.

THE CHAIR: Thank you. Mr. Nickerson.

MICHAEL NICKERSON: Good morning Madam Chair, committee members, and fellow witnesses. Thank you for having me here today. My name is Michael Nickerson and I am a business agent with IUOE Local 727, the union that represents Nova Scotia paramedics and LifeFlight RNs. Before that, I was a paramedic for 18 years. I know the horrendous conditions our paramedics are facing on a daily basis. Mr. Daniel alluded to some of them earlier.

It's time we work together to find a solution. As my business manager pointed out, we did something similar three years ago. Enough is enough. We need to come together and work together to find solutions.

I look forward to hearing your questions and providing insight and feedback.

THE CHAIR: Ms. Sullivan, did you want to make any opening remarks?

[9:15 a.m.]

VICTORIA SULLIVAN: Good morning and thank you to the committee for having us here today. All are aware that our emergency departments have been under pressure for years. In the past 12 months, we have seen much greater strain with increasing staff vacancies and patient volumes, combined with high occupancy rates. This has been exacerbated over the past two months with the impact of Omicron COVID-19 right across our health system.

I want to begin by thanking our staff and physicians who continue to put our patients first, working tirelessly to find solutions to the challenges we have and continue to face daily. We are truly humbled by their dedication, perseverance, innovation, and teamwork. It is our privilege as leaders to work with them.

Our partners across the health sector have seen similar strain due to COVID. Our collaboration with EHS is critical to the operation of the health system in Nova Scotia and the flow of patients through the system.

The QEII emergency department in Halifax is the busiest in the province. Since the QEII is the specialty hospital for all of Nova Scotia, what happens there can affect services inside and outside of hospitals across the province. Recognizing this, we have been working with government and EHS on strategies to address the delays that see paramedics unfortunately having to wait to transfer care of patients to the emergency department.

A transition team was put in place at the QEII emergency department late last Summer. It now operates 24 hours a day, staffed now by a registered nurse and a paramedic who can support offloading of ambulance patients from EHS staff and work under the direction of an emergency department physician. A preliminary analysis showed this was having an impact. While offload times continue to exceed the target of 30 minutes or less 90 per cent of the time, in the period from September to December, data did show a 17 per cent reduction in offload time at the QEII emergency department compared to our previous two years. However, we have seen offload times increase again with the current COVID surge.

Our partnership with EHS is not limited to the emergency departments. We depend on EHS to move people between hospitals. Sometimes it’s for a consultation or procedure at a larger facility and then back to their point of origin, and sometimes it’s to bring patients who are getting more acutely ill to the facility best suited to meet their needs. We work closely with EHS to schedule and prioritize these transfers, recognizing that delayed transfers can mean beds required by admitted patients in our emergency departments are not available.

We are pleased with the success EHS has had with expanding the use of the dedicated patient transfer unit and its medical transport service pilot, expanding their ability

to transport non-emergency patients while also freeing up emergency units to provide that care in the community. EHS will also be a partner as we roll out the Nova Scotia Health command centre, an innovative approach to access and flow that will be used in predictive analytics to improve decision-making and streamline patient flow. The initial command centre will be located at the QEII. The vision is that operations will expand to Central Zone facilities within the next few months, and then scale province-wide in the future.

I want to assure committee members and the public that all of us at the Nova Scotia Health Authority and our partners have prioritized access and flow improvements across the system as a critical area of focus so Nova Scotians will have that improved access to care.

THE CHAIR: Ms. Hamilton, my apologies. I did not scroll down far enough in my list of speakers here and I missed that you have opening remarks as well.

SAMANTHA HAMILTON: Good morning and greetings from the paramedics. I think right now we're at a critical crossroads with the paramedics. We've been talking for years about all these fixes, but I think at the end of the day, our top priority right now needs to be on retention. If you don't have paramedics on the ground, I'm not sure what the contingency plan is going to be. We really need EMC and EHS to actually acknowledge that there's a problem.

I've never seen my coworkers at the state that they are right now, and there's an absolute disconnect between our management and the paramedics. We need to collaborate together and come up with some solutions, and I'm looking forward to working with everybody.

THE CHAIR: Thank you very much, Ms. Hamilton. We'll now open the floor for questions. We'll start the first round of questions with the Liberal caucus, then we'll move on to the NDP and PC caucuses, each for 20 minutes.

Just so people know, when we've reached the 20-minute mark, I'll have to interrupt and cut off questions. I just like to give people a heads up. I'm not being rude - it's just the 20 minutes is up.

We will now begin the questioning with Mr. Maguire.

HON. BRENDAN MAGUIRE: First of all, I want to thank all of our paramedics for the hard work they do. I have some close friends who are paramedics, and I understand the stress they are under. Unlike many jobs, when they go home, it's very difficult to turn the switch off. A lot of what they see and experience, they take home with them.

One of my close friends talks about a lot of his calls, he needs the police with them. He's not a small guy, but it's for his own safety. He would tell me that they don't know

what they're walking into - that they don't know the state of peoples' minds when they're walking into their homes.

Another thing he mentioned, which I really never thought about, was pets. He said that when you're walking into a house and they have dogs, you don't know how those dogs are going to react to their owners being in an emergency situation and you putting your hands on them. So a big thank you.

I do want to talk to Mr. Nickerson about - and I'll be the first to acknowledge - the well-deserved raise for the CCAs. I personalize a lot of stuff. My foster mom who passed away a long time ago was a CCA, and she'd come home with bad knees and a bad back. It was just a very difficult job. I publicly said that I applaud the Houston government for the raise. We know that the work that paramedics do are of the utmost importance here on the front line. When people are at their worst, usually the first people they see are paramedics.

Has there been any discussion with the union about - and listen, I was in government for eight years, so I'll say this - a much deserved raise? I think that raise that we saw with our CCAs should be up for discussion with our paramedics. Has there been any discussion with the government about the 25 per cent increase for our paramedics?

THE CHAIR: Mr. Maguire, that was for Mr. Nickerson, correct?

BRENDAN MAGUIRE: Or whoever wants to take it. I'm just looking at him. I apologize, and I was looking at Ms. Hamilton, so whoever wants to take that question. Mr. MacMullin?

KEVIN MACMULLIN: I appreciate your remarks about the paramedics. Yes, our paramedics are going through a terrible time in that. Yes, it's very dangerous out there today. The COVID virus has put a lot of people on edge. Our patients who we go to see now are on edge sometimes. Mental health issues have skyrocketed. We're dealing much more with those issues - in partnership with policing forces. We definitely appreciate the police forces in coming to our aid and protecting our paramedics when they're out there on the field.

Yes, we have discussed with the Department of Health and Wellness and with the employer the need to increase the amount of renumeration for paramedics. As my colleague Samantha alluded to, retention is a big issue. Recruitment, yes, that's a big issue also, but how can you recruit if you can't retain your people? We're losing people to NSHA all the time because they go there and they get paid well, and they turn around and get off on time. They get their meal breaks, they're paid for their education, et cetera. People are going out west, they're going to other services, because the money is better there. We're losing people.

In order to recruit, we really have to retain people. That means we have to turn around and bring up - we've brought up the scope of practice changing since I've been involved as a paramedic to where it is today. It's tremendous. We have highly-trained paramedics in this province who bring the ER right to your home. We bring it there. They're highly skilled and highly trained. They have great capabilities these days. Yet, although we're the top trained across Canada, we're one of the lowest-paid services in Canada. Someone has to step up to the plate and start saying, in order to keep people, we have to pay them appropriately.

BRENDAN MAGUIRE: Thank you for your comments. Just a quick Google search will show that paramedics in Nova Scotia are $15 to $20 less an hour than other jurisdictions - which, for a lot of different professions, $20 an hour is good pay. That's a considerable difference. I'm hoping that discussion happens, that you do see that increase and then you go into contract negotiations.

I wanted to ask - and we can throw this out to the Department of Health and Wellness or to the paramedics' union - about the impact that the Omicron variant has had on the service delivery, this wave of COVID. Maybe Mr. Beaton or Ms. Jensen or Ms. Sullivan can tackle this one.

It seems as if the current government - there hasn't been that kind of urgency around Omicron that we've seen in the past. We know that in January, for example, Nova Scotia sadly has seen 35 people pass away from Omicron. We saw record numbers of hospitalizations and deaths since the beginning of Omicron, yet very little information being trickled out to the public - toned-down meetings and information sessions with the public.

Since you're on the front line and your members are on the front line, I just want to know what kind of impact Omicron has actually had on our health care system. Maybe I'll throw that at Mr. Beaton.

CRAIG BEATON: There's no doubt that each wave of the pandemic has created various challenges within the entire health workforce. Specifically with Wave 4, I think the biggest challenge that we've seen with Omicron has been the impact of close contacts as well as health care workers themselves contracting the virus and therefore leading to higher numbers of staff needing to be off, which only exacerbates the issues that we've faced from a staffing perspective.

If I may, I think Charbel might be able to also add to this one. I would like to maybe pass it to Charbel for some additional comments.

CHARBEL DANIEL: I would echo the comments that Craig has made with the impacts that this has had on our workforce. Omicron, this variant of COVID, has truly been relentless. We've seen on average anywhere from 40 to 50 of our team members either

exposed or testing positive in our workforce at any given time, with people coming back and others going off. It's definitely added further strain to the system and to service delivery.

It's now starting to trend downward, which we're happy to see, and our numbers of people that we see exposed or testing positive are down into the 30s and 20s. We're looking forward to that completely going away.

THE CHAIR: Mr. Maguire, did you want someone from IUOE to . . .

BRENDAN MAGUIRE: Mr. MacMullin wants to answer.

KEVIN MACMULLIN: Yes, I'd like to address that issue too. We're finding it's impacting our service delivery as paramedics because we sometimes have up to 70 members who have been off with COVID-19 due to this new wave, and unfortunately, in the past two years, now all paramedics are being more cautious.

At one time, I used to be able to go to work if I had a cold, what the heck. Now with COVID-19, everybody's concerned so they're taking sick days. What's happened, we've found, is now they're out of sick time so they're off work with no sick days. They have to wait two or three days before they can go on short-term disability. That's causing hardship for them financially, it's causing hardship for them mentally, and on an already-strained workforce, it's making it bad. Actually, Saturday night, I ended up working because our workforce was decimated in Cape Breton.

BRENDAN MAGUIRE: Thank you for stepping up on Saturday night. It's probably the last thing you wanted to do, but thank you for doing that.

My question is to Mr. Beaton or somebody from the Department of Health and Wellness. On July 14th, the previous government announced a program to improve patient flow that had $3 million budgeted to it, and that was the patient transfer. We heard earlier - I think maybe Ms. Sullivan or Ms. Jensen said - that there has been a positive impact from that patient transfer system. It was a pilot program, one that was meant to go province-wide, so my question to you is: Where is this program in regards to transferring from a pilot project to a province-wide, and what's the holdup?

THE CHAIR: Mr. Maguire, I heard three names there. We had Ms. Jensen . . .

BRENDAN MAGUIRE: It was for Mr. Beaton.

CRAIG BEATON: Just to clarify, I think what you're referring to is potentially the off-load teams that we've instituted. There was an initiative to put in an off-load team specifically at the Halifax Infirmary, and that was predicated on a model that showed some

success at the Dartmouth General Hospital previously around helping off-load times, which is establishing a set unit of a paramedic and a nurse.

I'm happy to report that that unit has been stood up. I think I would like to ask Vicky from an operations perspective to maybe speak to the details in terms of how that rolled out over the last number of months.

VICTORIA SULLIVAN: We did get approval here, Brendan, for a pilot, and it involves two transition teams. It's a transition team to actually help offload the ambulances and a transition team to help offload into the in-patient area, which is slightly different than the other programs that have been set up. We have been challenged to get that fully staffed. I think coming out of Wave 3, we did have some significant turnover in vacancies within the emergency department at the Halifax Infirmary.

It began with paramedics at the beginning of August, and it has gradually rolled out throughout the Fall, and it is fully staffed as of January with an RN/paramedic model. The period where we've seen the reduction is from September until the end of December. Again, with the staff absences we've had directly related to Omicron during that later December into January, we have seen a reduction because obviously from the emergency department, they have to prioritize their staffing in their areas. There were some shifts obviously that we were not able to fully staff and keep everything operational.

That's where we are, and we are starting to see our staffing numbers start to come back. This is really positive news that in all of our areas will allow us to gradually transition from where we are in terms of the focus on COVID-19 and dealing with the patients coming in to be able to transition and phase into some more regular operations.

But it has had a significant impact, as indicated by Charbel as well. We have seen across the health system - EHS, our staff in the in-patient areas - we've had a number of people out of the workforce over this period of time, requiring us to redeploy staff throughout the health system to keep vital services operational.

BRENDAN MAGUIRE: Thank you for that answer. The Houston government campaigned on health care, obviously, as Mr. MacMullin stated earlier. One of the things we know is that while money is needed for the health care system, a big part of it is bodies - recruiting people and having them stay. It's clear from the union's standpoint what is needed for retention, and it's greatly appreciated that you gave us that answer, but we also have to encourage people to join the profession.

My question to Mr. MacMullin would be, how many people, how many bodies, are you going to need, or would you need to recruit, to add to your workforce to feel comfortable? I know it's a simplistic question, but right now, if you had a magic wand and you said, we need x amount of new paramedics on the street, how many would that be?

KEVIN MACMULLIN: It's a pretty tricky question. Right now we have 21 per cent of our workforce out on leave of absence, short-term disability, workers' compensation, long-term disability. If I were to take a magic wand, I would love to have something like 250 more paramedics into the system to help us, at the minimum.

BRENDAN MAGUIRE: That is a big number. That's not one graduating class, obviously. How do we get that number? Like I said, the government campaigned on health care. I think one of the things that they're really going to run into is just boots on the ground everywhere. It's not going to be easy to put 5,000 new CCAs and LPNs in the system, because we don't know where they're going to come from, honestly. It's very difficult, 250 - I'm guessing you could probably add an extra 100 onto that and you'd be pretty happy.

How do we encourage individuals to join the profession, first of all? Second of all, is there a tuition forgiveness program for paramedics?

KEVIN MACMULLIN: No, there's no forgiveness on loans for paramedics at the present time, other than if you want to take some training to become an advanced paramedic after your initially becoming a primary paramedic. You can apply to EMC and EMC will grant you funding for your education. You have to sign an agreement that you're willing to work for a specified period of time for EMC in order to work off that money that they're able to give. I commend them for that. That's excellent.

We're trying to get boots on the ground, in collaboration with the Department of Health and Wellness and the College of Paramedics of Nova Scotia and their council. We've introduced a graduated licensing program, a temporary licensure for new graduates while they're waiting to get their COPR exam written to become fully qualified. That's a great step forward. That will get us some boots on the ground, yes.

But the key part of this is, we have an exhausted workforce right now. It's decimated. If we can get that exhausted workforce more time off - I just got emails last night from people getting denied vacations. This is February, and their vacations are denied. They can't get time off to rest.

They need renumeration. They've got to be brought up to the national standards. They've got to be paid more. They've got to get some meal breaks. They're working 12-hour days at a trot, and it's difficult to even get a break to have lunch. We need to change the working conditions, and it's a long-term game. We're not saying we're going to fix this issue tomorrow. We're talking long-term, but we will not recruit people to come from other jurisdictions if the wages are a lot higher up there than they are down here.

THE CHAIR: Mr. Beaton.

CRAIG BEATON: Great question. I think it's important to note that prior to the pandemic, we were recruiting on average around almost 100 - I think in 2019, there were

about 190 paramedics that were hired into EMC. That dramatically dipped as a result of the inability to provide in-class training throughout the pandemic. Those numbers decreased to a low of less than 50 in 2020, I think, and slowly increasing back up. I think last year it was around 85 numbers in terms of recruitment, so we haven't quite got back to where we were from a recruiting perspective. We know that that is a significant challenge.

My understanding, and Charbel can probably clarify this, but I believe that (Inaudible) paramedics were just recently hired in January. As Kevin had outlined, one of the initiatives that both the IUOE and the employer, EMC, brought to us was that graduated licenses as an opportunity to provide some immediate impact and get some boots on the ground, as you've indicated.

I'm happy to also report that we have stood up a paramedic working group, which includes the members here, the IUOE, ourselves, EMC, NSHA, to look at these issues around recruitment and retention. Central to that is our new Office of Health Care Professionals Recruitment. They're also involved in this and looking at a number of strategies that we can look at, whether that's compensation, whether that's loan forgiveness, a number of pieces.

Back to the earlier comments. I think we have the right people around the table to bring forward solutions, and we're dedicated and committed to doing that. I don't know if Charbel wanted to add any more to that, but thanks for the question.

THE CHAIR: We are done with the Liberal questioning now. We will now move on to the NDP caucus. Ms. Leblanc.

SUSAN LEBLANC: I also want to express gratitude and acknowledgement of the extremely difficult work that paramedics are doing and have done forever, but are doing today even as we have this meeting. I also want to say that gratitude is just simply not enough. It's great, and acknowledgement is important, but we need real action.

I want to reiterate a couple of comments that were made earlier, that we were having this conversation three years ago at the Health Committee. I was there with my colleague at the time, Tammy Martin, who was the then-MLA for Cape Breton Centre, and we were having this conversation well before the pandemic.

I just want to read into the record a little exchange between Tammy Martin and Terry Chapman from the union at that time. Tammy asked him: "How long typically does it take to get an ambulance?" He said: "That depends on the day." I won't read everything that everyone said. "That depends on the day", but in 1997, there was a requirement in a township for a response time of eight minutes and 59 seconds from the time you pick up the phone to the time that there's a paramedic at your door.

At that time, three years ago, Terry said: "Now that could be - we have actually seen one case that I witnessed in this city that was 58 minutes." Tammy said: "Is that acceptable?" Terry said: "To me, it's not." Tammy said, "Being from Cape Breton, I have known many instances where there have been zero ambulances available in CBRM. I also know that sometimes the nearest ambulance is in Baddeck or Antigonish. If that was my family member who needed an ambulance, let me tell you, you would hear me screaming from the rooftops. What happens when I call an ambulance - God forbid - in New Waterford, and the nearest ambulance is in Baddeck?"

[9:45 a.m.]

Terry said: "You wait." Tammy said: "My loved one has just had a cardiac arrest." Terry said: "You wait with a person who will probably be non-living when they arrive." That exchange was felt quite shocking at the time, and we know that exact scenario is still happening three years later in Nova Scotia. It happened in my community of Dartmouth North this past year. It happened in Halifax Chebucto earlier, and we will maybe hear a bit about those stories later on.

I guess my point in reading all of this is that I can't believe that we are talking about how we're standing this up and we're doing this. I understand health systems are complex, but this is too much and it's too late. We have a broken system. I want to hear from Ms. Hamilton actually, because this morning we received a letter from a paramedic who describes a terrible degree of burnout, as we've heard already today, and also silencing of paramedics when they speak out about the issues that they're facing.

Ms. Hamilton, I'd love for you to tell us right now - as difficult as it may be - what it's like to be a paramedic on the ground in Nova Scotia. Also, what changes do you think we need to better support paramedics and address the burnout that you're experiencing?

SAMANTHA HAMILTON: I have never seen it like this before. The burnout is just beyond every day. If you went and talked to a lot of my colleagues fit for duty, there would be a lot of people who are on the trucks right now that really shouldn't even be there, but there's nobody else who will be there. They all know that. We all know what the system is like.

I have responded from Kentville to Weymouth - which you heard in the letter is an hour and a half - for a respiratory distress. I didn't sign up for that. We didn't sign up for somebody to be in respiratory distress and not know what's going to happen for an hour and a half, and get there and they're tired. They can't breathe anymore. We can do a lot of things, we have a lot of treatments, but everything is time-based. We have all these wonderful things that we can do. We have clot-busting drugs, but for me to get somebody to the cath lab in the city, it has to be under an hour. A lot of times we don't even get there in under an hour.

We're getting sent all over the province now. We go from one call to the next call to the next call, and there's just no time to do anything. No time for meals, no time for bathroom breaks. It's devastating to see all of my colleagues and what they're going through, and nobody wants to listen.

SUSAN LEBLANC: We know that there's a lot to unpack in the whole system issue. We know that there are root problems that are facing paramedics. We've heard about the remuneration issue, which obviously makes a lot of sense. We also know that emergency rooms are overcrowded or closed, which means the offload times are challenging. We know that hospitals are operating above capacity in many cases and that there are not enough long-term care beds for folks who are waiting for placement in long-term care who are in the hospital. We know that doctors, nurses, paramedics and all of the clinicians on the ground are burning out.

I guess I'll ask this of someone from the union - you can choose who wants to answer. In terms of the system in general, what would you say are the changes needed to better support paramedics?

THE CHAIR: Any takers from the union? Mr. MacMullin, I'll go to you first.

KEVIN MACMULLIN: The system is in failure. As you alluded to, three years ago we had the same problems and they're not corrected three years later. This goes back even further than the three years. This system was taken over by EMC and it was brought up to a higher standard. However, we're now at the stage where a number of employees that were hired at that time are retiring. Unfortunately, they're retiring rapidly and not as slowly as we would like to see, because they're now in a position where they're getting burned out and they're retiring.

We have that gap there. We're losing highly-trained, highly-experienced paramedics to retirement, and ones behind them that come on the scene are now leaving for other jurisdictions because they want to go to somewhere where the work stress is a little less for them. We haven't done recruitment fast enough to replace these people.

As Craig alluded to, yes, we tried doing this with Ontario. We brought people in from Ontario, and we were successful at only keeping a certain amount of those paramedics. They came down here, they wanted to go back home. They needed to come down to get the experience in order to work on an ambulance system up there, other than a transfer service. You can't blame them for that.

It's hard to retain employees, like I say, without the proper wage for the employees and proper working conditions. It's a system that's in failure, and yes, Craig has alluded to rightly so that we have to cooperate together to work on this - union, ground paramedics, EMC, Department of Health and Wellness, everybody. But we have to have some

immediate fixes now. We need them now more than later. The planning stages are great, that's a big improvement, but we need some action now.

THE CHAIR: Ms. Hamilton.

SAMANTHA HAMILTON: I think we just need to acknowledge that there's a problem, and we need to fix it right now. We need to get our meals; we need to be off on time. In New Brunswick they're putting them off. They have a new mandate where at the end of their shift, they're out of service. We need the same thing. We can't be going to 16 hours.

Right now, I'm a 24-year medic, and to get to 12 hours, it is killing me. It's just too much. If you're in cardiac arrest and I'm supposed to be at my prime thinking right then on my 13th hour, my 14th hour, and I'm supposed to make all these decisions about your care - you want me at my prime, not absolutely exhausted. We need to do something like that.

We need to start prioritizing the calls. We go to low-acuity calls all the time, and the dispatch system that we're using is from 20 years ago. I used to work at dispatch. I don't think there have been many changes, and it's sending ambulances to things that could be put on hold. We have a system that's a CTAS system that we use. It's from one to five, and fours and fives, when we bring them into the hospital, they will go right to the chairs. We need to start prioritizing those calls.

Very rarely do we go to a low-acuity call that ends up being a CTAS 1. The statistics are very low. Responding from Kentville to the city for a call, and I've been put on three, four calls that I never get to. A lot of them are low-acuity calls. Why am I doing that? It just doesn't even make sense.

SUSAN LEBLANC: I guess that segues into my next question, which is about the Code Critical situation. The union has done a great job of advertising when there is a Code Critical on social media and getting that information out. It's common for me to get many, many notifications, dozens of Code Critical notifications, from around the province in a week.

I'm wondering if you can talk a little bit about what is entailed in a Code Critical. What are the criteria? What does it mean for paramedics when there is a Code Critical? What does it mean for people waiting for an ambulance? Mr. MacMullin?

KEVIN MACMULLIN: Am I getting picked on here? Thanks for the question. You're correct. Code Critical is a situation where we have two or less ambulances available in a county.

Just to tie into that, I can give you some statistics. This is just from January 1st to present. We have had 247 Code Criticals. That's a lot. We're running short all the time. The Code Criticals: all the province, five; all the mainland was five; Western Zone is a hard-hit area with 88; Northern Zone, 20; Central Zone, seven; and Cape Breton has 14 Code Criticals. Those are just the ones that are reported.

SUSAN LEBLANC: When you read the numbers like that, it's quite stark, isn't it? It's really troubling.

I just want to quickly go back to the letter that we received and ask the EMC - I'm wondering if the department or EMC can commit to the questions in that letter that are asking for a provision of statistics around half-staffed or empty ambulances, hours of forced overtime, and the numbers of paramedics who are not able to access vacation time.

In many parts of the health care system, we have reporting of statistics. I'm wondering if EMC can commit to reporting those statistics on a monthly or weekly basis - maybe monthly to start. I'm wondering what your reaction might be to that, Mr. Daniel.

CHARBEL DANIEL: Thank you for that question. A couple of things I'd like to quickly address as well: there's no denying the strain on the workforce right now and the challenging work environment that exists. The paramedic profession is definitely a difficult profession, and what our teams are exposed to is by no means an easy type of atmosphere. Making sure that people get their meal breaks and ensuring that people get home on time has always been our number one priority. We are working diligently on a shift-end mitigation process.

We do collaborate with our partners in other jurisdictions. As Ms. Hamilton alluded to, we know that New Brunswick had tried to do a shift-end mitigation process where they were ensuring people were getting off at the end of their shift. However, that was unsuccessful. It only lasted for a few days, and they had to retract that process because they couldn't maintain it and they couldn't sustain that process. We are working on the foundation to ensure that we can do that in a safe and efficient manner for both our staff and Nova Scotians.

Going back to the question at hand, these statistics are things that we do track and do collect, and we do share them with the Department of Health and Wellness. I would have to pass this question off to Craig to respond to.

THE CHAIR: Mr. Beaton.

CRAIG BEATON: We do collect a number of stats. We would have to look at what specific stats - I don't have the letter that you're referring to, Ms. Leblanc. I would have to look at what those stats are and see what we can come up with.

I think one of the important things that I would outline is that with the new contract with EMC, one of the things we are committed to is increased transparency. We will be producing a yearly EHS report as a result of that. Perhaps those stats could be incorporated into that report as well.

[10:00 a.m.]

THE CHAIR: Mr. Nickerson and then Ms. Jensen.

MICHAEL NICKERSON: To Mr. Daniel's point about New Brunswick and their shift in mitigation policy, the other day when I spoke with my colleagues in New Brunswick, they actually informed me that policy is still in place today - just for the record.

JAN JENSEN: We do a fair amount of reporting between EMC and EHS-DHW, certainly in terms of all sorts of different aspects of the organization and the operations for EHS operations. I'm sure that this is something that we could collaborate on as well.

If permissible, Madam Chair, I wouldn't mind looping back around to the excellent point that Ms. Hamilton brought up about low-acuity calls. If we could just return to that - the processes that we use within the provincial EHS medical communication centre and some of the steps we're making moving forward in terms of call management for lower-acuity callers.

As Ms. Hamilton mentioned, and as is experienced, our medical communication officers use a very structured internationally-accredited call screening process for all emergency calls that come in through 911, and the medical calls that come through to our EHS medical communication centre.

The communication officer walks with the caller through a process to identify what's wrong with the patient and the acuity of that patient. Indeed, there are opportunities for alternative care pathways for lower-acuity EHS patients.

Right now, when we have longer response times, our advanced care paramedic who is in the com centre, along with our medical communication centre physician, will call those patients back and do a clinical check-in with them. We are moving forward with government support on implementing a nurse within the medical communication centre. That clinician's role - and we're very much looking forward to it - is also to use a structured program and for our lower-acuity EHS callers.

We'll be walking through to do additional clinical assessment with them and identify all . . .

THE CHAIR: Order. The time for the NDP questioning has elapsed. We'll now move on to the PC caucus, starting with Mr. Young.

NOLAN YOUNG: Thank you everyone who is joining us here today. Before I begin, I'd like to thank all the paramedics for the high-quality care that they provide Nova Scotians each and every day and acknowledge their hard work and dedication. I know a lot of paramedics in my county, and personally I'd like to extend that thanks, sincerely, for your service.

As this is a backward-looking committee, I'd like to talk about policies that were rolled out. My first question is: What positive impacts on the system do you anticipate with the announcement of a new temporary graduate license that will allow paramedic students to work in their field sooner? Could you see this also helping with recruitment and retention? To Mr. Beaton or Mr. McMullin.

THE CHAIR: Mr. Beaton.

CRAIG BEATON: I can start. I'm happy to pass over to my colleagues as well. As we talked about earlier, the immediate impact will be to have those graduates - who typically have to wait a few months to write their proper exam before they can actually practice - working side-by-side with a fully-licensed paramedic. There are obviously benefits to that of them getting first-hand training, but also increasing workforce immediately upon their graduation, and really getting them into the Nova Scotia experience. Maybe Charbel might also want to answer, as well as Kevin.

THE CHAIR: Mr. Daniel.

CHARBEL DANIEL: Just to put into perspective the timelines and the impacts that this will have. Previously, graduates could wait up to three months after finishing their paramedic program to write the COPR exam. Upon completing the COPR exam - it's usually about 12 weeks to receive the results of that exam - after both of those timelines have been met, they can apply for employment and go through the onboarding process. We were seeing a delay of almost potentially up to six months after classes graduate before we can actually recruit those graduates.

With this new announcement - and I've been working closely with the union and DHW and the college on this - we're excited about the implications and that ability to recruit sooner. Any additions that we can do, anything we do on the recruitment side, will help ease the strain on the entire workforce that exists today.

THE CHAIR: Mr. MacMullin.

KEVIN MACMULLIN: From the union perspective, yes, we were very pleased to collaborate with Craig and the Department of Health and Wellness and with EMC and the college in regard to this.

As Charbel noted, it gives these people who are graduating from classes a chance now to get right into the workforce and keep their skill level up. Before, they could be anywhere from six months to nine months - some even a year - before they get into the workforce, and then they're a little bit rusty. They're nervous. They don't get a chance to get that experience that they're going to get now by getting a temporary licence.

It's a process that's been accepted in other jurisdictions, as well as in the RN field here in Nova Scotia, so we're very happy to have that. It's definitely a help, but we definitely do need more help. That's for sure.

NOLAN YOUNG: Thank you. I'll pass it to my colleague, Ms. Sheehy-Richard.

THE CHAIR: Ms. Sheehy-Richard.

MELISSA SHEEHY-RICHARD: I also want to say thank to the hard-working paramedics across our great province. I feel in my heart - it's hard not to choke up as I speak to you today. I also want to help them work on getting some solutions and immediate impact.

Ms. Sullivan, I was going to go back to the offload times. I'd kind of like to think that the health care system may be like the chains of a bicycle, where they all connect together. With the recent announcement for the construction projects for more long-term care beds across the province, as well as the higher pay for the CCAs, could you speak about how developing the capacity for care for Nova Scotians outside the acute-care system would benefit our emergency services?

Do you expect that as we get these acute-care beds operating again in our long-term care, that should have a good impact or improve our offload times?

VICTORIA SULLIVAN: That's a great question. You're right: from an acute-care perspective right now, we do have over 400 clients across Nova Scotia health facilities who are waiting for long-term care. We have been working with our Department of Seniors and Long-Term Care colleagues, and you are absolutely right. The initiatives the government has recently announced with some of the recruitment strategies - increased wages for continuing care, working with our Seniors and Long-Term Care colleagues to be able to open that closed capacity - will make a big difference in terms of being able to appropriately move those individuals to where they get the care they deserve. The additional capacity will also help meet some of the growing demands.

In addition to that, through some of the special programs and other programs that EHS offers, we are able to focus on trying to keep certain individuals out of the hospital. For many, that is a much better plan, to be cared for at home - for example, someone requiring palliative care - or supporting people to go home with Home First. There have

been some augmentations to Home First around some additional funding to support families to look after their loved ones at home, which is facilitating some discharges home.

We do expect, as the long-term care sector opens up, that we will free up the acute-care capacity and that will help overall flow from a system perspective. I think what we know is that flow - keeping people in the community, flow through the hospital, or sending people home to the community - it's critically important that the whole system is working together. Our partnership with EHS and with Seniors and Long-Term Care to look at initiatives will actually help that. It is critically important.

MELISSA SHEEHY-RICHARD: Thank you, Ms. Sullivan. As this is quite a topic for all of us, impacting all of our communities, I want to give my colleague Mr. Ritcey a chance to ask questions as well today.

THE CHAIR: Mr. Ritcey.

DAVE RITCEY: I too would also like to thank all the paramedics and health care workers right across the province for all that you do to keep us safe and healthy, so thank you so much.

My questions are directed to Ms. Sullivan or Mr. Beaton. Our government has expanded access to virtual care for Nova Scotians waiting for a family doctor to ensure everyone has access to a form of primary care while recruitment efforts are enhanced. Are you able to quantify for us the number of lower-acuity emergency department visits that could be seen in a primary care setting? Also, could you touch on the anticipated benefits that the virtual care pilot expansion will have on reducing the strain on emergency departments that are at or above capacity in Nova Scotia?

VICTORIA SULLIVAN: I don't have the specific data in terms of the number of emergency visits it will avert. What I can tell you from a VirtualCareNS perspective, the pilot originally started from Need a Family Practice Registry in Northern and Western Zones. It has now, in mid-December, rolled out to Eastern Zone as well as Central Zone. It is now rolled out. Invitations were issued from the Central Zone and Eastern Zone in the middle of December.

There has been good uptake. They did focus those invitations on the areas in specific zones where the largest number of people were on the Need a Family Practice Registry. For example, in the Central Zone it would have been in the Chebucto area. Those invitations have gone out. We have gotten good uptake in terms of people who do need to be seen, and a certain number of those patients are requiring in-person visits.

We do see and we know a certain number of people were coming to emergency departments because they didn't have access to a primary care practitioner, so that is one avenue. The other pilot taking place in February that's being supported as well through

government is a virtual pilot that will happen in Northern Zone in the Truro hospital. For people coming in who are of a lower acuity level, they will be offered the opportunity to have a virtual visit. We do see that will help with the wait times for those people, but also free up some space there. That is coming up in the middle of February, I believe is when that's scheduled. Based on that proof of concept, we hope to be able to expand that out further.

There are lots of initiatives looking at how we can improve access to primary care that could potentially move people out of emergency departments to more appropriate settings of care.

THE CHAIR: Mr. Beaton, did you want to add anything to that?

CRAIG BEATON: I think Vicky covered most of it with the virtual care. The one thing I would add is about one third of all emergency calls are actually treated by paramedics. That prevents them from showing up to the ER - many of those would have been four and fives. I think that's a real benefit of our system.

As Kevin and others have talked about with the scope of practice with these highly-trained professionals, the ability to treat emergencies and prevent them from showing up is something that we continually look at - to try and prevent them from actually coming. I believe the stat is, and Dr. Travers can probably speak better to this in terms of his clinical oversight - I think it's about only five per cent of those who are treated on site by those paramedics have an instance of having to show up for a follow-up. I think really good stats to showcase the professionalism and the abilities of our paramedics.

THE CHAIR: Dr. Travers.

DR. ANDREW TRAVERS: Mr. Beaton is correct. It's an important metric for the committee to understand that one in three emergency 911 calls are not transported to the emergency department. That is a number that's been there for years. It's been very stable at that, so not all 911 calls need to be an ambulance transfer to an emergency department. An alternative pathway can be created, and we're building those pathways in partnership with the Nova Scotia Health Authority.

It's very important to understand that we need to make sure there's quality and safety for that patient, so for those patients who are not transferred to the emergency department, when we follow up with them, only 5 per cent of them relapse back to a 911 call. I think that's a very good measure that it's a safe program and safe measures that paramedics are doing. Of those who relapse back, that 5 per cent, only one in eight of them are actually sick in terms of requiring a time-sensitive element to their care.

[10:15 a.m.]

Regardless of those cases, we always do deeper dives on those to make sure we can learn lessons from it. Again to summarize, one in three 911 calls are not transported to the ED, and by proxy, that's analogous to virtual care for these patients.

DAVE RITCEY: Thank you to the witnesses answering my questions. This again goes back to Ms. Sullivan and Mr. Beaton. Could you talk to us a bit more about telehealth and the 811 service, particularly its impact in helping alleviate this capacity problem, if at all?

THE CHAIR: Ms. Sullivan.

VICTORIA SULLIVAN: I would defer to Craig to speak to 811. I do know that that during the pandemic and throughout this period of time, we have offered the ability for virtual visits that have increased and supported people's access. That has primarily not only been in primary health care, but I know that we've offered some wellness programming and other programs through virtual, as well as access to some specialists - appropriate visits that could be done virtually, as opposed to in person.

THE CHAIR: Mr. Beaton.

CRAIG BEATON: Yes, 811 continues to be another toolkit that we have in terms of accessing and getting patients another opportunity to call in and use virtual care in a different way. It is a different process from what we set up with VirtualCareNS.

I think we've had a great relationship with 811 over the years - the ability to provide care to patients, particularly throughout the pandemic. The amount of changes that they've been able to do to be able to support not only notifications and information for the public around proof of vaccine, but also vaccine bookings - they've stood up a number of times for us. We've had as high as 9,000 calls a day through 811 at the peak, and they've been able to handle that very well.

DAVE RITCEY: Again, thank you to the witnesses for the answers. I'm going to pass it on to my colleague John MacDonald.

THE CHAIR: Mr. MacDonald.

JOHN A. MACDONALD: I do want to thank the paramedics and all the first responders. I'm fortunate that in 10 years of volunteering, I've worked with a lot of paramedics, and yes, they definitely deserve more than what they're getting.

To get a better understanding of the call volumes in regard to emergency transfers - or actually, all patient transfers - I'm wondering, how many are we getting for this and

will the new patient-transfer process that's been rolled out do any benefit? I was thinking it was going to be Mr. Daniel, but I see Ms. Jensen put her hand up.

JAN JENSEN: You aren't wrong, Mr. MacDonald. I will end up passing it over to my colleague Charbel to speak to this as well.

EHS does provide a critical function within the Nova Scotia health system in terms of patient access and flow with EHS transfers. We're in the vicinity of 150 to 220 transfers per day. About 30 per cent of our overall EHS call volume are transfers. Those are movement of patients to, from, and within the health system or between the different hospital sites.

Regarding your question about the impact of increased transfer resources or medical transfer service and increased number of patient transfer units, one of our main goals with that was to ensure that more transfers are facilitated by those units rather than by emergency paramedic crews. In January of this year, about 62 per cent of our transfers were managed by emergency paramedic crews, and that's now dropped to about 36 per cent or so. How often we're on time at the time that the transfer is requested has increased from the low 70s up into around 82 per cent or so.

We'll continue striving and working closely with the Nova Scotia Health Authority on patient access and flow, patient prioritization, coordination. Certainly, the command centre that Ms. Sullivan spoke about earlier is going to help significantly with coordination between Nova Scotia Health and EHS. We implemented a screening software system in our communication centre in July to screen the transfer requests in a particular way to accurately identify the patient needs for those transfers, and how urgently those transfers are needed.

We have approval to move forward with a system to move from what right now is largely transfer requests phoned in to the communications centre. We're going to be moving toward an online system where any requester - family member, the patient, the hospital, clinician - can book it online, receive live-time updates to any changes to it, and more use of artificial intelligence to help increase efficiencies. Some things coming down the pipe in terms of transfers that are going to be quite helpful.

Charbel, I'll pass it over to you, if you have anything you'd like to add from an operational perspective.

CHARBEL DANIEL: As Jan alluded to, there's been a lot of increased efficiencies on the patient transfer side of things that I'd just like to speak briefly about - how we were able to accomplish these.

As we spoke about earlier, there was the introduction of our medical transport service early last year, which at the beginning of last year did not exist. We started with a

pilot of three of those units and have since increased that to 10 of these units across the province. These units are able to transport between six to seven patients, non-critical ambulatory patients, that are spread out across all regions of the province.

Moreover, some of the stresses that we see in the system and the call volume that land on our emergency ambulances, we've been trying to find capacity to move some of the transfers off, as Jan had spoken to, and move that into our patient transfer services.

Late last year, we saw the expansion of the patient transfer units which had introduced a new role into that area - called the transport operators - which allowed us to increase the capacity of our patient transfer units by twofold, 100 per cent. This year, we're further expanding this service and looking at our multi-patient transfer services and using the same type of strategy to increase that capacity across the province as well. We're looking forward to more efficiencies and also being able to remove more of that patient transfer capacity off of the emergency ambulances.

THE CHAIR: We have about 30 seconds left, Mr. MacDonald.

JOHN A. MACDONALD: I don't think I can say anything for less than 30 seconds, so thank you.

THE CHAIR: We'll now move on to our next round of questioning, which will be short. Each caucus will get an additional three minutes. Mr. Maguire.

BRENDAN MAGUIRE: I don't think I can say a full thing in three minutes. (Laughs) I'm just joking.

My question is to Mr. Beaton. We've seen Code Criticals - we've seen the union do a very good job to Code Criticals. We've heard here today how they are feeling and how their members are feeling. I feel like there's a bit of a disconnect, and I'm not blaming one side or the other. I feel like there's a bit of a disconnect. What is your opinion on the Code Criticals, and what is causing this disconnect between the employer and the employee?

CRAIG BEATON: I think in terms of the relationship with the employer, I would turn that over to Charbel. To answer your question, as we said earlier, there's been a lot of strain in the health system, as we know. Everybody is tired, including paramedics on the front lines. They've been through quite a bit over the last two years, and we're asking more of them each and every day throughout this.

In terms of the actual employee/employer relationship, I know that EMC is dedicated to doing that. They have a number of new initiatives, including an employee advisory group that they've just recently started screening. Maybe I could ask Charbel to speak to that.

CHARBEL DANIEL: As Mr. Beaton alluded to, there's the formation of our employee advisory committee that has started and will have the input and co-lead of Dr. Ron Stewart as well. Our goal with that is to have representation from all of our frontline paramedics to provide input into our operations, different areas that we can continue to improve and enhance, and provide a pathway for direct input from our frontline teams.

Above and beyond that, we also do host bi-monthly town hall sessions. We have great turnouts at those; 300-plus attend these from our entire workforce. That is an open venue for us to talk about initiatives that we're working on, along with a Q&A session to answer any questions. This is of course above and beyond regular communications - the opportunity to directly email any of us through different venues, or simply just to reach out directly. Our doors are always open and we're heavily focused and we're always listening to feedback from our team.

THE CHAIR: Mr. Maguire, very quickly.

BRENDAN MAGUIRE: I just want to say thank you to everyone for being here today, along with the paramedics, the dispatch operators, all of them. It's a very stressful job. Right next to my office was a paramedics depot, so I saw first-hand every day what they were going through. Also, to the staff at Public Health . . .

THE CHAIR: Order.

BRENDAN MAGUIRE: I was going to thank them too, so thank you.

THE CHAIR: We'll move on to the NDP caucus. Ms. Chender.

CLAUDIA CHENDER: I know I only have a couple of minutes. I want to echo the thanks you heard from everyone on the committee, but I do want to ask a specific question. I'd like to put it to both the IUOE and the department, but I think I'll stick to the IUOE, given the exigencies of time.

As an MLA on the media list for the Nova Scotia Health Authority, I get notices of emergency room closures more than any other single piece of email. Emergency rooms are closed all the time, and those closures have increased year over year for a decade almost. It's not just Omicron. My question is: What is the specific impact of those closures on the issues that we're discussing today? I don't know if someone from the IUOE would like to take that on. I'd love to hear what the experience of that is on the ground.

THE CHAIR: Ms. Hamilton.

SAMANTHA HAMILTON: My experience with it is I actually work out of Middleton, and Middleton is closed and has been closed for a long time, so it just increases our time for our calls. A lot of the time, when Middleton is closed, Digby is closed as well.

That just expands our area to just a huge area. We normally have to go to Valley Regional then or to Yarmouth Regional, which is quite a distance. Now your call time that you're in the back of the truck with people is a lot longer, your treatment time is a lot longer, and then that's less ambulances for people in that area.

There are a lot more Code Criticals now, and it's beyond the point of being a Code Critical, because I go into work and it's a Code Critical when I start my shift. Every day is a Code Critical now in my area. That's my exposure with the closures. It's really impacting our work.

CLAUDIA CHENDER: With the remaining moments, maybe NSHA could comment briefly on what's contributing to the ongoing closures of emergency departments across this province, particularly in rural Nova Scotia, as we just heard.

THE CHAIR: Ms. Sullivan.

VICTORIA SULLIVAN: The emergency room closures are directly related to staff and physician availability in terms of being able to keep them open. I think from an overall perspective, that has been an ongoing challenge. In our small rural sites, the emergency rooms are staffed by family physicians or primary care practitioners . . .

THE CHAIR: Order. The time for the NDP questioning has elapsed. We'll now go to the PC caucus. Mr. Boudreau.

TREVOR BOUDREAU: Just like the rest of my colleagues on this committee meeting, I certainly want to extend my gratitude and thanks to the medics and emergency staff that play a role. In my riding in Richmond, and all of Nova Scotia, not only are paramedics leaders in emergency care, but they're also a huge volunteer base and support in our communities. I can tell you that a lot of my friends are paramedics who go above and beyond not just in their profession, but in volunteering their time in our communities. I want to extend that thanks.

I do have one question that I'd like to ask, and maybe I'll put it toward Mr. MacMullin and Mr. Beaton, and anybody else who wants to answer. Yesterday our government announced an important safety upgrade with an additional $3.5 million in funding for new power stretchers and loaders in ambulances. Can you expand on the details of this announcement - maybe, Mr. Beaton - and how it will benefit paramedics and the system more broadly?

CRAIG BEATON: Sure, thanks for the question. Yeah, yesterday we were pleased. That was one of the recommendations that was outlined in the Fitch report for injury prevention, and we know that a large number of injuries that paramedics are facing are musculoskeletal. This is an opportunity to ensure that they have the right equipment in those vehicles to ultimately negate some of that.

I'm happy to report that all of the - it was previously half, but this new announcement will now ensure that there are outfitted power loaders and power stretchers in all of our ambulance units. This is not only helpful for paramedic injury prevention, but also for patient safety, as well, in terms of enabling those lifts.

[10:30 a.m.]

THE CHAIR: And the time for the PC caucus is now elapsed. If anyone has a closing statement, we can go to those now. Mr. Beaton.

CRAIG BEATON: No closing statement. Just want to thank the witnesses and the members here for the opportunity to speak to this. I appreciate everybody's time.

ANDREW TRAVERS: Folks, just that February is Heart Month, and I think it's an important thing to recognize that despite all the concerns that communities may have about ED closures and delayed response times, we have had a lot of successes. Everything we do as physicians, nurses, the emergency department, the department of ambulances, for cardiac arrest, for example, is paled by what a bystander can do if they have access to an AED.

I think we should be proud: we've got 1,586 AEDs registered in the province, we have four 24-hour public SaveStations, and those are growing. We anticipate there's going to be more AEDs in communities, and it's exciting that every Nova Scotian that calls 911, that our teams are able to provide the direction toward AEDs, as well as providing CPR instructions. We have challenges before us, but I'm excited to make Nova Scotia even more of a heart-safe community across the province.

THE CHAIR: Mr. Daniel, do you have a closing statement?

CHARBEL DANIEL: I'd just like to thank the committee members for having us here today. I also want to recognize and continue to thank our frontline team members for all of their hard work and contributions and sacrifices that they make on a daily basis, especially during this pandemic where they were very quick to put their capes on and step up as the health care heroes we so desperately needed. Thank you.

THE CHAIR: Ms. Jensen.

JAN JENSEN: Yes, thank you very much. On behalf of myself and Charbel, and all of EMC/EHS operations management, we do want to thank you, the Chair and the members, for inviting us here today to have this discussion. Certainly, the opportunity to discuss the challenges that are facing the EHS and the greater health care system right now, but even more importantly, the focus on improvement as we advance our system into the future to meet the needs of Nova Scotians.

Also, just want to take a moment to say to the EHS paramedics, com officers, nurses, physicians, and all of our teams, we do hear you. We're listening to you, and we want to thank you. You have worked tirelessly to provide quality care and services, and to be there when Nova Scotians need you. I'd like to thank you, as well, and thank you very much, again, for the invitation to be here today.

THE CHAIR: Mr. MacMullin.

KEVIN MACMULLIN: Thank you very much for inviting us, as the union representing paramedics in Nova Scotia, to have this conversation. I think it's an important one. We need more collaboration with the Department of Health and Wellness, with EMC, and CPNS, and we're doing so.

There are positive things, but, also, we cannot forget that in that time frame I gave you, from January to now, there were 255 missed lunches. There were 182 shift overruns. That's people who are not getting home to see their children to say goodnight. That's time lost that's never coming back. We need help out there now. I can't thank our paramedics enough for all they're doing every day, on every shift. I can't thank them enough, but we need to step up to the plate and help them now.

We're helping them with some collaborative initiatives now with new power load stretchers - that's great. The fact that we've got a graduated license system with temporary license, that's great, but we really do need help for our paramedics out there. They're virtually hanging on by their fingertips.

THE CHAIR: Mr. Nickerson.

MICHAEL NICKERSON: I don't really have any closing remarks other than as legislators, please heed our warnings that we mentioned today. I would like to recognize Mr. MacDonald: I totally agree with you that paramedics need to be paid more, absolutely. They're doing their best every day, day in, day out, but they're struggling, as Ms. Hamilton and Mr. MacMullin alluded to earlier. I don't think any of us are naive enough to think that there aren't problems out there. When paramedics have to call in sick after their shift just so they can go back to their home base, there are major problems and issues within the system.

THE CHAIR: Ms. Hamilton.

SAMANTHA HAMILTON: Thank you so much for inviting me. I really hope that you will take some time and really go over the letters that were sent in. We desperately need your help. All my colleagues - everybody has an exit strategy right now, and if there are no paramedics, I'm not sure what's going to happen.

We're beyond Code Critical - we're at code disaster. I'm willing to work with anybody and I'm willing to work with our leadership to change the culture. If you need any more information, please reach out to me. I will meet with you.

THE CHAIR: Ms. Sullivan.

VICTORIA SULLIVAN: From the Nova Scotia Health Authority, I just want to clearly thank you for the opportunity to be part of this Public Accounts Committee session. I also just want to stress, from a Nova Scotia Health Authority perspective, our partnership and collaboration with EHS is critical to the operation of the health system in Nova Scotia and the flow of patients throughout this system.

From the Nova Scotia Health Authority, we are continuously trying to work toward change and improvements to address the challenges in our health system and we'll continue and commit to do so. I think the recent announcement with respect to the command centre is a good step forward, and our working relationship with DHW and EHS and our other partners - looking at opportunities to improve access to care across the health system for Nova Scotians. Thank you very much.

THE CHAIR: I'd like to thank all of our witnesses here today. You may now leave the meeting, you're free to go. We are going to conduct committee business now, so you don't need to hang around for that. Thank you so much for coming and spending time with us and informing us.

Now we'll move on to committee business. We have correspondence from Mr. Young to the Chair dated February 10th and my response about the committee minutes, but I did indicate to Mr. Young that we could discuss the issue going forward. We wouldn't have been able to do it today with the physical distancing requirements that are still under way at the House. Does anyone have anything they would like to say on this particular matter? Mr. Maguire.

BRENDAN MAGUIRE: Can you just read the motion so we're clear on what it is?

THE CHAIR: There is no motion at this point. This is a matter for discussion. This was about Mr. Young's letter to me wishing that today's particular meeting would take place in person, but because of the number of witnesses, we would not have been able to do that and still have the proper physical distancing. That is what the letter was about. Mr. Maguire.

BRENDAN MAGUIRE: Going forward, what I'm trying to understand, there are two questions that I have around this. One is, I think the original motion - and maybe this is something Mr. Hebb could talk to us about. I think the original motion to go virtual was that we would revert back to in-person meetings with the direction of Public Health.

I'm wondering, was there any direction from Public Health to this committee to go back to in-person meetings? It seemed like the original motion - and that was my argument, originally - was that it took the authority out of the committee's hands to make this decision. It was something I argued with this committee. Now Mr. Young is trying to put a motion forward to make that decision, which I guess is contrary to the original motion. That's my first question.

My second question is that . . .

THE CHAIR: Excuse me, Mr. Maguire. I'm just going to interrupt for a minute.

Mr. MacMullin, you're no longer required for the meeting. You can leave. Thank you so much.

BRENDAN MAGUIRE: Unless he wants to hear all the boring stuff.

THE CHAIR: Unless he wants to hear all the boring stuff, yes. Mr. Maguire.

BRENDAN MAGUIRE: So that's my first question. My first question is that the original motion said we couldn't go back to in-person unless directed by Public Health. That was something that I argued in this committee. Are we just throwing that motion that we voted for out the door now?

Secondly, my other question is around what happens if we get into another situation like today, where we have more witnesses than Public Health deems that we can have in one room together? Are we just going to switch back and forth between virtual and not, or is that something we're going to have to vote on every single time?

THE CHAIR: I will come to you, Mr. Young - I do see your hand up.

I do believe it was about Public Health direction, and I do believe that referred to the number of people allowed in a certain space in terms of physical distancing and that kind of thing. I think that's what the motion referred to, but I could be wrong. Perhaps the clerk could just see if we can find what the particular motion was.

I will go to Mr. Young.

NOLAN YOUNG: Madam Chair, Dr. Strang would have released our province's reopening plan this week. It allows for increased gathering limits beginning on Monday, February 14th. Based on Dr. Strang's guidance and following Public Health protocols, it appears safe and appropriate for the PAC committee to resume meeting in person.

To Mr. Maguire's point, it was another committee I was in yesterday, Veterans Affairs, where we talked about the amount of people who would be able to be in a room at

a time for witnesses. There was some discussion around the possibility of a hybrid format for the witnesses, if need be. I guess that would be a discussion for this committee.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: We in the NDP caucus are prepared to start meeting in person. I think we should put a motion on the table, and I can do that, if you want.

I move that, given that Public Health - we're now in Phase 1 of the reopening plan - that the Public Accounts Committee resumes meeting in person.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: There are a few questions on the floor. Before we vote on this, I'd like some answers. Ms. Langille's looking for the original, and I'd just like to hear the original motion that was on the floor that we passed.

Secondly, I agree that we should start meeting in person, but I will note that this past month was the worst month for COVID in our province's history. There were 35 deaths. This month, we're tracking to have an even worse month unfortunately. As of a couple of days ago, we were at 19 deaths. We just heard from the paramedics and from the Department of Health and Wellness that the health care system is strained. I would like to note that is something that we need to take a look at also.

I'm glad that we're meeting in person. We have very little information coming out about COVID-19, and that's one of the disturbing things for us, for me personally. We have a Premier who's very seldomly meeting with the public; he'd rather be on Oak Island or whatever - that show there - instead of giving us statistics and numbers. When we were at an all-time high for deaths in this province, instead of holding a press conference to discuss that and to comfort Nova Scotians and have a direction put forward, he decided to go on a TV show and smile for the cameras. A lot of Nova Scotians were extremely offended by that, that while they're searching for answers on COVID-19 . . .

DAVE RITCEY: Point of order, point of order.

BRENDAN MAGUIRE: No, no. Madam Chair . . .

DAVE RITCEY: Mr. Maguire, talk to the relevant question. Madam Chair, it's a point of order.

THE CHAIR: Mr. Ritcey, Mr. Maguire has the floor.

BRENDAN MAGUIRE: Thank you. That is not actually relevant, what he said. I'm actually talking about it. I'm talking about COVID-19, which is exactly what this motion is for.

[10:45 a.m.]

I would like to see us meet in person, but I think we need to have options in place on this motion to put the safety of, more so I would say, the witnesses than the members. I do know that there are members of Public Accounts Committee that have family members that they live with that are at high risk. Let's be honest, they're at high risk, and I just would like to see the current government take this issue more seriously and be able to inform the public.

As I stated earlier, January, by all measures of COVID-19, was the worst month in this province's history for hospitalizations and deaths, and we had a Premier that spent 20 minutes in front of the public discussing it, and an hour on TV smiling for the camera. I would just like to know what that original motion is from Ms. Langille. If she could give that to us, that'd be great.

THE CHAIR: I believe that Ms. Langille is still looking for it, with her apologies. Mr. Young.

NOLAN YOUNG: I believe there's a motion on the floor currently, and I know our Liberal member needs all the time to talk about those important topics right now with the Public Accounts Committee. However, we've always taken guidance from Doctor Strang, the same as the Liberals have taken guidance from Doctor Strang. With that said, there is a motion on the floor that we'd be prepared to vote on. I'd like to call the question.

THE CHAIR: Mr. Ritcey, you had your hand up as well?

DAVE RITCEY: I'd just like to put the motion on the floor, as well.

THE CHAIR: We have the clerk to speak, and also Mr. MacDonald. Ms. Langille.

KIM LANGILLE: The previous motion, was, "I move that the Public Accounts Committee follow the lead of other committees and move virtually."

THE CHAIR: There was no direction there about Public Health direction changing. Mr. MacDonald.

JOHN A. MACDONALD: Madam Chair, I was about to let the Clerk know where it was, but she caught it already. Thank you.

THE CHAIR: Thank you. Mr. Maguire.

BRENDAN MAGUIRE: I see Mr. Ritcey reacting. I do have the floor and I'm allowed to speak, and that's all part of the democratic process here in Nova Scotia. What I would like to say is that while I agree with the motion, I think we have to have language in it in case we get back into a situation where we have to go virtual, or we have to accommodate witnesses.

Some of the confusion - and I'm not trying to waste time here. I really mean this - like Mr. Young had stated earlier that maybe doing something virtually if we have too many witnesses, and things like that. If Mr. Young could just add something like that to this motion, I'll gladly vote for it. But I think we have to be able to accommodate people that are in a situation where maybe still meeting publicly and taking it home could impact their health and the people around them. Also, if we're going to go over the potential gathering limits.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: The clerk just read the previous motion, and this motion obviously goes against that motion - and that's fine. We can put motions on the floor that contradict previous motions - that's the way it works. If it happens in the future that we get into another wave, or we have too many witnesses for the gathering limits, we can put a motion on the floor and fix that issue.

I would respectfully say that this is a bunch of time-wasting. It's exactly what the Public Accounts Committee should not be doing, which I will bring up further if we ever get to my motion in this meeting. I say we just vote on this motion. It's a very simple thing to do.

THE CHAIR: Ms. Langille.

KIM LANGILLE: I just continued to review, and that was a motion that was put forward, but that was not the motion that Mr. Young put forward, so I'm still trying to find it. I'm sorry.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: I would like the member for Dartmouth North to retract that statement. I've heard her talk at this committee many times, and I don't appreciate her saying that my concerns about COVID-19 and gathering limits is a waste of time. I think it's extremely disrespectful for someone to say that, and I would appreciate if that statement was retracted.

I'm still waiting on Ms. Langille's statement. I've told all of you that there are concerns. Mr. Young had concerns, and I'm just following up on that.

THE CHAIR: I think we have a motion on the floor, so I would ask Ms. Leblanc to read her motion so we all know what we're voting on and we don't have any confusion. Ms. Leblanc.

SUSAN LEBLANC: I move that going forward, we begin meeting as the Public Accounts Committee in person.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: Ms. Langille had her hand up first and then I'll go.

THE CHAIR: Ms. Langille.

KIM LANGILLE: I found it - my apologies. The motion was that the Standing Committee on Public Accounts move to a virtual format until Public Health recommends otherwise, and that motion was carried.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: Do we vote on this first, or is it possible to put an amendment to it before we vote?

THE CHAIR: When there's a motion, it belongs to the House. You can't withdraw it. You can't revise it either . . .

BRENDAN MAGUIRE: No, the current one.

THE CHAIR: I understand. In terms of amendments, members vote twice, first on whether to amend the motion and then on the motion itself. A member could propose an amendment to the motion, we would discuss that, and we would vote on whether to accept the amendment. Then if we accepted to vote on the amendment, then we would move on to the amended motion, depending on whether it passed or didn't. Mr. Maguire.

BRENDAN MAGUIRE: I just want to put a quick amendment on the floor. I'm actually not going to talk about it so we can get this vote through. My amendment would be that if we do know that witnesses are coming forward and how many there are going to be, that we vote previously, maybe the week before via email to ensure that if we need to go virtual, we can so that it doesn't take up committee time. My amendment is looking at the witnesses list, if we know it's over capacity, that we vote beforehand via email so that it doesn't take up committee time.

THE CHAIR: Mr. MacDonald.

JOHN A. MACDONALD: Madam Chair, with the word vote - that means majority, not unanimous, correct?

THE CHAIR: That is correct. Ms. Langille.

KIM LANGILLE: If it's done by email poll, it has to be unanimous.

THE CHAIR: Mr. Young.

NOLAN YOUNG: We will be supporting Ms. Leblanc's original motion. Just wanted to state that.

THE CHAIR: We have an amendment on the floor. We're not going to have any further discussion, is my understanding, on the amendment. I'm now asking members to vote on whether to accept the amendment.

BRENDAN MAGUIRE: Recorded vote.

THE CHAIR: We're just voting on whether to amend the original motion.

BRENDAN MAGUIRE: Recorded vote, please.

THE CHAIR: Yes, I heard that, Mr. Maguire.

Ms. Langille will call the role. This is whether or not to amend the original motion to include the possibility of an email vote if the number of witnesses exceeds allowable limits.

[The clerk calls the roll.]

[10:55 a.m.]

YEAS	**NAYS**
Hon. Brendan Maguire	Nolan Young
Hon. Kelly Regan	Dave Ritcey
	John A. MacDonald
	Melissa Sheehy-Richard
	Trevor Boudreau
	Claudia Chender
	Susan Leblanc

KIM LANGILLE: For, 2. Against, 7.

THE CHAIR: The amendment is defeated.

Mr. Maguire.

BRENDAN MAGUIRE: The question I have for Mr. Young is, how does he want to deal with witnesses who would be over the gathering limits? Does he want to deal with it during committee and take up valuable committee time, or does he have another recommendation?

THE CHAIR: Mr. Young, do you want to speak to that?

NOLAN YOUNG: I believe Ms. Chender has her hand up.

THE CHAIR: Ms. Chender.

CLAUDIA CHENDER: With all due respect, this committee has become dysfunctional. We should absolutely be able to deal with it during committee time. We should be able to put a motion on the floor and vote on it and then accept the outcome of that vote and move on.

There's no reason to put this to an email vote where it has to be unanimous versus a simple vote in committee. If we are all here doing our jobs, these votes should not go this way every time. Mr. Maguire, you in particular insisted that we all meet in person by voting against a unanimous poll some weeks ago when COVID was just as bad as it is now.

This is absurd. I think we need to follow Public Health instructions. I think the original motion that we passed around meeting virtually was overly broad, which we talked about at the time. Now we're going back and I think we can make this - we're all grownups. We can make this decision. We can have a vote in committee. We can discuss it, we can vote on it, and we can move on. That's our job. That's what we're sent here to do, and with all due respect, I think we should do it.

I'd like to vote on the motion that's on the floor, which is to go back to in-person meetings, and if there's a problem with that, we can deal with it, because that's our job.

THE CHAIR: Mr. Maguire.

BRENDAN MAGUIRE: With all due respect to Ms. Chender, I did vote for it. That's why we're here. Unanimously. There were some issues in the beginning. Those issues were solved.

Secondly, I called a question and I would like a recorded vote.

Mr. Young, you had your hand up. Can we vote, or do you want to make a comment?

NOLAN YOUNG: Question.

THE CHAIR: Okay. I will ask Ms. Leblanc to reiterate her motion so that we have that and we know what we're voting on.

SUSAN LEBLANC: It may be worded differently for the third time, Madam Chair, because I never wrote it down.

I move that we begin meeting in person as a Public Accounts Committee going forward.

THE CHAIR: Mr. Maguire, you asked for a recorded vote. Is that correct?

The clerk will go through the list.

[The clerk calls the roll.]

[10:59 a.m.]

YEAS	**NAYS**
Nolan Young	
Dave Ritcey	
John A. MacDonald	
Melissa Sheehy-Richard	
Trevor Boudreau	
Hon. Brendan Maguire	
Claudia Chender	
Susan Leblanc	
Hon. Kelly Regan	

KIM LANGILLE: For, 9. Against, 0.

THE CHAIR: The motion is carried.

We are at 10:59. Could we extend the committee? Ms. Leblanc.

[11:00 a.m.]

SUSAN LEBLANC: Yes, please, Madam Chair. I move that we extend the committee for 10 minutes.

THE CHAIR: This does not have to be unanimous, is my understanding. Those in favour of the motion - no, we don't even have to vote, do we? We just look for confirmation. It's been a while since I did this one, sorry.

GORDON HEBB: If there's a motion, you should vote on it. You can then just do it by unanimous consent, but if there's a motion, you can vote on it if you want.

THE CHAIR: I am seeing that there is a motion. We'll vote on the motion. All those in favour? Contrary minded? Thank you.

The motion is defeated.

It is now 11 o'clock. The meeting has come to an end. We have some correspondence that we were not able to deal with this particular meeting, but we will push them forward to our next meeting, which is on February 23, 2022. The witness will be the Department of Community Services, re: child protection services caseloads.

BRENDAN MAGUIRE: The vote - I know the committee's over, so I'm going to ask Mr. Hebb this, but that month -

THE CHAIR: Mr. Maguire, the meeting is over. We're now going to adjourn the meeting. You can have a conversation with Mr. Hebb offline. Thank you.

[The committee adjourned at 11:01 a.m.]