

Report 2: May 2011

AUDIT OF THE ACADEMIC AMBULATORY
CARE CENTRE PUBLIC PRIVATE PARTNERSHIP:
VANCOUVER COASTAL HEALTH AUTHORITY

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The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Province of British Columbia
Parliament Buildings
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Dear Sir:

I have the honour to transmit herewith to the Legislative Assembly of British Columbia my 2011/2012 Report 2: *Audit of the Academic Ambulatory Care Centre Public Private Partnership: Vancouver Coastal Health Authority.*

John Doyle, MAcc, CA
Auditor General

Victoria, British Columbia
May 2011

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AUDITOR GENERAL'S COMMENTS



JOHN DOYLE, MAcc, CA
Auditor General

A public-private partnership (P3) is a contract between a public sector entity and a private sector entity that outlines the provision of assets and the delivery of services. Although this can include almost any type of infrastructure or service, some of the more common P3 projects include hospitals, bridges, highways, new types of technology and new government buildings. P3s have become an increasingly prominent procurement vehicle for governments.

The purpose of this piece of work was to assess whether the Academic Ambulatory Care Centre P3 project at Vancouver General Hospital achieved its key value-for-money assertions based on the first five years of the Project Agreement.

While the report does include recommendations, you will note that they are forward looking as opposed to focused on this particular P3 project. The goal is to provide guidance for future P3 projects to ensure government, which would normally assume most of the risks associated with these major projects, can distribute appropriately the financial, technical and operational risks between both the private and public sector partners, thereby achieving the desired cost reductions and higher quality results.

I would like to thank the many staff at Vancouver Coastal Health Authority and other agencies for their assistance and cooperation during this audit.

A handwritten signature in black ink, appearing to read "John Doyle". The signature is written in a cursive, flowing style.

John Doyle, MAcc, CA
Auditor General
May 2011

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EXECUTIVE SUMMARY

IN BRITISH COLUMBIA, government is increasingly using Public Private Partnerships (P3s) for the delivery of infrastructure and services. As opposed to the conventional procurement practices of building and maintaining public infrastructure, P3 projects involve contracting with a private sector partner to design, build, operate, maintain and, in some cases, finance a portion of the infrastructure or service. This allows government, which would normally assume most of the risks associated with these major projects, to distribute the financial, technical and operational risks between both the private and public sector partners, with the goals of lower cost, greater efficiencies and higher quality results.

To provide the public with a summary and explanation of each P3 project, government produces a report that details the expected value for money through the partnership. These reports are issued shortly after project agreements are signed.

In November 2004, government released *Project Report: Achieving Value for Money, Academic Ambulatory Care Centre Project*, regarding a P3 project between the Vancouver Coastal Health Authority (VCHA) and Access Health Vancouver (AHV). The facility itself opened in the fall of 2006. We assessed how well the project delivered on its key value-for-money goals to date, as asserted in the report.

Overall, we found that not all of the key value-for-money goals were met. While the facility was completed on time, the final capitalized value was \$123 million – 29% greater than the estimated \$95 million capital cost in government’s Project Report.

Increased costs were incurred for a number of reasons. VCHA did not have a clear understanding of the scope and user requirements of the project, which resulted in numerous variations in the project and prevented the effective transfer of design and scope change risk to AHV. This added an additional \$11 million to the estimated cost. Another factor was a change in the discount rate used to estimate the capital cost in the Project Report. The final capitalized value, as



Distant view of the completed Academic Ambulatory Care Centre, part of the Vancouver General Hospital

reported in the audited financial statements, was based on a lower discount rate. The lower discount rate was the primary cause of the remaining \$17 million increase.

VCHA used a number of mechanisms to monitor AHV’s performance in managing the completed facility’s operations. However, we found that although the project agreement provides VCHA with a mechanism to address non-performance, payments under the agreement are not subject to reduction for non-performance as asserted in the Project Report.

We also examined stakeholder satisfaction with the project. We found that VCHA and AHV both had adequate monitoring mechanisms in place to assess that facility users were generally satisfied. A lack of public reporting since the Project Report prevents external stakeholders such as government or taxpayers from assessing the results of the project against their expectations.

The partnership is far from over. The Project Agreement commits VCHA and AHV for 30 years. While the agreement does include provisions for flexibility in managing the contract, VCHA was unable to provide documentation to support the evaluation for two financially significant contract amendments. Because of the length of the partnership, and the likelihood that individuals involved will move on to other projects, this documentation is necessary to preserve key knowledge and information.

While this audit focused on one P3 project, its findings should benefit future P3 projects. We have made several recommendations to enhance the public accountability of public-private partnerships in British Columbia.

SUMMARY OF RECOMMENDATIONS

WE RECOMMEND THAT THE PUBLIC SECTOR PARTNER OF P3 PROJECTS:

- 1** retain all documents related to key changes in the project agreement.
- 2** include explicit contingency budgets for variations in project budgets.
- 3** prepare and approve a project implementation plan at the outset of the project.
- 4** incur independent reviews of project reports before they are publicly released to ensure that key assumptions and disclosures are supported.
- 5** ensure that project reports are signed off by those who are directly responsible for the delivery of the program.
- 6** establish formal requirements for public reporting, after the completion of the capital construction phase and at set times throughout the operational contract. These reports should assess how well the project has achieved its value-for-money/risk transfer objectives in the respective areas.

ABOUT THE ACADEMIC AMBULATORY CARE CENTRE

The Academic Ambulatory Care Centre is a health care facility built through a public-private partnership (P3) on the Vancouver General Hospital site in Vancouver, British Columbia. The 365,000 square foot, 11-storey facility includes underground parking and retail and commercial businesses, and houses a variety of clinics, programs and offices that were designed to enhance patient care while increasing interaction between academics, researchers and practising clinicians. The facility also provides a lecture theatre and library for the University of British Columbia's (UBC) medical students.

A general overview of P3s is available [on our website](#).

Planning and procurement

Planning for this project was led by its owner, VCHA, in cooperation with UBC's Faculty of Medicine. The Ministry of Health and Partnerships BC were observers throughout the planning and procurement process.

After an extensive procurement process, VCHA chose Access Health Vancouver (AHV), a consortium of private companies, as the preferred private partner for this project. Shortly after being selected, AHV began contract negotiations with VCHA which led to the signing of a formal Project Agreement on September 2, 2004.

Project agreement

Under the Project Agreement, AHV agreed to design, build and finance construction of the facility and, once construction was complete, enter into a 30-year lease to operate and maintain the facility according to contractual requirements. At the end of the 30-year lease, AHV would return control of the facility at no cost to VCHA and in an agreed-upon condition.



Early construction on the facility

For its part, VCHA retained legal ownership of both the land and building and would lease back the majority of the facility from AHV (with the exception of the retail and teaching clinician space) for a contractually controlled cost.

Project risks were assigned to each party based on the terms of the agreement. For example, AHV accepted risks associated with design and construction, whereas VCHA accepted risks associated with vacant teaching clinician space. Both parties shared other risks, such as those related to utilities and maintenance costs.

Public reporting

Shortly after the Project Agreement was signed, facility construction began and two public accountability documents were released.

The first document – *Capital Project Plan: Academic Ambulatory Care Centre* (October 27, 2004) – met the statutory reporting requirements of the *Budget Transparency and Accountability Act*, addressing project objectives, costs/benefits and project risks.

The second document – *Project Report: Achieving Value for Money, Academic Ambulatory Care Centre Project* (November 2004) – summarized the project publicly and explained the expected value for money to be achieved over the life of the partnership. This Project Report was prepared by Partnerships BC based on information provided by VCHA.

AUDIT OBJECTIVE AND SCOPE

Our audit objective was to assess whether the Academic Ambulatory Care Centre P3 project achieved its key value-for-money assertions based on the first five years of the Project Agreement. The Project Report identified a number of value-for-money assertions. We assessed the following ones as key measures of success in achieving value for money:

- ◆ The facility will have an estimated capital cost of \$95 million.
- ◆ Payments will be performance-based and subject to reduction.
- ◆ Risks will be allocated to the partner best equipped to manage them.

Our audit criteria were developed based on our understanding of the risks associated with P3 projects. We asked if:

- ◆ the P3 partner delivered on the design/construction expectations so far?
- ◆ VCHA has effective procedures to monitor the progress of the P3 contract?
- ◆ key stakeholders are satisfied with the outcomes to date from the P3 contract?
- ◆ the P3 contract allows for flexibility and learning in order to improve future outcomes?

The audit focused on facility construction and early operations. We therefore did not examine decisions made at the project planning or procurement stages related to the business case, procurement options analysis or procurement process.

Because VCHA planned and managed the P3 project, it was the primary source for audit information. We gathered evidence from November 2009 to February 2010 and completed our analysis in March 2010. At this time, the project team focused on their financial statement audit responsibilities, returning to this project in the late summer. Detailed findings were reviewed with VCHA and the draft report was prepared. The audit was carried out in accordance with the standards for assurance engagements established by the Canadian Institute of Chartered Accountants.

OVERALL CONCLUSION

Overall, we concluded that not all of the key value-for-money goals of the Academic Ambulatory Care Centre P3 project were met:

- ◆ Construction was completed on time, but the final capitalized value of \$123 million was 29.5% higher than the estimated capital cost of \$95 million disclosed in the Project Report.
- ◆ The use of a P3 contract was not effective in controlling VCHA-initiated design and scope changes.
- ◆ The performance-based payment structure for operations and maintenance of the facility does not represent good practice.
- ◆ Facility users are generally satisfied with the building and services provided. However, there has been no public reporting on the ongoing results of the project since the Project Report was released in 2004.
- ◆ The P3 agreement is flexible in allowing for change. However, VCHA was unable to provide us with documentation to support the analysis and approvals for key contract amendments.

We make several recommendations to support future P3 projects.

KEY FINDINGS AND RECOMMENDATIONS

Design and construction

As noted in the Project Report, one of the objectives of the Project Agreement was to transfer key design and construction risks, such as construction schedule and cost, from VCHA to AHV.

Construction schedule

One of the key benefits of this P3 for VCHA was the ability to transfer the construction schedule risk to AHV. The requirements for substantial completion were clearly defined in the Project Agreement and confirmed by an independent third party. The earliest possible substantial completion date would have been mid-August, 2006.

Substantial Completion Date: The date whereby construction is sufficiently complete (according to the construction contract) and the owner may occupy or use the facility.

Substantial completion of the facility was achieved in two phases: floors 1–9 were completed on August 18, 2006; and floors 10 and 11 were completed on September 22, 2006. While phase two was completed approximately six weeks later than initially planned, it included only the top two floors, which were administration offices. We accepted that these floors were a secondary priority in comparison to the teaching and clinical space completed in phase one. We therefore concluded that the delay was not significant and that construction schedule risk had been effectively transferred to the private partner.

Construction cost

The final capitalized value for the Academic Ambulatory Care Centre facility was \$123 million. This was \$28 million (or 29.5%) greater than the \$95 million estimated capital cost disclosed in the Project Report.

Estimated capital cost

The Project Agreement did not set a total price that VCHA must pay AHV for capital construction. Rather, it established three payment streams that in total allowed AHV to cover its design, construction and financing costs over the term of the agreement. The payment streams were:

1. Monthly basic rent (rate per square foot) from VCHA for the facility space it occupies.
2. Annual rent (flat rate) from VCHA for the parking area.
3. Rights to collect and retain the monthly rents on all commercial space and teaching clinical space in the facility.

While VCHA explained in the Project Report that it determined the \$95 million estimated capital cost using the net present value of expected VCHA payments to AHV, the health authority was unable to provide us with documentation to support this assertion.

As well, we noted that VCHA's capital cost estimate included only the direct payments from VCHA to AHV (payment streams 1 and 2 above). It did not include a value for the commercial and teaching clinician rents paid directly to AHV.

Final capitalized value

The final capitalized value of \$123 million was the capital cost recorded in VCHA's audited financial statements. This comprised \$112 million as "Facility under capital lease" (the net present value of the 30 years of basic and parking rent payments to AHV), and nearly \$11 million in capitalized variation costs.

Project Variations: After the Project Agreement had been signed, additional capital costs could still be incurred through a process referred to as "Variations." This formal process allowed VCHA and AHV to make design and scope changes during construction.

Causes for the increase

The two main factors influencing the \$28 million capitalized value increase were: the nearly \$11 million in project variations; and the change in the discount rate used – from the estimated weighted average cost of capital in the Project Report, to VCHA's incremental cost of borrowing for the audited financial statements. The reduced discount rate (from 7.12% down to 5.37%) resulted in a significant increase in the base net present value calculation and was the primary cause of the additional \$17 million increase in capitalized value.

Capital Cost Versus Value

For Access Health Vancouver (AHV), the value of the building was a combination of all payment streams. This included direct payments from Vancouver Coastal Health Authority and revenue from leased space (commercial and teaching clinicians) in the building. Using the actual results of commercial leasing revenue for the first three years of operation, we estimated the additional net present value from the commercial lease space at approximately \$38 million for the 30-year term.¹

¹ The commercial and teaching clinician cash flows are based on current information, as opposed to historical figures at the date of substantial completion. It also does not reflect longer-term risks associated with commercial lease vacancy rates, which could impact the calculation.



Artist's rendering of the facility lobby

Design and scope risk transfer

Under the Project Agreement, AHV was responsible for managing risk from design changes, while VCHA was responsible for risk associated with changes to project scope during the construction period. Therefore, we would expect minimal changes in the agreed-upon contract price. However, we concluded that the Academic Ambulatory Care Centre P3 agreement did not effectively control cost increases. Total project variations were in fact significant – \$10.68 million – about 11.24% of the estimated \$95 million capital cost.

A significant number of the variations were initiated, and paid for, by VCHA. We were informed that a number of these variations related to the UBC Faculty of Medicine expansion. The expansion was announced prior to the Project Agreement being signed, but the functional design of the expansion was not clearly established before the signing.

In order to effectively transfer design risk and limit scope changes, project scope and user requirements should have been adequately identified by the public sector owner (VCHA) before signing the Project Agreement.

We concluded that the P3 agreement in this case did not effectively manage the project scope risk, and that VCHA did not have a clear understanding of the scope and user requirements before going to market for a private partner. Facility users' requirements were not clarified until after the Project Agreement was signed and the resulting changes led to a significant amount of the variations.

Had facility users been more involved in the design at the planning stage, user requirements could have been reflected in the procurement documents. By tailoring the design details to the risks in the procurement stage, greater cost certainty could have been achieved.

Facility operations and maintenance

After completing construction of the Academic Ambulatory Care Centre, AHV's operations and maintenance contractor assumed responsibility for the day-to-day management of the facility. This work is overseen by the Facilities and Property Management division at VCHA. Specifically, the division ensures that AHV meets the provisions of the Project Agreement and approves ensuing payments.

Payment structure

In addition to the "rent" payments to fund the capital cost (noted in the previous section), AHV receives payments for the ongoing operations and maintenance of the facility. The Project Report discloses that these "payments will be performance-based and subject to reduction for addressing instances where agreed-upon standards for facility operation and maintenance are not met." This statement suggests that the payments made to AHV under this contract have the flexibility to be reduced (adjusted) based on performance.

Performance standards

The Project Agreement sets out AHV's performance standards. This includes a general standard to "operate and maintain the Facility and the Site to the standards of a prudent long term owner of a comparable ambulatory care facility in North America and comparable buildings in Vancouver, taking into account the age and use of the comparable facility...."

In addition to the above general performance standards, a number of Service Requirements were defined, including service level expectations and specific quantitative measures for response and resolution time.

Performance monitoring

We found that VCHA had effective processes in place to monitor AHV's general performance standard, but that there was a deficiency in the quantitative measurement of performance as set out in the Service Requirements.

Staff at VCHA managing the operational aspects of the contract have backgrounds in property management. They monitor AHV's operational performance using a number of mechanisms including the review of monthly reports from AHV, monthly facility user meetings, annual facility client satisfaction surveys, and periodic on-site facility

inspections. These processes are effective for assessing the general performance standard.

However, we found that the quantitative performance standards set out in the Service Requirements were not measured and monitored. These quantitative measures for response and resolution time provide measurement criteria against which to assess performance.

We concluded that although the Project Agreement provides VCHA with a mechanism to address AHV non-performance, payments under this Project Agreement were not subject to reduction for non-performance as asserted in the Project Report.

The Academic Ambulatory Care Centre Project Agreement does not reflect good practices in performance-based payments. A performance-based payment structure that gives the service provider an incentive to perform well would be structured so that periodic payments are tied to the performance. If the service provider performed well during the period in question, then payment would reflect that positive performance. Conversely, if the service provider did not perform well, payment would be reduced.

For the Academic Ambulatory Care Centre, when a performance-standard deficiency is identified, the Project Agreement provides a multiple-step process to be followed before VCHA can adjust its payment to AHV (for VCHA costs incurred to remedy the deficiency). No link or adjustment based on AHV's actual performance is made against the performance standards set out in the Project Agreement.

Satisfaction with the facility

An objective of the project was to design, construct and operate a facility that meets the needs of facility users.

Internal stakeholder satisfaction

As noted in the previous section, VCHA uses a number of mechanisms to monitor the satisfaction of facility users. Users have been provided with adequate mechanisms to communicate their level of satisfaction with the facility. Similarly, we found that VCHA and AHV received sufficient and appropriate information to effectively monitor facility user satisfaction.

To assess internal stakeholder satisfaction, we reviewed the 2007, 2008 and 2009 annual facility user satisfaction survey results, minutes from the facility user group committee and AHV monthly reports, and conducted interviews with several facility users.



View of the entrance to the facility

We concluded that although satisfaction levels varied, the overall feeling of internal stakeholders was positive. The trend over the three years showed improved facility user satisfaction.

In reviewing the various forms of feedback from facility users, we identified two noteworthy issues affecting users' satisfaction:

1. The shift to having facility users pay for all services, including not only those at market-based lease rates but also all non-contractual services. Before construction of the Academic Ambulatory Care Centre, many of these service costs were absorbed by VCHA.
2. The challenge for both VCHA and AHV in addressing multiple user needs. For example, during facility design, VCHA decided to add a fifth elevator, resulting in the elimination of a staircase between the first and second floors. This impacts certain users' ability to access the building when the lecture theatre on the first floor empties and the lobby fills with people waiting to access the elevators.

Negative impacts on one user can be a benefit to other users. Using the examples above, the user pay system adds transparency in costs to all users, including VCHA Facilities and Property Management. Also, the trade-off between internal stairs and a fifth elevator benefits those users accessing floors three and above by increasing capacity to move people.

External stakeholder satisfaction

We found that external stakeholders (government agencies and taxpayers) did not have adequate mechanisms to effectively assess the ongoing results of the Academic Ambulatory Care Centre P3 project. Since the Project Report was released, no further project assessments have been completed, nor are any future assessments scheduled. External stakeholders therefore have no means of assessing the success of this project.

Flexibility and learning to improve future outcomes

Flexibility in the project agreement

One of the characteristics of P3 agreements is their long-term nature. In the case of the Academic Ambulatory Care Centre, the Project Agreement spans 30 years. It is important that the agreement have some degree of flexibility while still ensuring that each party is contractually obligated to honour its commitments.

We concluded that the Project Agreement was written with some understanding that changes will occur over the term, and that it provided mechanisms to address change. In some instances, this flexibility was the result of an agreement to share certain risks. For example, the Project Agreement required a recalibration of operating costs every five years. There was also a provision for changes in the P3 structure. Finally, and as noted previously, the agreement included provisions for changes and variations.

Key changes in the project agreement

We expected any changes in key terms of the Project Agreement to be fully supported by financial modeling. This is especially true given the long-term nature of P3 agreements and the fact that individuals involved at the beginning of the project often move on to other projects after the procurement and construction phases.

Since the original Project Agreement was signed, two amendments have changed VCHA's basic rent payments. However, we were unable to assess the accuracy of the basic rent adjustments as VCHA was unable to provide documentation to support the changes.

RECOMMENDATION 1 – *We recommend that all documents related to key changes in a P3 Project Agreement be retained.*

Mechanisms established to share lessons learned

The unique nature of P3 projects requires specialized knowledge and expertise that public sector project owners often do not possess, yet they are ultimately responsible for meeting the Province's objectives in delivering effective P3 projects. For this reason, Partnerships BC provides project owners with technical support at various stages in the process. Even with this support, it is a significant challenge to ensure that knowledge gained from one P3 project will be transferred to similar projects across the province.

During this audit, we noted a number of processes in place to address knowledge transfer between stakeholders. Both the Ministry of Health Services and Partnerships BC, for example, observed the project during the RFP and negotiation phase. We also heard that lessons learned from the Academic Ambulatory Care Centre project have been incorporated into templates used for future P3 agreements.

In addition, representatives of the provincial health authorities have established the Health Authorities Infrastructure Planning Council to facilitate discussion of health care P3 projects across the health sector. This group provides a more formal mechanism through which lessons learned can be applied from one health care P3 project to future health care P3 projects.

Why monthly basic rent changed in the Academic Ambulatory Care Centre

In October 2004, the monthly basic rent in the Academic Ambulatory Care Centre was reduced by 8.23%. Under the Project Agreement, VCHA retained the short-term financing risk. When interest rates for the short-term financing decreased, the benefit of the lower rates resulted in lower financing costs and therefore a reduced basic rent for VCHA.

In February 2007, the monthly basic rent was increased by 8.34%. Through an amendment in the Project Agreement, AHV agreed to pay VCHA \$4 million (referred to in the amendment as the "Variation Reimbursement Amount") in exchange for an increase in VCHA's basic rent payment. This transaction was, in effect, a loan from AHV to VCHA. Using information in the Project Agreement, we calculated the cost of borrowing for this transaction at 8.75% for the 30-year term. Considering that government's cost of borrowing for 30-year debt was approximately 4.7% in late 2006, this loan was at a significant premium. It would have been cost-beneficial to access the additional funding through government debt.

WE MADE THE FOLLOWING additional observations, which have relevance for future P3 projects undertaken by the Province.

P3 PROJECTS HAVE INHERENT DESIGN AND SCOPE PRESSURES

In a traditional capital construction project, the project budget will include a contingency (or reserve) for design and scope changes, recognizing that a certain level of owner-initiated change will occur during construction. As design or scope change occurs, funds are reallocated from the contingency budget to cover these costs. We found that the Academic Ambulatory Care Centre project did not have a reserve for design and scope change contingencies built into its capital budget. As a result, each project variation resulted in a budget overrun.

RECOMMENDATION 2 – *We recommend that P3 project budgets include explicit contingency budgets for variations.*

PROJECT IMPLEMENTATION PLAN

A project implementation plan is viewed as good practice in project management during the construction phase. This plan is a comprehensive document that guides the project team through key aspects of the project, such as objectives, scope, governance, budget management, detailed policies and procedures, and risk management. We found that the Academic Ambulatory Care Centre project did not have a project implementation plan.

RECOMMENDATION 3 – *We recommend that a project implementation plan be prepared and approved at the outset of a P3 project.*

ENHANCED PUBLIC ACCOUNTABILITY

A key component of effective public accountability includes timely, relevant and accurate information. The Project Report was one of the primary public accountability resources for the Academic Ambulatory Care Centre project. However, since the release of this report at financial close, there has been no public reporting on how well this project is meeting its projected objectives. An examination and reporting of results at key project milestones would be of particular interest to internal and external stakeholders who require an assessment of the project's progress in meeting objectives. Further, the public needs to be confident in the accuracy of the information provided. As we noted in our findings, we were unable to substantiate several aspects of the Project Report.

Looking beyond the Academic Ambulatory Care Centre to future P3 projects, there is a need for stronger public accountability requirements.

RECOMMENDATION 4 – *We recommend that all Project Reports be reviewed independently before they are publicly released to ensure that key assumptions and disclosures are supported.*

RECOMMENDATION 5 – *We recommend that all Project Reports be signed off by those who are directly responsible for the delivery of the program (for example, VCHA as the project owner should have prepared the Academic Ambulatory Care Centre Project Report).*

RECOMMENDATION 6 – *We recommend that formal requirements for public reporting be established after the completion of the capital construction phase and for set times throughout the operational contract. These reports should assess how well the project has achieved its value-for-money/risk transfer objectives in the respective areas.*

VCH RESPONSE TO AUDITOR'S REPORT ON AACC PROJECT

Vancouver Coastal Health (VCH) welcomes the Auditor General's report on the Academic Ambulatory Care Centre and is pleased to have this opportunity to respond. The Auditor General's recommendations provide our organization, and others involved with developing major infrastructure projects, an opportunity to examine areas for improvements that will benefit all taxpayers.

The completion of the Academic Ambulatory Care Centre (AACC) project on the Vancouver General Hospital campus in 2006 marked a number of firsts. The building was BC's first healthcare Public Private Partnership (PPP) project, it was the first large-scale facility dedicated to ambulatory care in BC, and it was the first purpose-built integrated healthcare, research and academic teaching facility in the province.

However, being a leader and innovator is not without risks. While there is now consensus that the AACC is a key component in the fulfillment of our clinical and academic mandate, we acknowledge that we faced challenges during the completion of the project. One of the challenges unique to this project was the expansion of the UBC medical school. The functional program for the academic space was revised after the agreement with our private partner had already been signed due to the

needs of medical school expansion. The changes required by the medical school expansion were incorporated into the \$11 million in variations to the original cost of the project. We also responded to changing health care requirements with further variations as the project moved ahead. While significant in cost, these variations also added greater overall value to the building, including a larger on-site medical library, an on-site Sterile Process Department, piped versus bottled medical gas, upgraded IT cabling, and an additional elevator that has proven to be essential to the movement of the high volume of users throughout the building.

VCH faced other challenges as we brought this landmark project to completion and many lessons were learned which were subsequently shared with the Ministry of Health, Partnerships BC and other health authorities. For example, health care public private partnerships in recent years have had better planning at the outset of projects; tighter document control processes; more realistic financial contingencies; a comprehensive user consultation process; more emphasis on performance-based agreements; and greater expertise in management of project agreements post-occupancy. Many of these improved practices coincide with the Auditor General's recommendation in this report. It should be noted, however, that some of the recommendations are for general PPP practice, which is outside of the VCH scope of control. Below is a table which addresses the auditor's recommendations for the public sector partner in PPP projects:

Recommendation	Comment
1. Retain all documents related to key changes in the project agreement.	Improved document control has been a continuing initiative of the Capital Implementation group of the Lower Mainland health authorities in both PPP and traditional build projects.
2. Include explicit contingency budgets for variations in project budgets.	Recent improvements in infrastructure planning at the provincial level include clear expectations about the use of contingency budgets.

Recommendation	Comment
3. Prepare and approve a Project Implementation Plan at the outset of the project.	Project Implementation Plans are a part of the project management plans of large scale capital implementation projects at VCH.
4. Incur independent reviews of Project Reports before they are publicly released to ensure that key assumptions and disclosures are supported.	It is accepted practice for the Health Authorities to use independent private accounting firms to review the financial models which form the basis of information on public reports on large scale public projects. In addition VCH supports the current practice, whereby the Auditor General has reviewed Project Reports in advance of being released to the public.
5. Ensure that Project Reports are signed off by those who are directly responsible for the delivery of the program.	This is current practice set by Partnerships BC.
6. Establish formal requirements for public reporting, after the completion of the capital construction phase and at set times throughout the operational contract. These reports should assess how well the project has achieved its value-for-money/risk transfer objectives in the respective areas.	After the agreement was signed with the proponent, VCH, Partnerships BC and the Ministry of Health publicly released the Value for Money Report for the project. Subsequent reporting on the project is done through Government's annual financial statements. VCH takes direction from Government regarding infrastructure and capital policy and will readily comply with any requirements for public reporting.

While we acknowledge the value of the work done by the Auditor General, we must point out a few areas where we believe the final report needs clarification.

The report states that the contract does not include performance-based payments. However, Partnerships BC has provided the Auditor General with an explanation of the performance-based payment mechanism included in the AACC contract. This demonstrated that the payment stream to the private partner is indeed at-risk to performance, much like the availability-based payment mechanisms in more recent PPP projects.

The report also states that the PPP agreement did not effectively transfer scope risk. This statement has been reviewed with the audit team and Partnerships BC has provided clarification that changes in scope by the owner are typically a risk retained by the owner. Therefore, this type of risk transfer was never intended. Further, the report states that VCH did not have a clear understanding of the scope and user requirements. VCH has pointed out that variations to the scope are largely attributable to owner changes that were unforeseen at the time of the project agreement signing (for example, the additional requirements of the UBC medical school expansion to the project). The landscape of healthcare is constantly changing and requirements change in

the years from financial close to project completion. Subsequent projects have become better at assessing the risks of these changes and mitigating them whether it is through the language of the agreement or acquiring the contingency budgets needed.

To conclude, despite the challenges faced there can be no doubt that the AACC has been a great success. In service for nearly five years, it is well maintained and heavily utilized. It helped decongest the hospital by creating dedicated space for outpatient services; instituted patient-focused one-stop access to diagnostic, clinical, and specialist services; created an environment conducive to physician collaboration; and allowed us to properly integrate medical students into clinical services on the hospital campus. A great benefit to patients, students and physicians, it has also proven to be an excellent value for taxpayers: a similar building in today's dollars would cost almost double to construct and significantly more to lease at commercial market rates. VCH is currently paying 40% less than comparable market lease rates amounting to savings in excess of \$25 Million over the term of the lease.

VCH has learned many valuable lessons from its first PPP project, and is confident that BC taxpayers and patients received value for money from this building and will continue to do so for decades to come.