

# Hospital Capital Planning and Policy Manual

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# 1

## Introduction

# Chapter 1: Introduction

## 1.0 SCOPE AND OBJECTIVES

The Government of Ontario, through the Ministry of Health (ministry), provides guidance and support to Health Service Providers across the province to build, renovate and maintain their health care facilities; the aim of which is to enable the delivery of high-quality, patient-centred care. The Hospital Capital Planning and Policy Manual (HCPPM) establishes the overarching framework for managing capital assets in the **hospital sector** and for setting out policies governing capital projects and processes, including approved capital funding. The HCPPM describes the submission requirements for hospitals proposing to undertake a capital project, and the subsequent review and approval processes carried out by the ministry based on strategic advice from the Ontario Health Agency.

The specific **objectives** of the HCPPM are to:

1. Communicate the ministry's capital planning and approval processes, policies and guidelines to stakeholders;
2. Ensure compliance with ministry and government policies to maintain legislative and fiscal accountability;
3. Provide direction on how to effectively navigate the capital submission and review process; and
4. Facilitate the development of capital submissions that foster the delivery of high-quality care through patient-centred design.

The HCPPM is written primarily for the hospital sector and is intended to be a foundational resource to guide the development and delivery of hospital-based capital projects. Senior leaders from all public hospitals as well as those involved in the planning, design and construction of health care facilities should familiarize themselves with the enclosed content. References are included throughout the manual to direct the reader to capital policies and guidance materials that offer additional detail with respect to:

- Understanding the range of legislative requirements, standards and best practices that may be relevant to a given capital project;
- Developing applications for capital projects, with or without seeking ministry capital funding support;
- Choosing the right Integrated Project Team to plan and implement capital projects;
- Navigating through the stages of a capital project;
- Understanding the submission review and approval processes for both the Traditional and Public-Private Partnership procurement delivery models; and
- Understanding which costs are eligible and ineligible for ministry capital funding.

### ***Guiding Principles of the HCPPM***

*Hospital capital projects should:*

1. *Support hospital service delivery and operational needs;*
2. *Deliver value for money through the application of sound capital and fiscal planning practices that are fair and transparent;*
3. *Promote and maintain patient safety; and*
4. *Protect the public interest.*

Hospitals in Ontario can contact the ministry's Health Capital Investment Branch (HCIB) to resolve any questions not addressed in the HCPPM or to request more detailed information on the capital planning process. HCIB has designated Senior Consultants who are geographically based (North and East, South and West, Greater Toronto Area) and can provide further assistance. All general enquiries should be sent to [HealthCapitalInvestmentBranch@ontario.ca](mailto:HealthCapitalInvestmentBranch@ontario.ca).

## 1.1 LEGISLATIVE AND POLICY REQUIREMENTS

Hospitals are required to comply with the following legislation, regulations, and policies during the capital planning process.

### **Ministry of Health and Long-Term Care Act R.S.O. 1990 (MOHLTCA)**

- As reflected in the MOHLTCA, it is the function of the Minister of Health to, among other things, oversee and promote the health of the people of Ontario and to develop, coordinate and maintain comprehensive health services and a balanced and integrated system of hospitals and other health facilities in Ontario. The MOHLTCA also establishes the Minister of Health's authority to preside over and have charge of the ministry and all its functions.

### **Public Hospitals Act R.S.O. 1990 (PHA)**

- The PHA defines a hospital as any institution, building or other premises or place that is established for the purposes of the treatment of patients and that is approved as a public hospital under the Act. It establishes the Minister of Health, or delegate, with the legal authority to provide operating and capital grants (Sections 5(1); 5(2); 5(3); 5(4)) to hospital corporations. The PHA stipulates that no additional building or facilities shall be added to a hospital until the plans have been approved by the Minister or delegate (Section 4(3)). Further, no land, building or other premises or place or any part thereof acquired or used for the purposes of a hospital can be sold, leased, mortgaged or otherwise disposed of without prior approval (Section 4(4)).

### **Broader Public Sector (BPS) Accountability Act, 2010 and BPS Procurement Directive**

- The *BPS Accountability Act and Procurement Directive* outlines the responsibilities of broader public sector organizations, including hospitals, throughout each stage of the procurement process to ensure the process is open, fair and transparent.

### **Other Legislation, Directives and Policies**

- There are several additional statutes which apply to a variety of hospital-based programs and services. For example, when a hospital acquires certain diagnostic equipment, such as a Computed Tomography (CT) Scanner, it must adhere to the *Healing Arts Radiation Protection Act* (HARPA). In the context of capital projects, there will be statutes applicable to health and safety and building construction (Ontario Fire Code, Ontario Building Code, etc.).

Hospital personnel planning a capital project are encouraged to refer to the section of the Appendix on Legislation and Codes as a starting point for additional information. The ministry also recommends consulting with legal counsel regarding applicable legislative requirements that may apply.

The ministry may invoke temporary emergency measures which may supersede this document.

In certain circumstances, Ontario has a duty to consult, and address the concerns raised by potentially impacted Aboriginal communities. Please contact [HealthCapitalInvestmentBranch@ontario.ca](mailto:HealthCapitalInvestmentBranch@ontario.ca) for more information.

## 1.2 DEFINING A HOSPITAL CAPITAL PROJECT

A hospital "Capital Project" can be defined as alteration(s) to a hospital building through demolishing, building, modifying, renovating or adding to a physical space which enables that space to support clinical functions; or a project that provides or replaces essential equipment to perform a defined function for building operations (infrastructure project). It can either be self-funded (own funds) or cost-shared by the ministry.

Hospital capital projects follow a project cycle of identifying a need, developing a concept, creating a plan, implementing the plan, closing out the plan, and monitoring ongoing operations. Success is generally measured by the extent to which the capital project is completed on time, on budget, within a pre-defined scope, and able to meet intended health service delivery requirements.

There are two main types of capital projects: 1.) Renewal; and 2.) Expansion.

**Renewal projects** are undertaken to restore, rehabilitate or replace an existing asset to its original capacity or performance capability. Such projects are fundamentally carried out in order to extend the useful life of building assets. Internal renovations that restore the functionality and/or condition of an existing space without increasing the physical footprint would be considered a renewal project, such as recommissioning the hospital's heating and ventilation system. Renewal projects do not address regular facility maintenance requirements but rather, the work that is above and beyond day-to-day facility upkeep as they extend the useful life of the asset as the related expenditures are amortized.

By contrast, **expansion projects** are designed to increase an organization's ability to deliver services by adding a new asset to an organization's system (e.g., new clinical programs), or by increasing the physical capacity (e.g., building footprint) of an existing asset. For example, an expansion project could include adding a new building or wing of a building to a hospital to accommodate demographic growth, new programs and services not previously offered at a given site, or an increase in demand for clinical services. It could also involve renovating existing space (e.g., space made available through relocation of other services) to adapt to new and emerging models of clinical care.

Although it is difficult and often not possible to entirely distinguish between costs to achieve renewal and/or expansion objectives within a given business case, it is useful to articulate and provide supporting evidence for how a proposed project will achieve one or more of these objectives.

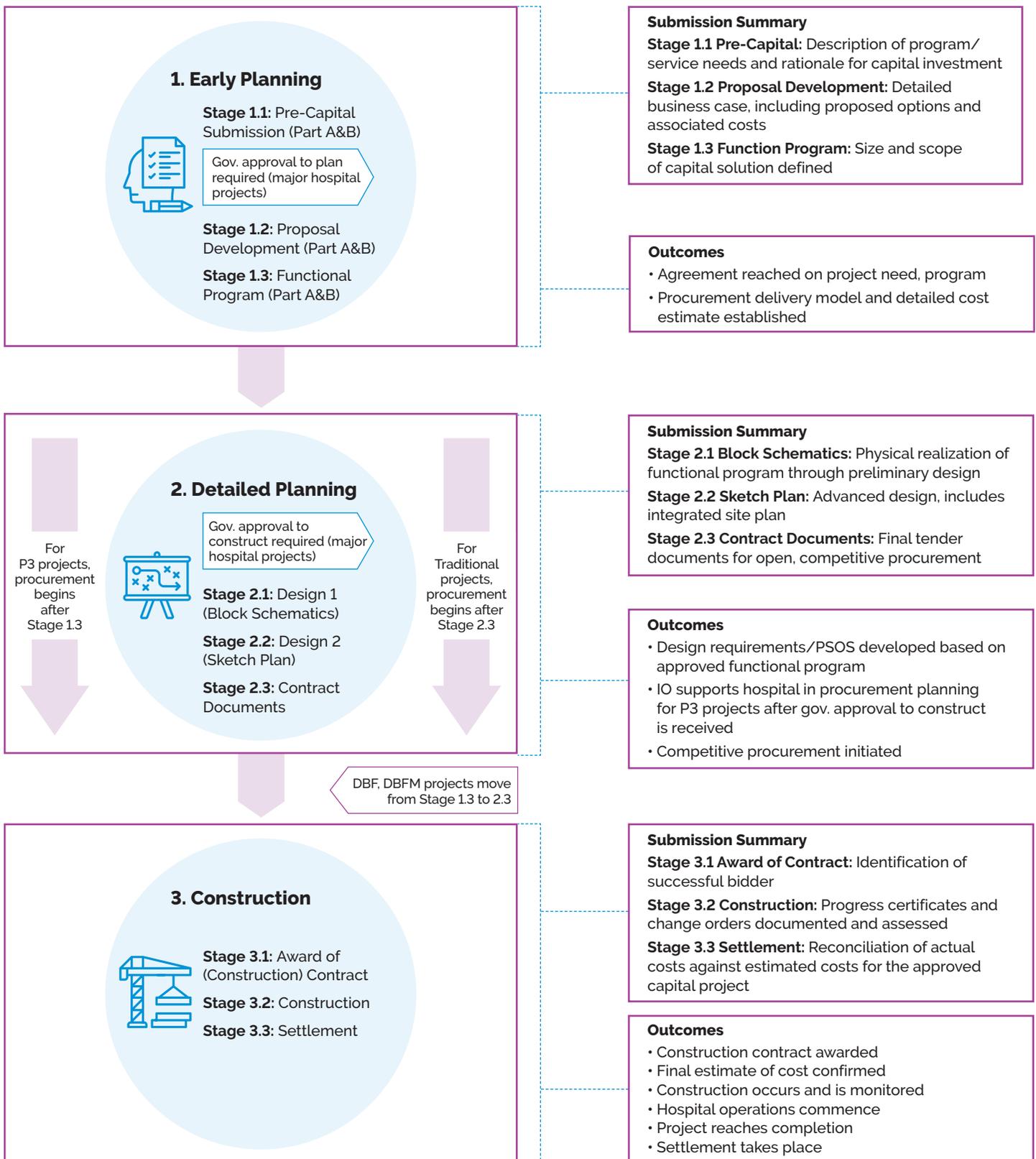
Please note that under the HCPMP, hospitals must receive ministry approval to implement a capital project (renewal or expansion) except for projects funded through the Health Infrastructure Renewal Fund and own funds projects with value below the relevant cost threshold. Please see the Risk-Based Matrix (Figure 2a) for more details.

## 1.3 CAPITAL PLANNING PROCESS INTRODUCTION

All capital submissions must enter and navigate through the multi-stage capital planning process (see Figure 1a). The “stages” in capital projects have been developed to follow the methodology employed by the construction industry and therefore, other than the concept/application stage (“Pre-Capital”), reflect naming conventions familiar to the industry.

Embedded within the capital planning process is the capital approval process. To proceed from one stage to another requires approval from the government and/or ministry. The level of authority within the government and/or ministry required for approvals at each stage can differ depending on the *project type* and *project classification*. Additional information on the capital planning process and associated approvals, including submission requirements, can be found in Chapters 2 and 3.

**Figure 1a: Overview: Hospital Capital Planning Summary and Approval Process**



Note: Government approvals for major hospital projects shown above. Additional ministry approvals will be required.

## 1.4 ROLES AND RESPONSIBILITIES IN CAPITAL PLANNING

### Ministry of Health

The mandate of the ministry is to establish the overarching policy framework and reporting requirements for all health capital expenditures in Ontario, and to provide evidence-based advice to the Minister of Health as well as Treasury Board/Management Board of Cabinet on health capital-related decisions.

HCIB, as the designated representative of the ministry, retains the legislative requirement to review hospital capital plans through the PHA. Specific responsibilities of HCIB include:

- Developing capital programs and policies, and comprehensive multi-year plans to provide leadership and capital funding allocations across multiple health sectors;
- Applying provincial planning and design goals and objectives to ensure a standard level of performance is achieved in the design of all the province's health care facilities;
- Working collaboratively with other areas of the ministry that hold operational oversight and/or program oversight for sectors that are eligible for capital funding;
- Engaging with hospitals to navigate through an industry standard multi-stage capital planning process and reviewing design and planning documentation to ensure alignment with ministry goals and objectives; and
- Providing capital funding (where applicable) to support construction and operating funding for hospitals following construction through the *Post Construction Operating Plan (PCOP)* program.

### Ontario Health

In Ontario's health system, Ontario Health is the single centralized agency created to oversee key areas of the health care system, improve clinical guidance and provide support for providers to ensure better quality care for patients. Ontario Health also plays a significant role in the early stages of capital planning (Stage 1.1-Pre-Capital; Stage 1.2-Proposal Development; Stage 1.3-Functional Program). Its focus is on ensuring that the programs and services outlined in a proposed capital project meet the needs of the local and provincial health system.

Ontario Health will consider endorsing early capital planning submissions where:

- Program and service needs are informed by demographic profile and service utilization;
- Program and service needs are aligned with local, regional and provincial health system priorities;
- Program and service needs are aligned to established clinical criteria, where applicable, to support safe high-quality care;
- Options for program/service delivery, including integration opportunities, collaboration and alternate service delivery models, human resources capacity and shared services have been considered;
- New and existing health services are effective, sustainable and responsive to community needs;
- Operational implications are clearly articulated; and
- Planning occurs within the fiscal framework and priorities established by government.

In addition to these functions, Ontario Health offers strategic advice to the ministry regarding the development of *planning parameters* which provide direction to hospitals as they engage in early

planning and design activities associated with a proposed capital solution. The ministry may engage Ontario Health to develop or inform prioritization of all or a sub-set of capital project proposals received from service providers. The ministry may also engage Ontario Health to develop or inform sequencing of all or a sub-set of capital project proposals received from service providers.

## Hospitals

Ontario's public hospitals are responsible for keeping their facilities in a state of good repair and supporting the evolving health care needs of their communities. As part of this responsibility, the hospital serves as the main project sponsor and lead planner when seeking approval from Ontario Health and the ministry to undertake a capital project. Primary hospital representatives typically include Board members, administrators, facility/redevelopment staff, clinical planners as well as infection prevention and control personnel. Secondary hospital representatives are comprised of Project Manager(s), Architects, Functional Programmers, Engineers, Planners, Cost Consultants and other Consultants hired to plan and deliver a capital project.

In capital project planning, hospitals carry out the following functions:

- Maintaining an up-to-date Master Program and Master (Site) Plan for the Hospital Corporation;
- Preparing proposals for capital projects for Ontario Health and ministry review; and
- Implementing approved capital projects through the procurement of Planning Consultants and Contractors; and ensuring adherence to applicable contractual, legislative and government policy requirements.

## Infrastructure Ontario

When directed to do so, in writing by the Minister of Infrastructure, *Infrastructure Ontario* (IO) is responsible for delivering larger Major Capital Projects such as *Public-Private Partnership* (P3) projects, together with sponsoring hospitals and the ministry. The specific services rendered by IO on a given capital project are agreed to with the ministry and sponsoring hospital during early capital planning and may include:

- Undertaking due diligence and developing a budget based on an independent 3<sup>rd</sup> party cost estimate;
- Leading the procurement process together with the sponsoring hospital;
- Managing the construction of the P3 projects in accordance with the contract documents;
- All other roles and responsibilities subject to Appendix xxii.

Please see Chapter 4 for more details.

# 2

## Planning a Health Capital Project

# Chapter 2: Planning a Capital Project

## Purpose

Chapter 2 explores the key planning concepts associated with new capital projects, including a review of the purpose and function of the Master Plan and Master Program; identification of capital needs and factors driving those needs; an overview of project types and procurement models; and a summary of the capital planning, review and approval process.

## 2.1 MASTER PROGRAM AND MASTER PLAN

### Master Program

The Master Program is a foundational planning document that outlines the type and extent of health care services to be delivered within a hospital's facility(ies) as well as its role within the broader community. The Master Program typically addresses projected service, staffing and departmental space requirements and identifies in reasonable detail the potential needs of facility(ies) over the mid-term (5-10 years) to long-term (15, 20, and 25-year).

### Master Plan

The Master Plan is used in tandem with the Master Program to ensure that development proceeds in a coordinated fashion. The Master Plan should align with the strategic vision for the hospital, local health system and province by demonstrating how health care services will be delivered. Hospitals are expected to maintain a Master Plan, regardless of whether they require a capital project.

An effective Master Plan optimizes the potential for developing a specific site and must provide for optimum flexibility to adapt to changes in health care needs and service delivery models. Like any effective planning tool, the Master Plan must be reviewed and updated regularly and should consider both the current needs and the long-term "whole life" perspective of the facility.

Health care professionals should work together with various design professionals in an Integrated Project Team to define the various components of the Master Plan. Factors such as the location of the facility and the characteristics and condition of the building(s) ought to be addressed in the development of a robust Master Plan. In addition, site plans, the Master Program, civil and environmental design, and municipal and transportation plans should be considered simultaneously.

#### **i** *Did you know?*

*Every hospital needs a Master Program and Master Plan that is aligned with the strategic direction of the hospital. Both the Master Program and Master Plan are prepared at the corporate level for all hospital sites within a single Hospital Corporation.*

## 2.2 NEEDS IDENTIFICATION AND ANALYSIS

In assessing whether to submit a request to the ministry for capital funding, hospitals should first review their service delivery needs and the underlying factors driving those needs. This will require a detailed examination of programs and services, including current and future clinical service volumes for the near and long-term, compared against the existing asset base (space) and asset condition. An examination of the existing asset base must consider the hospital's Master Program, current and future maintenance requirements as well as the anticipated lifecycle costs that will be required to maximize the expected useful life of all new or renovated building(s). This information should also be reflected in the Master Plan.

The primary objective of the review is for the hospital to develop a range of potential options to address any misalignment or "gaps" that exist between a.) current and future service delivery requirements, and b.) the hospital's existing capital asset stock. Potential solutions to the identified gaps should seek to answer key questions such as:

- Is there a way to efficiently meet our service delivery needs without new capital spending?
- Is there a way to better use or manage existing assets that could reduce the need for additional capital expenditures?
- Which option will best support provincial and local health system integration, capacity and service delivery strategies?
- Which option will deliver the greatest long-term value for Ontarians?

### Factors Driving Capital Needs

There may be a single compelling reason to initiate a capital project, or multiple interconnected reasons that are dependent on local circumstances. However, early capital proposals, also known as Pre-Capital Submissions, generally arise from one or more of the following factors:

#### Primary Factors

- Proposal supports the delivery of current, new or innovative models of care;
- Proposal supports provincial and/or local health system integration, capacity and service delivery strategies;
- Proposal addresses demographic growth and associated increases in clinical service demands; and/or
- Proposal addresses infrastructure needs (physical condition of facility).

#### Secondary Factors

- Proposal addresses gaps in services or a need in the community identified as a result of program evaluation or analysis<sup>1</sup>;
- Proposal addresses the need for relocation of existing programs and services<sup>2</sup>;
- Proposal supports the uptake of technological innovations;
- Proposal responds to economic, business or social changes; and/or
- Proposal improves building energy efficiency, including reducing the carbon intensity of new and existing hospital asset(s)<sup>3,4</sup> and improves or incorporates climate resistance.

#### Notes:

<sup>1</sup> Assumes project is not directly aligned with provincial and/or local health system priorities.

<sup>2</sup> Ibid.

<sup>3</sup> Non-revenue generating hospital assets only.

<sup>4</sup> Energy efficiency measures can also address infrastructure needs (e.g., more efficient windows).

Given the size and complexity of hospital-based care in Ontario, capital funding requests submitted to the ministry each year will typically exceed the fiscal resources available. As a result, (Pre-Capital) submissions are reviewed for funding consideration within the government's current fiscal framework. Submissions requiring a provincial funding contribution will have a greater probability of receiving ministry approval to proceed to Stage 1.2 (Proposal Development) of the Capital Planning Process if:

1. They provide evidence and a clear articulation of need by addressing one or more of the factors noted above, and
2. They meet the ministry's planning principles outlined below.

## Planning Principles

- Planning must occur within the fiscal framework and priorities established by the government.
- Community-based primary care delivery should be enhanced by transferring appropriate resources from hospitals to the community sector (e.g., home care, long-term care).
- Planning should be based on population profile and demographics (e.g., socio-economic indicators such as level of education, household income, seniors over age 75 who live alone, and morbidity/mortality data), and focus on improved health outcomes for the community.
- Health services must be effective, sustainable and responsive to community needs including population growth now and into the future.
- Development of flexible and innovative approaches to service delivery should be fostered.
- Current methods of practice and service delivery should be challenged, and alternatives should be explored, including the sharing of medical/professional staff, technology, and administrative and other services.
- Enhancement or expansion of service delivery must include a comprehensive and sustainable human resource plan.
- Critical mass exists to support and sustain quality health services. This may include considering co-locating multiple services in a single location to improve patient outcomes while retaining necessary primary care services locally to facilitate patient access (particularly relevant in rural and/or remote communities).
- Physical planning should follow clinical needs.

## Facility Data and Analytics

The Facility Condition Assessment Program (FCAP) provides objective data to assist hospital facility personnel in assessing the physical condition (e.g., mechanical, electrical, structural, and architectural systems) of their facilities and preparing evidence-based Pre-Capital Submissions for ministry consideration. Established in 2007, FCAP is administered through the application of onsite hospital assessments carried out by accredited Engineers procured by the ministry. Assessments typically occur on a four-year cycle and offer vital information for hospitals and the government on the stock and condition of existing hospital buildings. They also support the development of long-term projections of capital investment requirements and assist with the evaluation of funding requests associated with facility renewal.

The core elements of FCAP include a physical review of hospital facilities and sites using an asset management software program that measures, records, and stores data on the condition of hospital physical assets. Each asset receives a Facility Condition Index (FCI) score that determines the priority for renewal. Hospitals are required to update their data in the FCAP database to ensure that accurate information is available to identify their renewal needs, and to inform both policy and funding

decisions. For additional details, refer to the Health Infrastructure Renewal Fund Guidelines or contact [HealthCapitalInvestmentBranch@ontario.ca](mailto:HealthCapitalInvestmentBranch@ontario.ca).

## 2.3 PROJECT TYPES

The ministry categorizes hospital capital projects into one of four distinct project types:

### 1. Health Infrastructure Renewal Fund Projects

Hospitals are responsible for planning infrastructure repair and rehabilitation activities to ensure their facilities remain in a good state of repair.

Recognizing the need for continuous infrastructure renewal, the ministry established the Health Infrastructure Renewal Fund (HIRF) in 1999.

HIRF is designed to supplement a hospital's existing renewal program and to help address infrastructure repair and replacement requirements on a priority basis (i.e., health and safety; code compliance; imminent breakdown).

The ministry provides an annual allocation of funds to eligible hospitals (see HIRF Guidelines) across the hospital sector each year that reflects input from Ontario Health and is informed by the results of the FCAP assessments.

Minor infrastructure projects generally supported through the HIRF program are projects that:

- a.) have no impact on programs and services or operational funding;
- b.) can be amortized; and
- c.) do not require the preparation of a *functional program*.

As such, HIRF projects do not follow the full multi-stage capital planning process discussed in Chapter 3.

For additional details, including eligibility requirements, refer to the latest Health Infrastructure Renewal Fund Guidelines.

### 2. Small Hospital Projects

The ministry provides capital funding directly to hospitals for small capital grants. The source of funding is derived from annual submissions and allocations approved by government.

Small hospital capital projects are currently defined by the ministry as those projects with a total project cost of less than \$20M. Funding is prioritized based on need including the primary and secondary factors outlined in section 2.2.

### 3. Major Hospital Projects

The ministry provides capital funding directly to hospitals for major capital grant(s). The source of funding is derived from annual allocations approved by government.

As currently defined by the ministry, major hospital capital projects have a total project cost of over \$20M. Funding is prioritized based on need including the primary and secondary factors outlined in section 2.2.

## 4. Own Funds Projects

The term “Own Funds Capital Projects” means capital projects funded by a public hospital without a capital financial contribution from the ministry.

Often, such projects are financed directly by a hospital through community-based fundraising initiatives and onsite revenue generating activities. Other sources of funding could include, but are not limited to, support from other levels of government (municipal, federal) and/or external partnerships. Own Funds Projects may be any value in cost and address various primary and secondary factors. The unique feature is that they are completely funded by the hospital. Hospitals may wish to supplement a HIRF, a small or major hospital project with their own funds.

### 2.4 CAPITAL GRANTS

The aim of the ministry’s Capital Planning Process is to support excellence in patient care through physical infrastructure planning while also maintaining accountability for public funds.

Due to the impact that the built environment can have on patient well-being, a legislative requirement exists for hospitals to seek the Minister’s written approval prior to undertaking capital improvement projects. This requirement is independent of whether the government is sharing in the cost of the project.

The ministry uses various grants to enable approved capital projects to progress through planning, design and construction. The type of grant and point in the capital process where it may be provided is dependent upon the nature of the project and current ministry policy.

Capital grants always represent an “up to” amount calculated on the best available cost estimates as determined at the point in the capital process in which they are provided. For example, the ministry may provide a grant of “up to” \$100 to complete a capital project, but the expectation is that the hospital will apply competitive procurement practices and diligent planning and oversight to bring the project to completion at less than this value.

The proceeding section describes the three main types of capital grants used by the ministry:

#### Planning Grant:

As Ontario’s health care system transforms in response to changes in demand for health services, capital planning grants provide funding to support early planning for potential future infrastructure investments.

#### **Operational Funding**

*For capital projects that have program and service delivery impacts, all operational funding implications must be addressed before procurement and construction can proceed.*

#### **Funding Agreements**

*All capital grants are governed by contract law. Before government-approved funding can be provided, the ministry and Hospital Corporation must enter into a Funding Agreement (Agreement) which sets forth the terms and conditions upon which both parties must adhere. Planning parameters are contractual requirements that must be met.*

Utilizing capital planning grants with ministry-set planning parameters is the mechanism for ensuring that appropriately scaled and scoped capital solutions occur in alignment with the government's strategic direction.

Approval of a planning grant does not represent approval to begin procurement or commence construction, now or in the future. It is possible that a (major hospital) capital proposal will not proceed to construction, pending the outcome of evidence-based planning and further approvals. Planning Grants are only provided for Major Hospital Projects and may be provided at a few milestones including during Stage 1 or 2.

### Implementation Grant:

When planning grants have been provided, and subsequent government approval is received to proceed, an implementation grant is employed to fund either design and construction, or construction.

### Full (Planning and Implementation) Grant:

The full planning grant provides an "up to" amount to fund both planning and implementation of the approved capital project. It is generally available for less complex projects such as minor, uncomplicated infrastructure projects or Small Hospital renovation projects.

## 2.5 PLANNING AND APPROVAL PROCESS

### Levels of Approval

For a proposed capital project to become an approved capital project and then progress through the stages of the Capital Planning Process, government and/or ministry approvals are required. There are three general categories of approval:

#### 1. Government Approval

Government approval is required for the Major Hospital Capital Project classification (over \$20M). The approval authority for these types of projects is held by Treasury Board/Management Board of Cabinet and is usually divided into two distinct phases: **1. Approval to Plan**, and **2. Approval to Construct**. A Major Hospital Capital Project must receive a Government Approval to Plan before any Ministry Funding Approval (e.g., for a Planning Grant) can be issued. Unless expressly stated, Approval to Plan does not imply support for implementation of the project. For a hospital proposal to move beyond early capital planning, Government Approval to Construct will be required.

Government approval is not required for individual Small Hospital projects or HIRF projects. For these project types, approval is provided directly by the Minister (or delegate on behalf of the Minister).

#### 2. Ministry Funding Approval

Approval by the Minister (or delegated authority) is required for all new funding associated with capital projects in all project types; this includes both initial grants and any subsequent grant increases.

#### 3. Ministry Stage Approval

Ministry administrative approvals are required to move a capital project from one stage to the next. These approvals are made by designated ministry positions at various points in the process.

Although ministry stage and funding approvals may occur at the same time at specific points in the capital planning process, they are different and separate. Stage approvals are essentially process approvals and have no funding authority.

## Stage Submissions

Informing the ministry's approval at each stage of the Capital Planning Process is a review of key documentation called "Stage Submissions." Stage Submissions consist of documents related to planning (including confirmation of need, model of care and operations), tender, construction or settlement that the hospital is required to develop and submit to the ministry.

Each stage of the Capital Planning Process is informed by a *Stage Submission Checklist* that captures all of the potential types of information/submissions that may need to be completed by the hospital and provided to the *Endorsing Organization* (e.g., Ontario Health (OH)) and/or ministry.

The ministry provides the hospital the appropriate Stage Submission Checklists and *Capital Planning Bulletins* to facilitate efficient planning. When warranted, the ministry may also engage hospital personnel prior to the start of each stage to review the items on the potential list of documentation for that stage and to identify those items that will be required. Once this is complete, the hospital will understand the documentation requirements for that stage, the desired format, and how to submit to the ministry for review and approval. The ministry will provide OH with stage submission progress. Based on the Risk-Based Matrix (Figure 2a) the ministry may expediate and streamline a project. This will be communicated to the hospital.

## Capital Planning Bulletins

Capital Planning Bulletins (Bulletins) offer helpful information, advice and guidance to hospitals as well as to those who plan, design and construct hospital facilities.

Bulletins support the Capital Planning Process by offering detailed information on design fundamentals and technical submission requirements. They are also one of the key ways in which the ministry advocates and supports planning and design excellence for Ontario's health care facilities.

The latest electronic copies of the Bulletins are in the Policies and Guidance Documents section of the Appendices.

## Stage Submission Review Requirements

The level of review required by the ministry for each stage submission is highly dependent on the size, scope, complexity and relative risks associated with each individual project.

In some instances, hospital attestations may be used in place of direct ministry review to enable a more streamlined progression through the Capital Planning Process.

**However, unless otherwise specified, government and/or ministry approval is required to progress from one stage of the capital planning process to the next.**

Figure 2a provides further detail with respect to those project classifications that are eligible for attestations in place of direct ministry review. Figure 2a also contains information on the ministry's stage submission and approval requirements by project classification. Please note that for Diagnostic Imaging projects the MRI and CT Protocols supersedes this. Please note radiation and PET replacement equipment follows a separate process supported by HCIB and OH. Please contact OH/HCIB for more details. See the Appendix for more details.

When a project change of status occurs – such as from own funds to funded project, or expansion from non-clinical space to clinical space – complete stage submission reviews are required to determine the path forward.

### **i** *Did you know?*

*Adherence to the ministry's Capital Planning Process will facilitate the progression of a project through the various stages and will expedite the planning of a project through to the start of construction.*

## Figure 2a: Risk-Based Assessment Tool

The following risk-based assessment tool is designed to assist the ministry and hospitals in determining the correct review and approval path that a capital project will follow. The tool will be applied for all projects that proceed beyond the Pre-Capital Stage. Final determination regarding project categorization, including stage submission and approval requirements will reside with the ministry. Refer to explanatory notes below for additional information, including attestation requirements.

Stage Submission and Approval Requirements (1-4)	Parking	Infrastructure Replacement - no impact on clinical services (1)	Infrastructure Replacement - no impact on clinical services (1)	Diagnostic Equipment Replacement - no renovations (2)	Diagnostic Equipment Replacement - with renovations (2)	Renovations/New Construction - non-clinical space, any value	Minor Renovations - clinical space (3), construction under \$2M	Renovations/New Construction - clinical space, over \$2M	Infrastructure Replacement - no impact on clinical space	Infrastructure Replacement - direct clinical impacts	Renovations/New Construction - non-clinical space, any value	Renovations/New Construction - clinical space, any value
	Other	Own Funds Projects						Ministry-Funded Projects				
Stage 1.1 Pre-Capital	●	●	●	●	●	●	●	●	●	●	●	●
Stage 1.2 Proposal Development	●				●			●				●
Stage 1.3 Functional Program					●			●				●
Stage 2.1 Block Schematics								●				●
Stage 2.2 Sketch Plan			●		●	●	●	●	●	●	●	●
Stage 2.3 Contract Documents			●		●	●	●	●	●	●	●	●
Stage 3.1 Award of Contract		●	●		●	●	●	●	●	●	●	●
Stage 3.2 Construction									●	●	●	●
Stage 3.3 Settlement									●	●	●	●
Other: Post-Occupancy Evaluation									●	●		●

- Documentation required for review as per Stage Submission Checklist; requires ministry approvals in order to move to next stage.
- Documentation required for review as per Stage Submission Checklist or Attestation letter template; no formal ministry approval required to move to next stage.
- Ministry will decide whether required after Pre-Cap.
- Review of Local Share documentation only.
- Review of Change Orders only; for alignment with Hospital Capital Cost Share Guide.

### Explanatory Notes:

- Attestations letter(s) may be required by the ministry for stage submissions where direct ministry review and/or approval is not required. Such letters require designated hospital personnel to attest in writing that all legislative, clinical, and code requirements have been followed.
- Pre-cap and ministry approval is not required for own funds infrastructure projects under \$2M for small hospitals and \$5M for large hospitals (defined by the Health Based Allocation Model). If there is a direct patient care impact or the project crosses departmental boundaries it shall be classified by the ministry under the Renovation/New Construction to clinical space. Where a Health Service Provider (HSP) chooses to exercise its own funds options for infrastructure projects, an attestation that the project has no direct patient care impact and/or does not cross departmental boundaries will be required in a format defined by the ministry. Additional attestations may also be required.
- Diagnostic imaging replacement projects refer to submissions received by the ministry under the CT/MRI Protocol.
- The ministry at its sole discretion reserves the right to further amend stage submission and approval requirements reflect in the above-referenced risk-based matrix.

The ministry's goal in the planning and design of capital projects is to foster an environment that enables health services to be delivered in the most effective, efficient, accessible, and safe manner while incorporating the needs of patients and staff. To achieve this goal, the ministry uses OASIS planning and design objectives in its review of stage submissions for all hospital capital projects, regardless of funding source. To this end, the following planning and design (OASIS) objectives will be applied by the ministry in its review:

**Table 2b: OASIS Principles**

Planning and Design Objectives	Definition
Operational Efficiency	The planning and design of hospital facilities should focus on creating an operating environment that is efficient and effective in the delivery of health care services. This includes developing physical solutions that promote/improve patient outcomes (e.g., lighting, noise control, nature views) while also creating an enabling work environment for staff and other health care providers. The ministry supports patient-centred care models.
Accessibility	Accessibility can be addressed by identifying barriers to access and removing these barriers. Barrier-free design provides a level of accessibility for people living with disabilities; whereas universal design strives to be a broad-spectrum solution that helps everyone and not just people with disabilities. The ministry supports the principles of barrier-free and universal design, as well as ergonomic design of the workplace.
Safety and Security	This objective is important to staff and users of any facility. Feeling and being safe in any environment increases patient and staff outcomes. Privacy and confidentiality are two important concepts to promote a safe and secure environment. For example, this objective can include clear sight lines between patient and staff and the ability for staff to have visual supervision and control of a program.
Infection Prevention and Control	Adherence to Infection Prevention and Control Guidelines includes the understanding and implementation of infection control guidelines for staff and patients. This is accomplished through a review of the proposed Processes and Project Design Features by a Certified in Infection Prevention and Control (CIC) Professional. The review must determine whether the proposed process(es) and architectural design features, and the recommended direction, are either acceptable, partially acceptable or not acceptable. If the proposal is partially acceptable or not acceptable, a list of recommended changes for the unsupported processes/design features must be developed. Additionally, the CIC Professional must be present throughout construction to monitor potential issues, in accordance with <i>CSA Z317.13-12 Infection Control</i> during construction, renovation and maintenance of health care facilities.
Sustainability	This objective can be measured through value analysis, energy conservation and planning for future flexibility to accommodate changes in the provision of care and/or program expansion. This objective is part of the larger goal to promote the sustainability of Ontario's health care system. Sustainability considers not only the direct capital projects in the built environment but also the ongoing services delivered in these buildings (i.e., total cost of operation).  Within the context of sustainability, flexible and efficient hospital design should also be considered. This may involve building flexible space (modules) that can be re-purposed based on current program and service delivery needs <sup>1</sup> .

See Appendix for full OASIS Capital Planning Bulletin.

<sup>1</sup> See Appendix for information on how a hospital's Energy Conservation and Demand Management plan developed under the Ministry of Energy's broader public sector energy reporting regulation can support sustainability by helping hospitals identify and implement energy conservation projects.

Once the content review is complete there are two potential outcomes:

1. The ministry finds that the documentation provides all necessary information to complete the review for that stage of the process. Where this occurs, the ministry will inform the hospital that no further work is required for that stage and the hospital may proceed to the next stage of the Capital Planning Process if approved.  
OR
2. The ministry finds that there are gaps in the documentation provided, or areas that require further clarification or additional information. Where this occurs, the ministry will inform the hospital that changes to the documentation are required to address either the identified information gaps or current best practice.

## 2.6 REVIEW CYCLE

The requirements for changes or clarifications to the stage submission documents are sent to the hospital in written correspondence. This correspondence for stage submissions is referred to as ministry "comments." The hospital will then be required to revise and re-submit the stage submission to respond to the ministry's comments and to address all other comments in an **Issues and Comments Form** used by the ministry. Each of these actions of submitting stage documentation for ministry review and receiving a subsequent response from the ministry is known as a "Review Cycle." Based on the complexity of each proposal, the ministry will consider combining stages in order to expedite review.

### *Reducing Submission Review Cycles*

*The number of review cycles required at each stage of the Capital Planning Process will directly impact project timelines as set out in the project schedule.*

*Where the ministry comments include questions, requests for additional information, or directions to make changes, the hospital will need to factor in enough time to respond and re-submit for ministry re-review. Therefore, each review cycle (i.e., ministry review of submission and comments, and hospital changes and response) can take several months to complete.*

*The following actions can limit the need for additional cycles:*

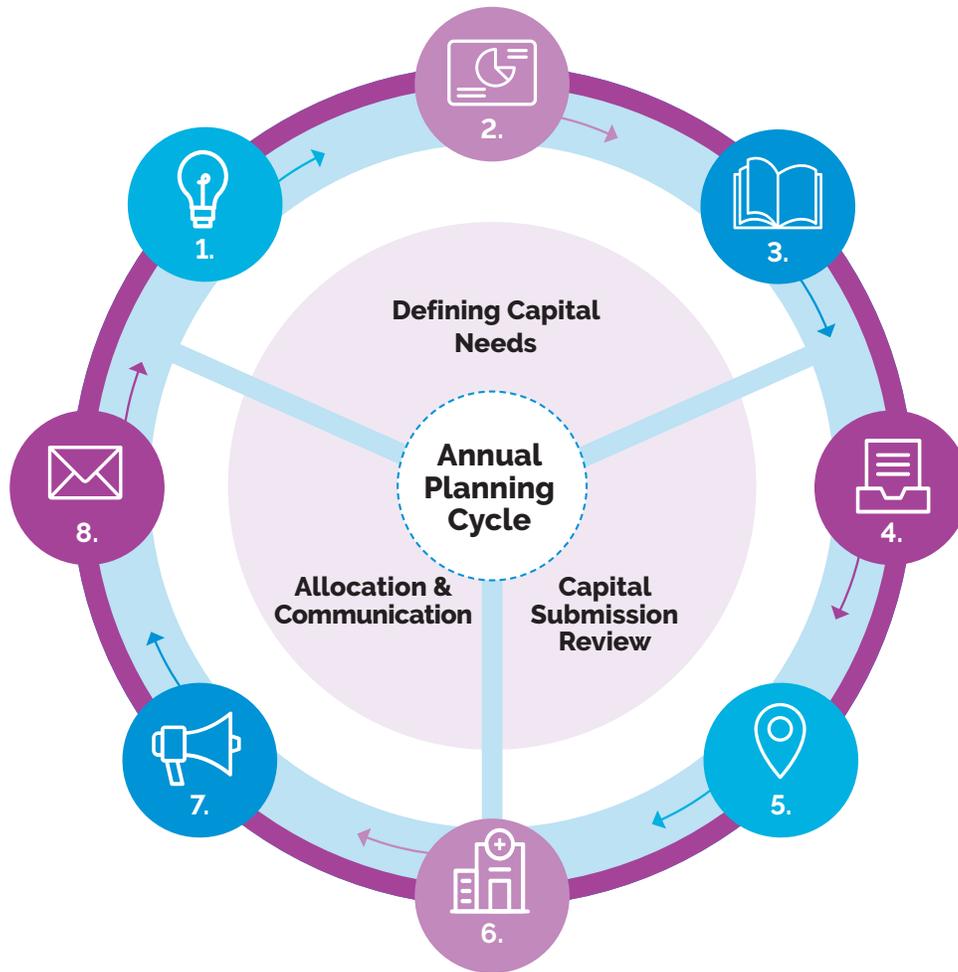
1. *Documentation requirements are clearly defined by the ministry and fully understood by the hospital, using the Stage Submission Checklists at the initial project planning meeting and in subsequent meetings prior to each stage of the Capital Planning Process;*
2. *The hospital and its Integrated Project Team ensure that each submission package is complete (i.e., contains all materials identified as necessary for that stage review);*
3. *The hospital and its Integrated Project Team are fully aligned with planning direction provided by the ministry through the issuance of planning parameters (if applicable);*
4. *The hospital and its Integrated Project Team complies with the ministry requirements regarding the format and number of copies of stage submission document packages;*
5. *The hospital ensures that the submission complies with all ministry and government procurement and cost share policies and guidelines; and*
6. *The hospital and its Integrated Project Team respond fully to all ministry comments, requirements and recommendations when submitting a revised stage documentation package.*

## Government Fiscal Planning Cycle for Capital Projects

Figure 2c depicts the typical fiscal planning cycle for all capital projects, including the time of year in which the ministry submits its annual capital plan to government and the time in which it receives its capital allocation.

While most capital project decisions by government fit within the annual capital planning cycle, hospital stage submissions, as well as ministry review of those submissions, can occur at any point in the year and follow their own timeline. There may also be instances where particularly urgent projects are reviewed and approved by government outside of the planning cycle, including own funds projects.

**Figure 2c: Government Capital Fiscal Planning Cycle**



**1. Intake of Pre-Capital Submissions**  
Ministry receives continuous intake of Ontario Health-endorsed Pre-Capital Submissions from hospitals



**5. Winter/Spring**  
Government decisions on ministry capital allocation\*



**2. Ministry Assessment**  
Ministry assesses new Pre-Capital Submissions in collaboration with Ontario Health



**6. Spring**  
Ministry finalizes resources available to support existing & new projects



**3. Fall**  
Ministry prepares capital submission to government as part of annual planning cycle for upcoming fiscal year



**7. Public Throne Speech**  
Provincial Budget Tabled  
Provincial Estimates Tabled



**4. Fall/Winter**  
Capital submission for upcoming fiscal year finalized and entered into government planning cycle



**8. Late Spring/Early Summer**  
Ministry advises hospitals of project/proposal status

\*Capital projects are reviewed throughout the year and urgent projects can be approved by government outside of this cycle.

## 2.7 CONSIDERATIONS IN PLANNING A HOSPITAL CAPITAL PROJECT

### Integrated (Capital) Project Team

Capital projects, like any other project, require a project team with the knowledge and skills necessary to effectively plan and deliver the project. The highly complex nature of hospital design requires the balancing of many functions and requirements to meet the needs of occupants and the systems that support the facility. While some architects work in relative isolation at the initial stages of design development, and only later in the design process receive input from consultants and stakeholders, the growing use of Integrated Project Teams has proven to be a more effective way of creating efficient, sustainable, and user-friendly health care facilities. The ministry recommends an Integrated Project Team approach for all capital projects, starting at the earliest stages of planning to ensure a project of the highest quality is delivered.

Generally, Integrated Project Teams are composed of experts from various fields who might positively influence the successful development of the project. They are essential to planning an effective capital project that can be delivered on time, on budget and within the approved scope. All team members share in the responsibility of meeting the team's goals and maintaining a clear understanding of the project's overarching objectives.

In planning and delivering a capital project, the hospital will provide resources from within and potentially from outside its organization as Subject Matter Experts (SMEs) to work with a group of procured consultants through various stages in the Capital Planning Process. Together they form an Integrated Project Team. Hospital personnel bring to the project a keen understanding of the organization and the needs of their patients and community. Conversely, the external SMEs contracted by the hospital will possess project-specific skills in planning, designing and delivering hospital-based capital projects. The range of resources that may be required for any given project will be based on the size, scope and complexity of the project.

For more information, CSA Z8000 Canadian Health Care Facilities and related CSA standards provide a detailed overview of Integrated Project Teams as applicable to the planning, design and construction of health care facilities.

### Project Manager

The Project Manager's role is to oversee the planning and delivery of the project, including managing the scope, cost, project schedule, resources, quality control, communication, procurement, and project risks. The scope of work should be clearly identified and understood by the Project Manager at the outset of his/her involvement.

The education of a Project Manager can be varied. The ministry requires that they be a professional with demonstrated project management experience directly relating to capital projects. The Project Manager could be an Architect (Ontario Association of Architects ("OAA")), Engineer (Professional Engineer of Ontario ("PEO")) or have project management professional ("PMP") credentials.

It is up to the hospital to evaluate the organization's management capacity and to determine when the Project Manager should be hired or appointed. However, current practice suggest the Project Manager should be onboarded before the other main consultants are retained by the hospital.

## Types of Planning Consultants

Depending on the project a variety of consultants may be included to plan, design, cost, and implement the project. Below are some examples that may be included. Please see the *Hospital Capital Cost Share Guide* for further details.

1. Functional Programmer: Jointly develops the requirements of the functional program with the hospital.
2. Prime Consultants (Architect/Engineer): Provide the major design services in association with their sub consultants.
3. Sub Consultants: Part of the Prime Consultants Team; and
4. Cost Consultants: Prepare detailed cost estimates during the preliminary design and contract document developments.

For additional information on Integrated Project Teams refer to the Integrated Project Management Framework Bulletin, located in the Policies and Guidance Document section of the Appendices, as well as to external sources such as CSA Z8000 Canadian Healthcare Facilities and documentation available through the PMP Institute.

## Performance Measurement

A key component in planning a successful capital project is determining early in the process how performance will be assessed and the relative merits of proceeding with the proposed solution. This includes the development of both quantitative and qualitative performance measures that assess the extent to which the proposed project will address identified service gaps in a manner that best benefits and protects the public interest. The specific and tangible benefits of the proposed capital solution should be clearly reflected in the hospital's Stage 1.2-Proposal Submission to Ontario Health and the ministry.

Table 2d captures some of the common value drivers and performance measures found in typical health capital projects.

**Table 2d: Hospital-Based Capital Projects: Performance Measures**

Value Drivers	Performance Measures
Physical Condition of Asset	Extent to which facility condition will be improved (e.g., FCAP score) as a result of project
Project Costs	Extent to which project is affordable, including hospital management of <i>local share</i> obligations Extent to which project costs are managed within defined budget
Project Schedule	Extent to which project is delivered by estimated date of completion
Efficiency of Asset Utilization	Difference between current operating costs and projected operating cost of new asset(s) (e.g., maintenance, lifecycle, energy costs, etc.) Degree to which new space can be re-purposed should service delivery needs change in the future Degree to which project produces efficiencies in staff time and supply costs
Utilization of Asset(s)	Degree to which asset(s) meet intended service delivery needs and/or clinical service volumes (e.g., utilization by levels of care) Degree to which technological efficiencies improve patient care Degree to which project enables innovation/new models of care in clinical service delivery Degree to which project improves patient access and safety (e.g., proximity of services, building access, infection prevention and control, etc.)

One of the ways the ministry assesses the performance of a capital project is through a Post-Occupancy Evaluation. Refer to Chapter 3 for more information on the POE process.

## Risk Analysis

All capital projects have some degree of uncertainty or risk. It is for this reason that hospitals should follow sound risk management practices when planning, setting up budgets, procuring, and constructing capital projects.

A hospital's risk management plan for their capital project may describe means and methods for the quantification of risks (e.g., using Quantitative Cost Risk Analysis–QCRA) using assessments of probability of occurrence and impact for each item identified in the project risk register. Such assessments should inform the allocation of appropriate contingency funds. Best practice also includes a risk register – specific to project scope – throughout the lifecycle of projects.

Mitigation plans should be identified for all risks and be iteratively reviewed/refined/implemented through the project lifecycle.

The government's *Transfer Payment Accountability Directive* (TPAD) sets out the administrative accountability framework for the oversight of transfer payment recipients and activities funded through transfer payments, including the assessment and management of risks.

While the type of individual risks inherent in hospital-based capital projects can be quite unique, there are common categories to assist in identifying and classifying risks using a standardized framework, as found in the following table:

**Table 2e: Definitions of Risk Categories**

Risk Categories	
Risk	Description
Delivery/Operational Risk	Uncertainty on the performance of activities designed to carry out any of the functions of the hospital, including design and implementation
Financial Risk	Uncertainty obtaining, using, maintaining economic resources; meeting overall financial budgets/commitments, including the hospitals local share obligations
Stakeholder/Perception Risk	Uncertainty on the expectations of stakeholders (media, public, etc.); maintaining positive public image; ensuring satisfaction and support of partners
Timeline Risk	Uncertainty on the ability to deliver initiatives by outlined timelines
Governance Risk	Uncertainty of having appropriate accountability and control mechanisms
Policy Risk	Uncertainty that strategies and policies will achieve required results or that policies, directives, guidelines, and legislation will not be able to adjust as necessary

Refer to Appendix for applied examples of each of the risk categories.

Hospitals are responsible for developing and maintaining their internal (capital) risk management plan. The ministry does not generally review the full plan; however, some aspects may be required within the context of the capital planning review and approval process. For example, a hospital's *Local Share Plan* submission should include a risk analysis and risk mitigation section that estimates the impact of a change on cost assumptions, scope and affordability of the project.

## Hospital Capital Cost Share Guide

The ministry's Hospital Capital Cost Share Guide (Cost Share Guide) defines eligible costs for a ministry-approved and funded small or major capital project. These costs are often referred to as the ministry "shareable" costs. Generally, the ministry will fund 90% of the eligible project costs and 100% of eligible planning, design, financing, and transaction costs.

Funding of both the remaining 10% of all eligible project costs and any costs not eligible for ministry funding are the financial responsibility of the hospital. These costs are also known as the hospital's "local share" for the project.

The following are main areas of focus within the Cost Share Guide:

- **Capital Costs During Construction**  
(e.g., hard construction costs, financing costs during construction for P3 projects, etc.)
- **Hospital-Related Project Costs**  
(e.g., ancillary costs, change orders, variations, furnishings and equipment, etc.)
- **Facility Maintenance Costs**  
(e.g., P3 – DBFM only)
- **Other General Costs**  
(e.g., commissioning, insurance, taxes)

The most recent version of the Cost Share Guide provides specific details with respect to the elements of a capital project that are eligible and ineligible for ministry funding. **Any hospital intending to apply for ministry capital funding should first thoroughly review this document which can be found in Appendix v.** Hospital representatives who have additional questions are advised to contact HCIB and speak with their designated Senior Consultant.

## 2.8 PROCUREMENT MODELS

### Overview

There are two main procurement delivery models supported by the ministry:

1. Traditional; and
2. Public-Private Partnership (P3)

As explained in Chapter 3, all hospital-based capital projects follow the same pathway in early capital planning up to the end of Stage 1.3-Functional Program.

During Functional Program development, a decision is made by government on the procurement model that approved capital projects over \$20M will follow.

### Traditional Procurement Model

Capital projects procured using the Traditional Procurement Model are those where the hospital and its Integrated Project Team are responsible for both the design and construction of the project. They are often referred to as 'design-bid-build' projects.

For traditional procurement projects, the ministry encourages the use of standardized *Stipulated Price Contract* for services (following CCDC 2) between the hospital and General Contractor/Builder. The General Contractor/Builder will then sub-contract certain specialized services from other companies, as required.

Under this procurement model, which may have lowest upfront costs, the hospital and government retain design, construction and financing risks as well as potential increases in project cost (e.g., change orders). Funding is generally provided to the hospital by the ministry as construction progresses.

## Public-Private Partnership Model

Public-Private Partnership (P3) Projects are an alternative to the Traditional Procurement Model described above. P3 projects utilize private sector financing to strategically build or re-build large, complex infrastructure while ensuring public control and ownership.

Using the P3 model, the hospital contracts a project consortium (*Project Co.*), which provides project financing, delivery and risk management, in accordance with the hospital's requirements and specifications.

P3 integrates key project components using performance-based output specifications, thereby encouraging design excellence and minimizing scope changes.

Funding is provided to the hospital by the ministry at key project milestones defined in advance to optimize value such as interim completion, *substantial completion*.

As noted in Section 2.4, there are many potential risks for complex construction projects in terms of design errors and omissions, unforeseen site conditions, labour and material costs, as well as ongoing maintenance and financial risks. In P3 contracts, many of these risks are transferred to Project Co.

IO recognizes that projects have different characteristics and requirements and thus has developed three P3 contractual models for use in hospital-based capital planning and delivery:

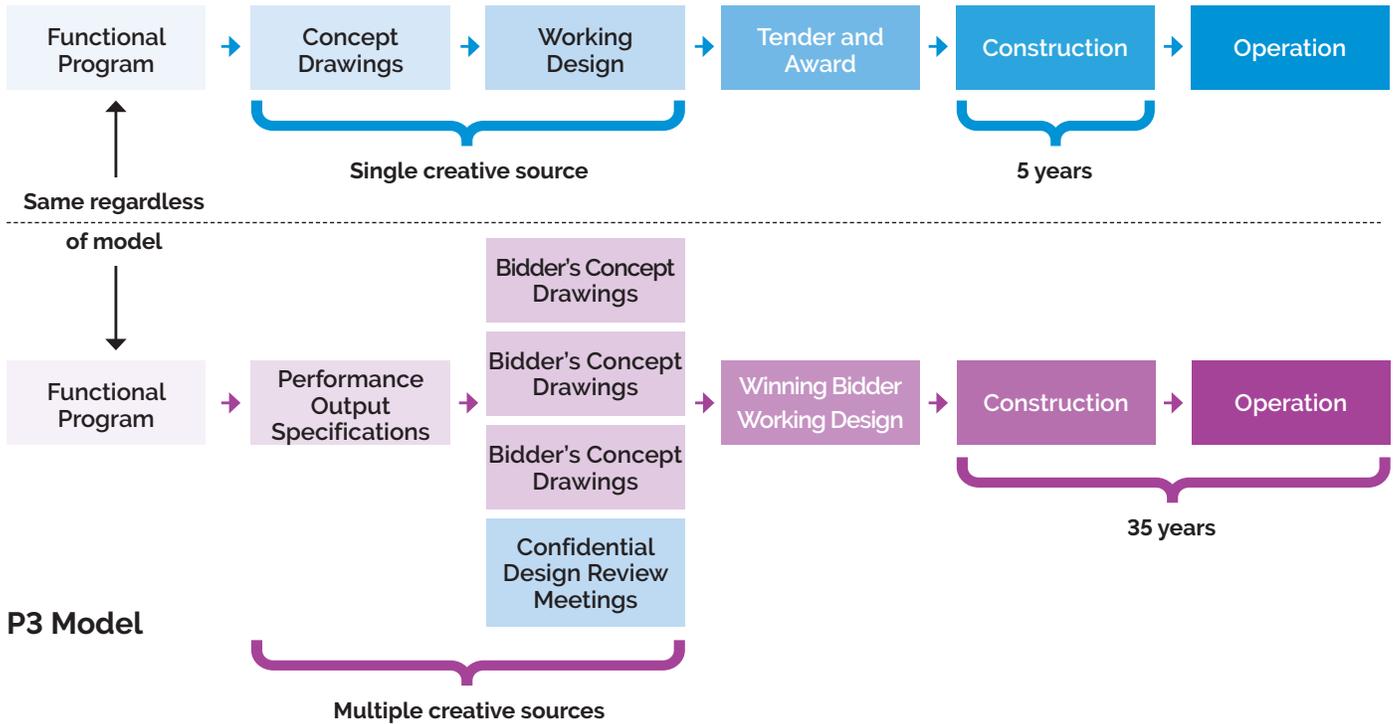
- **Build-Finance (BF):** Project Co. is responsible for construction and financing during the construction period. Design specifications follow a path like traditionally procured projects (hospital prepares design, but design coordination risk is transferred to the private sector).
- **Design-Build-Finance (DBF):** Project Co. is responsible for design, construction and financing during the construction period. The Performance-Based Output Specifications articulate design requirements for the project with associated design risks transferred to the private sector.
- **Design-Build-Finance-Maintain (DBFM):** Same as with DBF; however, Project Co. is also responsible for maintenance of the facility, paid for by hospital through Local Share, which is typically over a 20 to 30-year term.

P3 models can be delivered in a progressive manner where a Development Partner is selected initially to advance the design of the project progressively and price it in collaboration with the hospital and Infrastructure Ontario before entering into one of the above listed P3 contracts. Please see the Appendix for more details.

Figure 2f presents a visual depiction of the planning pathways for a traditional major hospital capital project and a major hospital P3 (DFBM) project. As noted in the visual, both projects follow the same capital planning pathway up to the end of functional program, at which point the P3 project moves into the development of the performance-based output specifications instead of prescribing the design solution.

**Figure 2f: Planning Pathways by Procurement Model**

**Traditional Model**



Supplemental information on P3 project planning can be found in Chapter 4 of the HCPPM and the Appendix as well as Infrastructure Ontario's website ([infrastructureontario.ca](http://infrastructureontario.ca)).

# 3

## Capital Planning Stages

# Chapter 3: Stage Submission Process

## Purpose

Chapter 1 identified the scope and objectives of the manual, provided guidance regarding how it is to be used and introduced the roles and responsibilities of the various stakeholders.

Chapter 2 explained key concepts in planning a hospital capital project including needs identification and analysis, submission and approval requirements by project classification, and procurement models.

Chapter 3 provides a more fulsome examination of the various stages of ministry review and approval. These stages adhere to the methodology employed by the health care planning, design and construction industry and therefore, other than the Pre-Capital Submission, reflect naming conventions familiar to the industry. It is important to note that specific activities within each stage of the document submission requirement(s) may differ depending on the project type (e.g., Own Funds, Small Hospital, and Major Hospital) and project classification (refer to Chapter 2, Figure 2a, Risk-Based Assessment Tool).

The conditions upon which a hospital may be eligible for supplemental operating funding through the Post Construction Operating Plan is also presented.

## 3.1 EARLY PLANNING

### Stage 1.1 Pre-Capital Submission

#### Overview

The first step in the development of a capital project is the identification of program and service needs that require the support of new or renovated facilities. The identification and description of need will most often come from a hospital, but may also arise from Ontario Health, or from both a hospital and Ontario Health through joint planning efforts. Upon the identification of an initiative that requires capital investment(s), hospitals should undertake preliminary planning activities as noted in Chapter 2 to enable completion of the *Pre-Capital Submission Form* (PCSF).

Part A of the PCSF is intended to capture a high-level description of the role of the hospital in the local and regional health system and describe the initiative being proposed, including the program rationale and evidence of alignment with provincial health system priorities. Part B includes a description of the preliminary (capital) development concept.

After completing Part A of the PCSF, the hospital will submit the form to Ontario Health for review. Most hospitals complete Parts A and B together and it is useful for Ontario Health to have part B to support its review of Part A. Once written endorsement is received from Ontario Health, the hospital will submit both parts to the ministry. The ministry and Ontario Health will then establish the alignment of needs to determine whether the hospital will be given written approval to proceed to Stage 1.2-Proposal Development.

All Pre-Capital Submissions must be submitted on the PCSF - this will ensure standardization and consistency of submissions; (ii) Hospitals are required to submit the PCSF to OH only and that PCSFs submitted directly to HCIB without OH endorsement will not be reviewed - this allows OH to fulfill its role in ensuring projects address local system priorities.

#### Reference Documents:

- i. PCSF Template
- ii. Pre-Capital Guidelines
- iii. Integrated Project Management Framework Bulletin
- iv. Planning and Design: Goals and Objectives – OASIS Bulletin

## Ontario Health Support

At the Pre-Capital submission stage, Ontario Health will require the hospital to demonstrate a.) a basic level of consistency between proposed services and local health system priorities, and b.) a coordination with the capacity of adjacent facilities.

As the project is advanced through subsequent capital planning stages, Ontario Health requirements around consistency between proposed services and local health system priorities will become more stringent.

### 3.1.1 Steps to Follow

- 1. The hospital completes Part A (Program and Service Elements) and Part B of the PCSF for capital initiatives and submits the form to Ontario Health for review. This form clearly describes the program and service need driving the initiative, alignment with local health system priorities, projected future demand for the program and service, and alternative solutions considered to address the program and service need.*
- 2. Ontario Health will acknowledge receipt of the submission in writing to the hospital within 15 working days. With consideration to the complexity of the submission and other factors, the correspondence will provide a general estimate of expected review turnaround time and will be copied to the appropriate HCIB Manager.*
- 3. Ontario Health reviews the submission.*
- 4. Ontario Health will respond to the hospital once review of the submission has been completed. The response will seek additional information or clarification as required to enable Ontario Health to develop program and service advice and a recommendation.*
- 5. Ontario Health will develop a recommendation with regard to its position on the PCSF Part A submission.*
  - a. **Endorsement** represents Ontario Health support for the program and service elements of the initiative and allows the hospital to proceed with completion of Part B (Physical and Cost Elements) for submission to the ministry.*
  - b. **Conditional Endorsement** means that additional planning needs to be undertaken by the hospital to address specific program and service issues identified by Ontario Health. Upon conditional endorsement, Ontario Health will advise the hospital as to next steps, including whether the proposal must return to Ontario Health for further review.*
  - c. **Rejection** means that Ontario Health does not support the program and service elements of the initiative. If the hospital wishes to proceed with a different proposal, a new or revised PCSF Part A submission may be considered.*
- 6. If Ontario Health endorses the Part A program and service elements, Ontario Health will provide written rationale and advice to the ministry and request hospital completion and submission of the full PCSF – Part A and Part B – to the ministry. Ontario Health will communicate with the hospital regarding its endorsement to the ministry on the Part A program and service elements.*

### 3.1.1 Steps to Follow (cont'd)

- a. *Ontario Health will prepare a summary of its review and rationale for endorsement of the programs and services and provide this to the ministry in its formal advice.*
7. *If Ontario Health rejects Part A, Ontario Health will provide written feedback to the hospital that clearly describes why the initiative was not endorsed. The feedback may invite the hospital to develop a revised Part A submission that will satisfy Ontario Health criteria. This correspondence will be copied to the appropriate HCIB Manager.*

*Most hospitals complete Parts A and B together and it is useful for Ontario Health to have part B to support its review of Part A.*

8. *The hospital completes Part B of the PCSF. Part B of the form will provide a general description of the physical and cost elements of the proposed initiative.*
9. *The hospital attaches Part A and Part B and forwards the entire PCSF to the ministry. The ministry will acknowledge receipt of the submission in writing to the hospital within 15 working days.*
10. *The ministry reviews Part A and Part B including the formal advice received from Ontario Health with respect to Part A (see step 6. on previous page). The ministry will seek additional information or clarification from the hospital as required.*
11. *The ministry will initiate a meeting with Ontario Health to review the submission.*

- a. *If the ministry supports Part A and Part B including the advice received from Ontario Health regarding Part A, formal ministry support for the Pre-Capital Submission and approval to proceed to Stage 1.2-Proposal Development may be provided to the hospital. This correspondence will advise the hospital as to lead consultant roles for Stage 1.2 and could include a request for a formal meeting between the ministry, Ontario Health and the hospital. **A planning grant may also be approved for the development of a Stage 1.2-Proposal Submission.***

*Receipt of ministry support does not guarantee that all Pre-Capital Submissions will proceed to Stage 1.2-Proposal Development. All completed Pre-Capital Submissions with ministry support will be considered for funding within the fiscal framework established by government.*

## STAGE 1.2: PROPOSAL DEVELOPMENT

### Overview

Following the review of a Pre-Capital Submission, the ministry may provide formal support and approval for a hospital to proceed to Stage 1.2-Proposal Development, which is the second step in the capital planning process. During this stage the hospital develops a detailed overview of the need and options for the proposed capital initiative, including descriptions and analyses of both program and service elements (Part A) as well as physical and cost elements (Part B).

### **H** Hospital Land Purchase

*The ministry does not provide capital funding support for the purchase of land for hospitals, or upgrading and bringing services to the site.*

The Proposal Development stage will help the hospital understand and articulate issues such as:

- Future demand for services, including options for service delivery;
- High-level space requirements for the proposed service delivery model;
- Condition of existing facilities;
- Options for development;
- Benefits and detriments of pursuing different options; and
- Project costs and implementation schedule.

The Stage 1.2-Proposal Development process may start with an initial project planning meeting whereby the ministry meets with the hospital and Ontario Health to discuss the proposed project. The ministry will review with the hospital several key considerations that will impact successful project planning. These include but are not limited to:

- An overview of the Capital Planning Process;
- Roles and responsibilities;
- Procurement policies;
- Ministry capital policies;
- Funding eligibility;
- Project schedule; and
- Integrated Project Team composition.

The Stage 1.2-Proposal Submission Checklist, which outlines Stage 1.2 submission requirements, will be tailored to the proposed project based on the classification and complexity of the proposed project.

## Site Selection and Acquisition

Site selection for a new hospital, including the public consultation process, is the responsibility of individual hospitals with input from Ontario Health and the ministry in accordance with the *Public Hospitals Act*, 1990. In the event that the acquisition of property is required to support a capital project, site selection should be integrated with the requirements of the clinical programs to be delivered.

Hospitals will need to address issues such as:

- Proximity to other health care services;
- Opportunities for partnerships or integrations;
- Opportunities for expansion;
- Alternative models considered (i.e., lease vs. purchase, renovation vs. new construction).

In planning for the selection of a potential future location, hospitals should consider:

- **The size of the available land** to accommodate the Master Program and Master Plan requirements for expansion and facility renewal, municipal requirements, future developments, and the eventual replacement of the facility.
- **Access to the community** by main transportation routes including public transit.
- **Access to site services** such as hydro, water, sanitary connections, gas, etc. Note: the ministry does not provide capital funding to bring site services to a site, or upgrade site services off-site.
- **Existing use of the site and environmental impact** as a Greenfield (no pre-existing building or site services) or as a Brownfield (existing building or site services). Both conditions can affect the local community.

- **Accommodation for meeting municipal requirements** such as zoning and use, parking and loading, setbacks, and urban design considerations.
- **Natural topographic and soil conditions** including allowable useable lands which may be restricted by water features, flood plains or conservation designations.
- **Positive site features** that enhance patient and staff experience of the health care facility such as views, natural light and prevailing winds.
- **Land value and costs** for utility and transportation infrastructure, possible environmental remediation costs, etc.

## Facility Planning

The development of a Stage 1.2-Proposal submission requires extensive planning expertise and the contributions of both internal and external stakeholders. It considers the interplay between program and service elements, physical and cost elements, analyzes multiple development options, and identifies a preferred physical solution.

## Master Programming

For projects that have service delivery impacts, the hospital will be required to submit a comprehensive and integrated Master Program. As noted in Chapter 2, the Master Program is a document that reflects the hospital's present and future service delivery model and role within the community. It outlines current and projected services and associated clinical volumes, operating principles, major elements of the service, and component space requirements based on the demographic data in the health care services plan. It is used to determine both the mid and long-term planning of a physical site, as well as assist in determining the requirements of the next stage, functional programming.

If a hospital provides care from multiple sites, the Master Program must consider all facilities that form the organization. In addition to containing a section for each individual program and service associated with the health care facility, the Master Program should contain the following core elements:

Contents of Master Program	Present	Future
Program parameters: model of care, organizational structure, hours of operation	Current	Projected
Partnerships with community-based health care providers	Current	Projected
Scope and extent of services provided	Current	Projected
Workload by program/service	Past three years	Provide methodology and rationale
Service volumes by program/service	Past three years	Provide methodology and rationale
Attendances by program/service	Past three years	Provide methodology and rationale
Beds by program/service	Past three years	Provide methodology and rationale
Other factors affecting space	Current	(e.g., staff numbers in non-clinical areas)

### Notes:

- Timing, projections should be provided for the year of the proposal, 5, 10 years out and 20 years out.
- The population and demographic information should be based on Ontario Ministry of Finance data.
- Options for Changes in Service Delivery should identify model of care options as well as operating and capital implications.
- Refer to applicable CSA standards for health care facilities.

## Master Plan

A Master Plan translates the Master Program into a physical plan, analyzes site use options for alternative development scenarios and defines the predicted stages of development for the hospital. If a hospital provides care at multiple sites, the Master Plan must consider how the sites function individually as well as a collective whole.

A Master Plan should explore and demonstrate the potential for developing a specific geographic site within a Hospital Corporation. The resultant analysis ought to consider the impact of the proposed capital project on the site and account for all physical, regulatory and cultural opportunities and limitations presented by the site on the proposed capital project. In addition, the impact of the proposed capital project on community planning and development should be addressed.

In the context of the near-term (0 to 5 years), the Master Plan should be coordinated at a detailed level with the Master Program. It must also extend beyond the near-term at a strategic level and provide optimum flexibility to accommodate the changes that will occur in health care delivery generally and in the programs and requirements of that hospital facility over a 15 to 25-year timeframe. Moreover, a comprehensive Master Plan should envision how the hospital facility can be replaced, as building components age and require retrofit and/or replacement.

To remain current and relevant, Master Plans should be reviewed and updated regularly with the Master Program. Doing so will ensure the vision and framework for development are in keeping with the strategic vision for the hospital and in alignment with the ministry's strategic direction.

Depending on the scope and nature of the project, a physical feasibility study may also be required for an existing facility. The physical feasibility study evaluates potential use of existing buildings that have a reasonable life expectancy. The hospital should determine prior to undertaking master planning whether such a study may be warranted. Refer to CSA standards for Health Care Facilities, the Health Capital Planning Bulletin on Master Planning and the OAA's Canadian Handbook of Practice (CHOP) for additional information.

## Options Analysis

Following the development of multiple Master Plan options, the hospital must carry out an options analysis exercise based on hospital priorities and alignment with the ministry's strategic direction. This process should incorporate sound risk analysis and consider both internal and external criteria that bear on development, including but not limited to:

- Operational factors;
- Cost effectiveness;
- Short and long-term opportunities;
- Delivery (schedule);
- Economic impact; and
- Sustainability.

A business case analyzing the available development plan options and the prioritization process should be submitted to the ministry, including identification of the preferred solution for development.

**Greenfield hospital investments are the most costly form of health infrastructure investment, and have a lengthy implementation timeframe. If a hospital is proposing a Greenfield hospital project (new site, no existing facilities) a Brownfield (existing site, existing facilities) option must also be included as an option with consideration made to the criteria noted.**

## Facility Development Plan

The Facility Development Plan (FDP) is a component of the Master Plan which articulates the preferred option in greater detail. The FDP includes the priority programs that have been identified for immediate implementation at Stage 1.1-Pre-Capital Submission. The development of these priority programs, the areas of the master building plan that need to be immediately addressed, and associated costs form the basis of the hospital's request for a capital project reflected in the FDP. Every FDP that proposes a capital project to the ministry must conform with the current Master Plan and Master Program and be supported by a written description that demonstrates alignment.

The FDP provides floor plans that capture the major program location and boundaries of the scope of the proposed project, and that identify major circulation routes, entrances and exits. The FDP also includes a master site plan that reflects the major civil, parking and helipad considerations. The proposed FDP space summary is considered the basis for the proposed Stage 1 building cost estimate, which will be reflected in the funding/financing plan. The FDP should inform and align with the other documents that will be included in the Stage 1.2-Proposal Development Submission.

## Review Roles

Part A of the Stage 1.2-Proposal Development Submission typically includes the Master Program, preliminary operating cost estimate, service delivery options analysis and human resources plan. Part B contains the Business Case/Options Analysis, the Master Plan and the Facility Development Plan. Refer to the Stage 1.2-Proposal Development Submission Checklist found in the Policies and Guidance Documents section of the Appendix for the full listing of requirements that may apply.

Upon completion of both Part A and Part B of the submission, the hospital will distribute documentation as follows:

- Ontario Health: Complete submission for review (Executive summary and Part A and B) and if appropriate and supportive OH will endorse the Executive Summary and Part A; and
- Ministry: Provide the OH endorsed submission (Executive Summary, Part A and Part B).

Though the submission itself will be structured according to pre-established information requirements (Part A and Part B elements), the organization of planning activities will be determined by the hospital.

### Reference Documents:

- Stage 1.2-Proposal Development Checklist
- Stage 1.2-Proposal Development Guidelines
- Capital Cost Share Guide
- Planning and Design: Goals and Objectives – OASIS Bulletin
- Planning and Design: Master Planning Bulletin
- Planning and Design: Flexibility and Adaptability Bulletin

## Ontario Health Support

At this stage, Ontario Health will require that the hospital demonstrates a high level of consistency between proposed services and local health system priorities.

Further discussion will be required during Stage 1.3-Functional Program to achieve alignment between the proposed mix of programs and services to be provided and local health system priorities; siting (for multi-site facilities); and changes or introduction of innovations in the model of care.

### 3.2.1 Steps to Follow

1. *Following ministry approval to proceed to Stage 1.2, the hospital and its Integrated Project Team will engage in planning to complete all Stage 1.2 Submission requirements (Part A and Part B) identified during the initial project planning meeting or other form of correspondence with the ministry.*
2. *Upon receipt of the submission, the ministry's designated Senior Consultant will liaise with Ontario Health to:*
  - a. *Confirm that all submission requirements were received as per the Stage 1.2-Submission Checklist, and*
  - b. *Develop a general timeline for review of the submission. This timeline will ensure that Ontario Health and ministry review of the Part A submission is complete in order to inform discussion at the first alignment point, and ministry review of Part B.*
3. *The designated Senior Consultant, on behalf of the ministry and Ontario Health, will then prepare correspondence to the hospital that will include:*
  - a. *Confirmation of receipt of submission components within 15 working days.*
  - b. *Expectations regarding general review turnaround time.*
  - c. *Confirmation of a designated ministry contact for overall management of the review (ministry lead), as well an Ontario Health lead contact for management of the Part A review (Ontario Health lead).*
4. *Ontario Health will review Part A, consult with provincial agencies (if needed), and seek additional clarification and amendments on the submission directly from the hospital, as required.*
  - a. *Formal correspondence will be copied to the ministry's designated Senior Consultant.*
  - b. *The designated Senior Consultant and other ministry representatives will be invited to any meetings that occur between the hospital and Ontario Health with regard to Part A.*
5. *The ministry will conduct a concurrent review of Part A and B elements from the provincial perspective and provide comments to Ontario Health. The ministry's review will include consideration of:*
  - a. *Overall system capacity (bed and service volume projections);*
  - b. *Future system need; and*
  - c. *Provincial programs (e.g., Cardiac Care, Transplantation)*
6. **Alignment Point 1 (Ontario Health Lead):** *Ontario Health will take a lead role in initiating discussions with the ministry regarding results of their respective reviews of Part A elements.*

### 3.2.1 Steps to Follow (cont'd)

*Due to important interdependencies between various program and service elements, the ministry and Ontario Health will ensure alignment with regard to their respective reviews and any revisions or further planning that may be requested of the hospital.*

7. *Following ministry/Ontario Health alignment on Part A, Ontario Health will develop a recommendation with regard to its position on the Stage 1.2 Part A submission.*
  - a. **Endorsement** represents Ontario Health support for the program and service elements of an initiative and allows the ministry to finalize its review of Part B (Physical and Cost Elements).
  - b. **Endorsement with conditions** means that additional planning needs to be undertaken by the hospital to address specific program and service issues identified by Ontario Health. Upon endorsement with conditions, Ontario Health will advise the hospital as to next steps, including whether the proposal must return to Ontario Health for further review.
  - c. **Rejection** means that Ontario Health does not support the program and service elements of an initiative. If the hospital wishes to proceed with a different proposal, a new Part A submission may be considered.
8. *If Ontario Health endorses Part A, Ontario Health will provide written rationale and advice to the ministry. Ontario Health will communicate with the hospital regarding its endorsement on Part A, Ontario Health will prepare a summary of its review and rationale for endorsement and provide this to the ministry in its formal advice.*
9. *If Ontario Health rejects Part A, Ontario Health will provide written feedback to the hospital that clearly describes why the initiative was not endorsed. The feedback may invite the hospital to develop a revised Part A submission that will satisfy Ontario Health criteria. Correspondence will be copied to the appropriate HCIB Manager.*
10. *Concurrent with Ontario Health and ministry review of Part A, the ministry will conduct a preliminary review of Part B, physical and cost elements, and seek clarification from the hospital where required. As part of its review, the ministry will consider advice received from Ontario Health with respect to Part A elements.*
12. **Alignment Point 2 (Ministry Lead):** *Following ministry review of Part A and B elements, the ministry will take a lead role and collaborate with Ontario Health to ensure alignment between Part A and Part B elements of the Stage 1.2 submission. This process will provide opportunity to consider the relationship between the program and service elements and the physical and cost elements, ensuring appropriate agreement. If necessary, the hospital will be asked to clarify and/or revise submission requirements. (NOTE: if the alignment process results in material change to Part A, Ontario Health may require endorsement of the change. Material change refers to one with direct operating or program/service implications.)*
13. *Upon completion of its review of Part A and B, and Ontario Health advice, the ministry will finalize its review and advise Ontario Health of its findings and expected next steps regarding the Stage 1.2 submission. The ministry may seek government approval for the proposal and, if authorized, provide approval to proceed to Stage 1.3-Functional Program.*

**A planning grant increase may be provided for Stage 1.3-Functional Program development.** *Planning grants for large capital projects may be accompanied by a Planning Parameters document, agreed to in advance by the ministry and Ontario Health. Planning Parameters provide strategic direction in terms of expected scope (e.g., total bed numbers) and cost.*

## STAGE 1.3: FUNCTIONAL PROGRAM

### Overview

Following review of the Stage 1.2-Proposal Development submission, the ministry may provide formal written approval to proceed to Stage 1.3-Functional Program (FP). During this stage, the hospital and ministry reach agreement on a range of key information inputs needed to design the capital solution and to determine both costs and cost eligibility. Information at this stage includes, but is not limited to:

- Future program and service volumes;
- Models of care;
- Infection control and prevention requirements;
- Space test-fit;
- Space allocation (types of space/number of rooms); and
- Costing and project schedule.

The Functional Program documents detail the planned operational size and scope of services of the facility along with the accompanying capital requirements. The Functional Program expands and refines the Facility Development Plan prepared at Stage 1.2 by describing the components of the proposed solution in greater detail. During this stage, the hospital continues to refine and validate its program costs and demonstrates the sustainability of its proposed future operations by providing details of its current and projected activities, resources and space needs, and estimated future operating and capital funding requirements. The hospital also provides information about departmental and service relationships and locations, including associated workloads, staffing, equipment and space requirements, as well as architectural and environmental conditions.

The development of a Stage 1.3-FP Submission requires extensive planning expertise and contributions by both internal and external stakeholders. By the end of this stage the hospital should provide a sufficient level of detail in its submission such that an Architect/Integrated Project Team could design the space. The ministry uses the agreed to functional programming documents produced during this stage as the baseline to later compare any variances in space proposed during the design and pre-tender stages of the project.

After receipt of written ministry approval of the Stage 1.3-FP Submission and the parameters (service and physical space) therein, the project scope cannot be easily changed as it will directly impact the subsequent design stages and eventual capital solution.

Based on the submission requirements established at the initial planning meeting with the ministry at the start of Stage 1.2-Proposal Development, and following the submission requirements described in the FP Submission Checklist (see Policies and Guidance Documents section of the Appendix), the hospital will prepare the following documentation:

#### Part A Elements:

- Program Parameters;
- Functional Program.

## Part B Elements:

- Design and Spatial Requirements;
- Planning and Design Objectives;
- Phasing Plan;
- Preliminary Furniture and Equipment List;
- Project Budget;
- Capital Variance Template;
- Local Share Plan;
- Project Schedule; and
- Preliminary Post Construction Operating Plan.

## Space Planning and Design Standards

The ministry's planning and design development process plays an important role in promoting and achieving operational and design excellence in hospital facilities. Standardized planning components and systems can be of assistance to hospitals and their design teams in the development of design efficiency in project-specific Master Plans, Facility Development Plans and Functional Programs. While there are numerous industry guidance documents that can be referenced in constructing new hospital buildings, or renovating existing ones, the CSA standards for health facilities are the foundational resources recommended by the ministry.

For example, the CSA Z8000 is the nationally recognized design standard that provides requirements and direction for the planning, design, and construction of Canadian health care facilities. It is intended to be used by all facilities providing health care services regardless of type, size, location, or range of services. The standard was established for use by Architects, Engineers, Planning and Project Managers, Contractors and Builders, Commissioning Teams, Facility Managers, Maintenance Managers, Infection Prevention and Control personnel, and other health care professionals. Using the available knowledge in evidence-based design, CSA Z8000 supports the principles of safety, efficiency, quality care, inclusivity and accessibility, and the creation of a healing environment.

The CSA Z8000 and associated CSA standards should be used by:

- Hospitals and their Integrated Project Teams when preparing a Functional Program, and during the planning and design of hospital spaces;
- The ministry in its advisory role providing comments and feedback to hospitals and their Integrated Project Teams; and
- The ministry as one of many resources referenced when carrying out its advisory/approval role in the Capital Planning Process.

As the suite of CSA standards for health care facilities are continually reviewed and updated to reflect best practices, hospitals and their Integrated Projects Teams should refer to the CSA website found in the Industry Standards and Reference Material section of the Appendix to access the latest information available from CSA.

## Ministry Space Benchmarks

Once the model of care is identified and volumes are agreed upon in the Functional Program, the space in which care will be delivered should be considered. In addition to Ontario Building Code and CSA standards for health care facilities, the ministry has established benchmarks that hospitals are to follow when planning select locations within hospital facilities to maximize operational efficiencies. Refer to the Capital Bulletins in the Policies and Guidance Documents section of the Appendices for the current list of evidence-based, ministry-endorsed departmental space standards/benchmarks.

The aim of these standards/benchmarks is to:

- Encourage equity of investments;
- Reduce waste;
- Improve transparency;
- Support operational efficiency;
- Optimize environment to deliver quality health care programs and services; and
- Maintain health and safety.

The ministry recognizes that models of care are evolving, and, in some cases, hospital operations may support spaces outside of what the ministry has identified. Projects that propose to exceed existing benchmarks or hospital spaces not explicitly covered by existing space standards may be considered by the ministry on a case-by-case basis. Under such circumstances, a business case containing evidence-based design rationale for the additional space(s) must be prepared and submitted for review. Where the ministry does not accept the rationale to exceed the space standard/benchmark, the hospital will be required to use its own funds to support excess space.

## Infection Prevention and Control (IPAC) Requirements for Hospital Capital Project Planning and Costing

The ministry has requirements for IPAC specific to the planning and costing of IPAC technologies in new build and major renovation (includes additions to existing structures) hospital capital projects.

**The inclusion of all – or exclusion of some – of the technologies will be dependent on the range of clinical services programmed into the physical space. For questions about requirements for a specific project proposal, health care provider organizations eligible for capital funding are encouraged to contact Health Capital Investment Branch. *More details can be found in the Appendix.***

## Post Construction Operating Plan

An integral component of FP development is a continuing focus on the implications that the completed capital project will have on clinical and non-clinical activity for post construction operations to be managed effectively and efficiently. For capital projects with increases in clinical service volume and/or clinical service space, hospitals may be eligible for support through the Post Construction Operating Plan (PCOP).

PCOP provides a framework for the allocation of operating funding to public hospitals upon completion of an approved capital project. It ensures that the operating impacts associated with a capital project are agreed-upon prior to project completion. The process is a shared responsibility

between the ministry and Ontario Health. Ministry staff establish the accountability framework for the funding, and the final allocation is made with advice from Ontario Health and hospitals, subject to senior management approvals and an annual appropriation by the Legislative Assembly of Ontario. A hospital's preliminary PCOP is first submitted to the ministry in Stage 1.3-FP but is continually refined throughout the later stages of the capital planning process. The approved Functional Program and *Final Estimate of Cost* represent the PCOP's key approval documents and basis for arriving at funding allocations for incremental clinical service volumes, equipment amortization related to new equipment purchases, incremental facility costs for net new clinical space added, and other relevant costs (such as start-up, transition and trailing costs). PCOP funding, which is provided over several years, flows on an annual basis and is subject to annual reconciliations to assess the achievement of funded clinical service volumes. The Accountability Agreement between the province and hospital is amended to reflect the additional operating requirements associated with PCOP funding allocations.

For additional details on funding methodology and submission requirements, refer to the Post Construction Operating Plan Guidelines in Appendix xv.

## Local Share Plan

The Local Share Plan (LSP) is an important document that identifies the timing and sources of funds for the hospital's share of the *Total Project Costs* (TPC). It demonstrates to the ministry that the hospital has a sound financial plan to manage its local share obligations. The level of detail required in a LSP will depend on the size and scope of the project Preliminary Furniture and Equipment List as the submission requirements communicated by the ministry through the ministry's designated Senior Consultant. Topics to be addressed in an LSP can include:

- Financial support available from the hospital or its foundation for the capital project;
- Fundraising campaign(s) planned by the foundation;
- Various revenue sources including parking and retail (e.g., food service vendors);
- Federal, municipal contributions;
- Hospital's capital budget; and
- Sources of bridge financing.

With respect to fundraising campaign(s), the ministry may ask the hospital to demonstrate its ability to meet fundraising targets, including historical performance of other fundraising campaigns as well as the completion of a feasibility study. For bridge financing, the hospital may be required to disclose the terms and conditions of funding, as well as provide a viable financial plan to repay the obligations. For any uncertain funding sources such as fundraising or revenue forecasts, the hospital must provide a contingency plan as part of its LSP submission.

In Stage 1.3-FP, the ministry begins its risk-based assessment of the hospital's preliminary LSP. Such an assessment could include a review of the hospital's audited financial statements, Board minutes, cash flow projections, existing debts, hospital foundation commitments, and revenue projections from both onsite and external sources. The intent of the assessment is to confirm the hospital is able to manage the financial impacts of the capital project without unduly affecting existing programs and services.

Ontario Health also reviews the LSP when it includes hospital revenue sources such as parking, accommodation and retail.

## Value Analysis and Ministry-Directed Value Engineering

Value analysis is a management tool that can be used to maintain quality control over a capital project. It should be carried out throughout the planning and design phases to ensure that the proposed design solution supports patient care and provides the best value for money. Value analysis is not a one-time event for decreasing costs, but a structured approach to identify the functional requirements of a project to align scope with the intended objectives.

Where there are unexpected increases in capital or operational costs, or for other reasons, the ministry may determine that independent *value engineering* must be conducted and will direct the hospital to undertake such a study. This process may result in changes to the scope of the project when the independent analysis concludes the facility is not overdesigned and alternative solutions are not available. In other cases, the independent value engineering results may trigger changes to the project budget to accommodate the current scope. Both processes are time-consuming and have the potential to create unexpected project delays. It is therefore essential that a hospital's planning, design and construction process be fully transparent and that value analysis activities be carried out on a regular basis.

Should the ministry direct that value engineering be undertaken, the associated expenses are eligible for cost share under Prime Consultant services if total project costs are over budget by 10% or more. Where the Prime Consultant cap is exceeded, and there is significant value engineering required beyond the control of the Prime Consultant team, the ministry will consider cost sharing additional expenses on a case-by-case basis. Additional information on value analysis and value engineering can be found in the Appendix.

## Review Roles

Ontario Health retains the lead in reviewing Part A (program and service) and the ministry is the lead for reviewing Part B (physical and cost). Due to the importance of Stage 1.3-FP in defining the scope of programs and services to be included in the project, the ministry will also conduct its own review of Part A from a provincial perspective. The ministry has a particular interest in Part A pertaining to:

- Overall system capacity (beds and service volume projections)
- Future system need
- Provincial Programs (e.g., Cardiac Care, Transplantation, etc.)

In order to ensure a consistent and comprehensive response to Part A elements, Ontario Health and the ministry will reach alignment before advancing further in the Capital Planning Process. This step will consider the respective reviews of Part A elements to make sure that any questions or comments directed to the hospital are consistent. The alignment step will also ensure that the hospital's Stage 1.3-FP Part A elements are consistent with the local health system's priorities as well as the ministry's provincial perspective and views on overall system capacity.

### Reference Documents:

- i. Stage 1.3-FP Checklist
- ii. Capital Cost Share Guide
- iii. Capital Planning Bulletin: Planning and Design: Flexibility and Adaptability Bulletin
- iv. Planning and Design: Infection Prevention and Control Bulletin
- v. Surgical Suite, Space Benchmarks Bulletin
- vi. Emergency Department, Space Benchmarks Bulletin
- vii. IPAC Requirements for Hospital Capital Project Planning and Costing
- viii. Acute In Patient Benchmark (currently draft)
- ix. IPAC Bulletin

## Ontario Health Support

At the FP stage, Ontario Health will require that the hospital demonstrates complete consistency (strategic fit) between proposed services and local health system priorities.

### 3.2.2 Steps to Follow

1. *Following ministry approval to proceed to Stage 1.3-FP, the hospital and its Integrated Project Team will engage in planning to complete all Stage 1.3-FP Submission requirements Part A and Part B.*
  - a. *The submission should be assembled and numbered as per the Stage-1.3 Submission Checklist to facilitate review. Hospitals should consult with their designated ministry contact to determine whether the procurement method (e.g., Traditional or P3) contains any special requirements for submission format.*
2. *Upon completion of all Stage 1.3 requirements, the hospital will submit the complete Stage 1.3-FP Submission (Part A and Part B) to the ministry and Ontario Health.*
3. *Upon receipt of the submission, the ministry's designated Senior Consultant will liaise with Ontario Health lead to:*
  - a. *Confirm that all submission requirements were received as per the Stage 1.3-FP Submission Checklist; and*
  - b. *Develop a general timeline for review of the submission. This timeline will include the two alignment points and will ensure that Ontario Health's review of Part A elements is complete in order to inform final ministry review of Part B elements.*
4. *The ministry's designated Senior Consultant, on behalf of the ministry and Ontario Health, will then prepare correspondence to the hospital that will include:*
  - a. *Confirmation of receipt of the submission within 15 working days; and*
  - b. *Expectations regarding general review turnaround time.*
5. *Ontario Health will review Part A, including consulting with HCIB and provincial agencies where relevant, and seek additional clarification directly from the hospital as required.*
  - a. *All formal correspondence will be copied to the ministry's designated Senior Consultant.*
  - b. *The ministry's designated Senior Consultant and other ministry representatives will be invited to any meetings that may occur between the hospital and Ontario Health with respect to Part A.*
6. *The ministry will conduct a concurrent review of Part A and B from the provincial perspective and provide comments to Ontario Health. The ministry's review will include consideration of:*
  - a. *Overall system capacity (bed and service volume projections);*
  - b. *Future system need; and*
  - c. *Provincial programs (e.g., Cardiac Care, Transplantation, etc.).*
7. **Alignment Point 1 (Ontario Health Lead):** *Ontario Health will discuss with the results of their respective reviews of Part A. Due to important interdependencies between various program and service elements, the ministry and Ontario Health will ensure alignment with respect to their respective reviews and any revisions or further planning that may be requested of the hospital.*

### 3.2.2 Steps to Follow (cont'd)

8. Following ministry/Ontario Health alignment on Part A, Ontario Health will develop a recommendation with respect to its position on the Stage 1.3 Part A submission.
  - a. Endorsement represents Ontario Health support for the program and service elements of an initiative and allows the ministry to finalize its review of Part B (Physical and Cost Elements).
  - b. **Endorsement with conditions** means that additional planning needs to be undertaken by the hospital to address specific program and service issues identified by Ontario Health. Upon endorsement with conditions, Ontario Health will advise the hospital as to next steps, including whether the proposal must return to Ontario Health for further review.
  - c. **Rejection** means that Ontario Health does not support the program and service elements of an initiative. If the hospital wishes to proceed with a different proposal, a new Part A submission may be considered.
9. If Ontario Health endorses Part A, Ontario Health will provide written rationale and advice to the ministry. Ontario Health will communicate with the hospital regarding its endorsement of Part A.
  - a. Ontario Health will prepare a summary of its review and rationale for endorsement of the programs and services and provide this to the ministry in its formal advice.
10. If Ontario Health rejects Part A, Ontario Health will provide written feedback to the hospital that clearly describes why the initiative was not endorsed. Such feedback may invite the hospital to develop a revised Part A submission that will satisfy Ontario Health criteria. This correspondence will be copied to the appropriate HCIB Manager.
11. Concurrent with Ontario Health and ministry review of Part A, the ministry will conduct a preliminary review of Part B and seek clarification from the hospital where required.
  - a. As part of its review the ministry will consider advice received from Ontario Health with respect to Part A.
12. **Alignment Point 2 (Ministry Lead):** Following ministry review of Part A and B the ministry will take a lead role and collaborate with Ontario Health to ensure alignment between Stage 1.3-FP elements. This process will provide opportunity to consider the relationship between the program and service elements and the physical and cost elements, ensuring appropriate agreement.

If necessary, the hospital will be asked to clarify and/or revise submission elements. (NOTE: if the alignment process results in material changes to the program and service elements outlined in Part A, Ontario Health endorsement of the change may be required. Material change refers to one with direct operating or program and service implications.)
13. Upon completion of its review of Part B, and Ontario Health advice regarding Part A, the ministry will advise Ontario Health of its findings and expected next steps with respect to the Stage 1.3-FP Submission.

### 3.2.2 Steps to Follow (cont'd)

14. The ministry's designated Senior Consultant, on behalf of the FP submission and Ontario Health, will then prepare correspondence to the hospital that will include details of the status of the Stage 1.3-FP submission:

- a. Status of Ontario Health review;
- b. Status of ministry review; and
- c. Expected next steps.

*At this time the ministry may provide an approval letter authorizing the hospital to proceed to Stage 2.1-Preliminary Design 1 (Block Schematics) Development. A planning grant may be approved for work associated with design development.*

## 3.2 DETAILED PLANNING

### Design Submissions

#### Overview

All capital projects that follow the traditional procurement model and involve the development or redevelopment of a physical space follow the same basic steps in achieving final design drawings (working drawings) and specifications. The following section provides a high-level overview of the steps required in preparing a set of plans or specifications to a level of detail that a General Contractor/construction company can understand both what the hospital wants to build and how much it would cost for labour and materials.

For capital projects that solely address infrastructure repair or replacement and have no clinical service impacts or changes to existing space, detailed plans may not be required. The ministry will engage the hospital prior to the start of preliminary design development to determine which documents from the 2.1 and 2.2 Stage Submission Checklists must be submitted. The ministry may also grant permission for hospitals with minor, uncomplicated renovation projects to submit Stage 2.1 and 2.2 documentation together for concurrent review and approval. Refer to the Risk-Based Assessment Tool in Chapter 2 for further information on the conditions upon which select capital projects may undergo a streamlined Stage submission, review and process.

#### **i** Stop!

*Did you know you should have received agreement from the ministry on the Stage 1.3-FP before proceeding to Stage 2.1-Preliminary Design 1 (Block Schematics)?*

## STAGE 2.1: PRELIMINARY DESIGN 1 (BLOCK SCHEMATICS)

### Overview

The purpose of the Preliminary Design 1 stage is for the hospital to obtain agreement from the ministry on the functional layout of the project as well as minor variances that may have occurred due to space planning. The hospital also provides the ministry with additional detail on the physical realization of the Functional Program as it has progressed from the spatial diagrams into a design concept.

The objectives of Preliminary Design 1 are to:

- Provide the ministry with details of the physical realization of the Functional Program in the design solution;
- Demonstrate the inter and intra component relationships of the Functional Program (for components and individual spaces);
- Provide information about the civil, structural, mechanical, and electrical building systems (the ministry expects that key decisions about the building systems are made during this stage, including an examination of the capital costs for building systems in relation to ongoing operating costs); and
- Demonstrate that the hospital has made evidence-based decisions regarding the ongoing sustainability of its facility and that any such decisions will result in value for money.

Much of the Preliminary Design 1 submission is comprised of Block Schematics which include a description of the design concepts, a site plan, the location of building components, the location and relationship of major departments, the primary horizontal and vertical circulation routes, and the location and elevation of major entrances to and exits from the building. A design brief accompanies the block schematics. The design brief describes the proposed civil, landscape and architectural solutions, structural systems, electrical systems, energy sources, and energy budget, heating, ventilation, and cooling (HVAC) systems, plumbing and drainage, medical gases, mechanical and life safety systems.

In addition, the Preliminary Design 1 submission contains an updated project schedule and cost estimate. The project schedule should indicate the estimated start and completion dates required for:

- The preparation, ministry review and approval of sketch plans, working drawings and specifications;
- Expected tender of the project; and
- Construction and commissioning.

The capital estimate consists of construction and other costs such as commissioning and project management fees. Where possible, back-up information such as unit rates, ratio-to-gross floor area and quantities should be included for each element and sub-element. Total project costs should remain consistent over time and across submissions as well as aligned with the agreed upon scope.

In the event the hospital needs to deviate from the scope and costs agreed to at Stage 1.3-FP, it **must** contact the ministry to both discuss the associated implications and submit a *Capital Variance Template*. Failure to do so could impact further approvals and necessitate a return to an earlier agreement/approval point. Any material changes to the Functional Program shall also be reviewed and approved by the ministry. These changes include but are not limited to number and function of, and size (net or gross) of, any space listed in the Functional Program.

### 3.2.3 Steps to Follow: Preliminary Design 1 (Block Schematics)

1. Following the submission requirements described in the Stage 2.1 Submission Checklist (see Policies and Guidance Documents section of Appendices), and agreed to in advance with the ministry, the hospital collects or develops the various documents.
2. The hospital completes the Stage 2.1 Submission Checklist, which must be signed by the Board chair and facility administrator or CEO and enclosed with the submission prepared during this stage.
3. The ministry reviews the Stage 2.1 documentation for consistency with applicable ministry policies, the approved Functional Program and technical merits.
4. The ministry's timeframe for review of the submission varies depending on the size, type and complexity of the project. Incomplete submissions are returned to the hospital.
5. The ministry provides, in writing, its agreement with the Stage 2.1 Submission Requirements in the form of a ministry approval letter.

## STAGE 2.2: PRELIMINARY DESIGN 2 (SKETCH PLAN REPORT)

### Overview

The purpose of the Preliminary Design 2 (Sketch Plan Report) stage is for the hospital to obtain agreement from the ministry on the detailed physical layout of the Functional Program as it has progressed from the Block Schematic Design.

Specific objectives are to:

- Finalize the design development;
- Provide a mechanism for the control of project costs;
- Demonstrate the sustainability of the facility's operations;
- Demonstrate the placement of major furniture and equipment, and show all doors and windows;
- Demonstrate the design of all building systems; and
- Further test the capital costs for the various building systems (based on life cycle costing) in relation to ongoing operating costs.

Sketch plans are essential physical planning documents comprised of an integrated site development plan with existing and final contours, road and parking areas, drainage system, landscaping, and the location and elevation of all major buildings and other structures. They also provide developed layout plans with all functional spaces, circulation patterns, entrances and exits, location of major equipment, equipment rooms, and layout plans for special areas, such as kitchens and laboratories.

Sketch plans are accompanied by a design brief that articulates the specifications, descriptions and justification of the civil, landscape and architectural solutions, HVAC systems, electrical systems, life safety systems and any other systems that support the proposed design.

An updated project schedule and cost estimate is required with the sketch plans. The updated project schedule should indicate the time required for preparation, ministry review and approval of working drawings and specifications as well as an estimated timeframe for tender, construction and commissioning.

Depending on the size and scope of the project, and in consultation with the ministry, a furniture and equipment list and corresponding estimate may also be required. The equipment list identifies the hospital's equipment needs and basis for the equipment budget. Equipment can have a major impact on the design of a capital project. It is important to plan and identify design-sensitive equipment and requirements early in the design process. The following considerations should be carefully planned and addressed in an equipment list submission:

- Utility needs;
- Heat generation;
- Vibration sensitivities;
- Installation and service space needs;
- Structural, electrical and mechanical needs;
- Electromagnetic radiation; and
- Dimensions.

For renovation or ongoing development projects, the hospital should also consider its existing equipment inventory, replacement forecasting and maintenance costs.

### **3.2.4 Steps to Follow: Preliminary Design 2 (Sketch Plan)**

- 1. Following the submission requirements described in the Design Development Stage 2.2 Submission Checklist, the hospital collects or develops the various elements of the Design Development Report.*
  - 2. The hospital completes the Design Development Stage 2.2 Submission Checklist, which must be signed by the Board chair and facility administrator or CEO and enclosed with the submission.*
  - 3. The ministry reviews the Design Development documentation. The ministry's timeframe for review of the submissions varies depending on the size, type and complexity of the project. Incomplete submissions are returned to the hospital.*
  - 4. The ministry provides, in writing, its agreement with the Stage 2.2 Submission Requirements in the form of a ministry approval letter.*
- No further changes to the design are permitted after this agreement/approval point.***

## **STAGE 2.3: CONTRACT DOCUMENTS**

### **Overview**

During Stage 2.3–Contract Documents, the hospital prepares and the ministry reviews the proposed tender documents a.) to ensure a fair, open, and transparent process for obtaining bids; b.) to confirm that the scope of the project is accurately described in the final documentation; and c.) to ensure that the project remains within the approved budget.

## Pre-Tender Submission Package (Optional)

At this point in the process, the hospital may choose to submit a Pre-Tender package to the ministry for initial review of drawings, specifications and cost estimate. The purpose of the initial review is to allow the hospital to receive early feedback from the ministry, which generally results in a smoother transition to the formal tendering stage of the project. The ministry review is “high-level” and meant to confirm alignment with existing legislation, procurement policies and the Cost Share Guide.

Included within the Pre-Tender submission package is design documentation consisting of (*NOT FOR CONSTRUCTION*) working drawings and (draft) specifications for all professional disciplines associated with the project. These documents should be at 80% completion and are accompanied by a preliminary Class B cost estimate.

## Tender Submission Package

Final tender documents, as submitted by the hospital, must be reviewed and formally approved by the ministry before an open, fair, transparent, and competitive bidding process can be initiated. The submission package includes detailed design documentation comprised of 100% working drawings and design specifications for all professional disciplines along with appropriate professional seals, signatures and dates. A written report that contains a space comparison, a total estimated capital project cost, a Total Project Cost (TPC) and a schedule update must also be submitted with the drawings and specifications (refer to the Stage 2.3 Stage Submission Checklist in the Policies and Guidance Documents section of the Appendices for the full list of submission requirements that could apply).

While tender documents are prepared by the Prime Consultant, it is the hospital's responsibility to obtain final approval of the contract documents not only from the ministry, but also from other regulatory bodies where applicable. Examples of other regulatory bodies may include but are not limited to: Municipal Building Departments (Ontario Building Code), Ontario Fire Marshal (Ontario Fire Code), X-Ray Inspection, Atomic Energy Commission, and other ministries (MOH will advise what other ministries are required). All crucial reports pertaining to but not necessarily limited to site/soil conditions, hazardous materials and site surveys must also be included in the tender package.

Upon receipt of a ministry approval letter to proceed to procurement, the hospital must publicly tender the project based on the Final Tender documentation submitted to the ministry and in alignment with the *Broader Public Sector Accountability Act, 2010* and *Broader Public Sector Procurement Directive*. The final tender documents should be compliant with all government and ministry policies related to: bonds, insurance, permits, tender acceptance period and any specific documentation regarding staging, decanting and the ongoing operation and maintenance of the facility during the construction process.

## ✓ Key Concepts In Tender Development

### **Cost Estimate:**

*The tender cost estimate must be prepared by an accredited Cost Consultant and show a breakdown of costs for each element of construction and ancillaries. Back-up information should be included, where possible, for each element or sub-element of construction, such as unit rates, ratio-to-gross floor area and quantities. In addition, the following items should be considered as separate from construction costs: furniture and equipment; commissioning; project management fees; clerk of the works; decanting and move costs.*

### **As-Built Drawings:**

*It is the hospital's responsibility to ensure that all as-built drawings used as a basis for the development of contract documents are up to date. Existing as-built drawings can also be augmented with measurements and assessments by other Consultants, as needed. The ministry will not fund change orders that result from improperly updated as-built drawings or other documents.*

### **Construction Insurance:**

*It is strongly recommended that hospitals investigate whether their existing insurance policies contain coverage for construction, including the maximum specified amount, so that adequate protection is secured for the specified project. In addition, hospitals should consider including a request for construction insurance in the bid form as a separate price to leave open the possibility of co-insuring with the General Contractor.*

*Regardless of the preferred option, hospital personnel are advised to seek legal counsel so they are aware of and have in place appropriate insurance coverage prior to construction.*

## Forms of Tendering Supported by the Ministry

For all non-P3 projects, the ministry requires the hospital to use the traditional procurement method whereby prequalified contractors submit a fixed bid and schedule using capable sub-trades and suppliers. This method allows the ministry to financially track the expenditures of the project effectively during construction and at the time of settlement. The ministry has historically supported stipulated-sum as the preferred methodology but will consider Construction Management (as defined by the ministry) in some circumstances and with some conditions such as a cap on ministry financial contributions.

### **Tender Process: Traditional Procurement**

The ministry requires that a tender package developed as part of an open, fair and competitive procurement under the traditional model be structured as a stipulated price contract following Canadian Construction Documents Committee (CCDC 2) forms and documents. At its foundation, the stipulated price contract is a standard prime contract between the Owner (hospital) and General Contractor (builder) that establishes a single, pre-determined fixed price or "lump sum bid". This lump sum figure would be independent of any additional costs the General Contractor would incur during the construction phase which could be covered through change orders. Use of CCDC 2 standard forms is required for each aspect of the tendering process.

The ministry further recommends that hospitals follow the Canadian Construction Document Committee document 23 (CCDC 23), *A Guide to Calling Bids and Awarding Construction Contracts*, to support the uptake and use of industry best practices and standards.

## Pre-Qualification

If a hospital capital project is sufficiently large, exists within complex market conditions, has specific geographical challenges and/or may attract several unqualified bidders, public pre-qualification of potential bidders is highly recommended. The public pre-qualification process allows the hospital and its Integrated Project Team to better understand current market conditions regarding the availability of General Contractors, Sub-trades and Suppliers for the proposed project.

### **i** Did you know?

*As per the Broader Public Sector Procurement Directive, calls for open competitive procurements must be made through an electronic tendering system that is readily accessible by all Canadian suppliers. Available locations and sites, standard rules and procedures are available from local bid depositories and/or construction associations.*

In addition, public pre-qualification allows all potential bidders to express early interest in a project while enabling the Prime Consultant to develop a qualified final bidding list. Only those Contractors whose qualifications attain a pre-established, acceptable threshold would be permitted to submit bids when the tender call is issued. Typical pre-qualification covers General, Mechanical and Electrical Contractors; however, others in the construction industry could be pre-qualified depending on the specific nature and scope of work to be undertaken. The ministry suggests the use of CCDC 11 (Canadian Standard Form of Contractor's Qualification Statement) as a minimum requirement for hospitals that are pre-qualifying bidders.

To analyze pre-qualification applications, the hospital should establish an evaluation committee that includes the Prime Consultant, Project Manager and members of the hospital administration given their experience and level of expertise regarding program and service delivery as well as facility operations. This committee develops the evaluation criteria that will be used to determine the eligibility of prospective bidders. As part of due diligence, the committee should record its analysis and associated decisions in the event of appeals and/or inquiries from the vendor community. The committee generally selects a minimum of four to six eligible bidders to support competitive pricing.

A two-envelope bid submission system is typically supported by the ministry capital projects (i.e., final price is received and reviewed separately from the remainder of the submission to identify the lowest bona-fide base bidder). Refer to CCDC 23, Section 7.6 for risks and limitations of this system.

## Instructions to Bidders

The hospital's submission to the ministry should contain instructions to bidders that clearly outline the bidding procedure. Documentation provided to the bidders should contain all available information regarding the project. This will minimize questions during the tendering process and disputes after the contract is awarded.

In completing the procedures outlined in CCDC 23, the ministry requires hospitals to familiarize themselves with the Hospital Capital Cost Share Guide as it may influence some of the items to be indicated in the bid documents, such as:

- Instructions regarding cash allowances; unit, itemized, alternative and separate prices; and
- Instructions for proposing substitutions or alternatives (so that bidders do not inadvertently modify or limit their bids).

The hospitals should also consider a bid acceptance period of 90 days to facilitate the various ministry and owner (hospital) approvals; and should clearly indicate the procedure for the public opening of tenders (including any specific pandemic protocols that would impact a public opening) in the presence of acceptable witnessing parties (including clear description of electronic tenders opening process as established by electronic bid repositories) to facilitate ministry's adequate review of the process.

### **i** *Did you know?*

*The ministry supports the electronic bid submission process as most electronic systems offer the following benefits:*

#### ***Time Savings and Additional System Functionality***

- *Simplified online forms streamline the bidding process.*
- *Faster evaluations that will result in a faster award decision to be reached.*

#### ***Location Neutrality***

- *Vendors located outside of the designated bid recipient location (usually the sponsoring hospital) will not be disadvantaged by having to submit their bids via courier or mail to the designated bid recipient location earlier than local vendors.*

#### ***Reduced Disqualification Risk***

- *Less risk of submitting an incomplete bid due to the automated checks within each online bidding opportunity.*
- *System reminders sent to vendors by email, reducing the risk of late bids.*

#### ***Increased Procurement Visibility***

- *Vendors have access to all past bid submissions rendered online.*
- *Vendors have visibility into the status of an online bidding opportunity from start to finish.*

*Source: [doingbusiness.mgs.gov.on.ca/mbs/psb/psb.nsf/Attachments/OnlineBiddingFAQ\\_EN\\_Aug\\_24\\_2015/\\$FILE/OnlineBiddingFAQ\\_EN\\_Aug\\_24\\_2015.pdf](http://doingbusiness.mgs.gov.on.ca/mbs/psb/psb.nsf/Attachments/OnlineBiddingFAQ_EN_Aug_24_2015/$FILE/OnlineBiddingFAQ_EN_Aug_24_2015.pdf)*

*Electronic bid repositories are created and maintained by local or provincial government(s); construction or other professional associations; or are run by independent companies (such as MERX or Biddingo) using web-based technology that prevent irregularities. Notwithstanding the platform used for soliciting bids for a project, a hospital is required to use a system that is **public and accessible**.*

*For more information on procurement, refer to Appendix (X) for access to the Broader Public Sector Procurement Directive.*

A hospital must advertise the tender call in a publicly available print format (e.g.: Daily Commercial News, and ONE local newspaper) and optionally in electronic formats (MERX, Biddingo, etc.); and should consider a minimum of three strategic postings/advertisements during the bid period for print versions. As an additional source of exposure, the hospital may also consider local construction associations resources (websites, plan rooms, etc.). The tender call must list all pre-qualified bidders and their contact information, and the open bid period must be a minimum of 15 calendar days. The recommended minimum bid validity period is 90 days, however, hospitals should consult with their Senior Consultant if changes are contemplated. The hospital should consider a longer bid period for more complex projects or ones where labour and material shortages may be present or ones that have geographical challenges. The hospital must provide the ministry with proof of all the required advertisements, prior to award of tender.

## Privilege Clause, Selection Criteria and Critical or Formal Errors in Bidding

The following paragraph (or a variation thereof) should be included in the information to bidders:

*"The right to reject any or all tenders in whole or in part or to accept the tender or parts thereof judged most satisfactory is expressly reserved by the Board or Owner without liability on the part of the Board or Owner or the Prime Consultant. The ministry recommends accepting the lowest bid provided the bid evaluation conformance with CCDC 23, "A Guide to Calling Bids and Awarding Construction Contracts" must be followed."*

In a ministry funded project, the hospital retains an obligation to the ministry and the bidders to clearly explain the rationale for not accepting a valid tender that may be the lowest price. Valid reasons include but are not limited to:

- Bid(s) exceed approved budget;
- Bid(s) were either noncompliant or qualified; and
- Project scope has materially changed by  $\pm 15\%$  or project was cancelled.

Hospitals are further required to clearly state for the ministry the criteria used for selecting the successful bid. The ministry will not accept a recommendation to award a contract to a bidder that has either qualified or placed a condition on its bid, or in some way made an obvious **critical or formal error** in submitting the bid. To this end, hospital personnel engaged in capital planning should consult legal counsel throughout the process and ensure they are fully apprised of their legal obligations with respect to acceptable procurement practices. From the ministry's perspective, examples of critical or formal errors may include unsigned bid forms, conditional or qualified bid forms, as well as bids that do not contain the requisite security deposit to satisfy bonding requirements.

## Bonds

The General Contractor must provide the bonds outlined in the tender documents. The following bonds are typically used in a construction project:

- *Bid Bond*: The purpose of the bid bond is to guarantee the good faith of the bidder to the hospital. If the bidder's tender is accepted, the bidder is obligated to enter into a formal contract with the hospital within the time specified and to provide bonds or other specified security to secure the performance of the contract. The ministry requires 10% of the bid price as a bid bond.
- *Performance Bond*: A performance bond provides indemnity to the hospital up to the amount of the bond should the General Contractor default. A performance bond is not intended to cover

payment of labour and materials claims, but rather to obtain and pay for work not completed by the General Contractor. The ministry requires, as a minimum, a 50% performance bond, and may require a bond of up to 100%.

- *Labour and Materials Bond:* A labour and materials bond guarantees that all claimants will be paid for the labour and material furnished to the General Contractor for use on the project in the event of default. The ministry requires a minimum 50% labour and materials bond and may require a bond of up to 100%.

For additional information regarding bonds and insurance, refer to the CCDC guidelines which are available at [ccdc.org/](http://ccdc.org/).

## Separate Prices/Alternate Prices

Within the tender documents, the hospital can request that a Contractor recommend alternative products or materials of equal or greater value. Under such a scenario, these products or materials are excluded from the base bid price. The ministry also supports described alternatives that are solicited; however, unsolicited, bidder identified and described alternatives are not supported. The ministry bases its approval on the tender information and any changes made to the approved scope of a project must also be reviewed and approved before the tender is closed. Alternative prices should not be used to determine the true bona-fide low bidder or the true low base bid.

When requesting alternate prices, use of alternate prices or addenda that result in additional cost to the project are to be reported to the ministry for pre-approval. Note that the ministry will not approve additional scope of alternate work which is not included in the ministry-approved project. All alternate prices must be within the approved scope of the current project being tendered and not for infrastructure, planning or future preparation work for other projects.

The hospital should indicate all alternate prices being considered at the time of the Working Drawing and Specifications submission. Alternate prices added after this time will not be considered for cost share by the ministry. As noted in CCDC 23, the use of alternate prices should be minimized.

## Itemized Prices

An Itemized price is a distinct item or unit of work within a capital project whereby the hospital requests discreet pricing from bidders, but within the overall base bid price. The hospital retains the right to delete itemized prices from the contract price at its discretion.

## Unit Prices

Unit prices are used to provide measurable quantities of materials and labour for items that may be present on the site (i.e., contaminated soil removal per tonne, additional pipe insulation by the linear foot). While unit prices should be used with some discretion, they are particularly appropriate for the removal of unknown quantities of hazardous materials (e.g., site soil contamination, engineered fill, asbestos or mould abatement) or for site servicing components (e.g., excavation, underground sanitary or storm piping and granular materials) that may be encountered.

## Post-Tender Addenda

The ministry does not support the use of post-tender addenda where the additional project scope items should have been included in the original construction bid documents. Under such

circumstances, the issuance of post-tender addenda could indicate that the project was not ready for the bidding process, thereby eliminating the competitive edge provided by multiple contractors during the tendering period. Hospitals that wish to issue a post-tender clarification that does not expand or change the project scope should seek an opinion from the ministry.

## Cash Allowances

A cash allowance in a capital project is an estimated value for a scope of work that is not fully quantifiable prior to construction. The purpose of cash allowances is to allow the General Contractor to include in the bid price the cost for work that cannot be identified at the time of tendering, owing to factors that are outside the hospital's control. Ministry-approved cash allowances are aimed at reducing the risks inherent in cash management of a project and allow costs to be contained within the approved allocation.

The ministry does not permit cash allowances to be used for uncoordinated work identified in the contract resulting from errors, omissions, or unforeseeable conditions.

For renovation projects, hospitals should conduct a pre-construction investigation to identify potential issues related to tying into existing building systems.

### ✓ **Cash Allowance Approval**

*Once a cash allowance has been approved by the ministry, the hospital must utilize the allowance for the purpose for which it was intended. Cash allowances cannot be transferred from one allowance to another without ministry approval (see Cost Share Guide). The expenditure of all cash allowances must be tracked through the issuance of a change order or another formal document signed by the Prime Consultant, the Owner (hospital) and the General Contractor.*

## Permissible Cash Allowances

While the ministry may approve cash allowances for specific items, open-ended allowances (including open-ended allowances that duplicate the purpose of the Post Contract Contingency) will not be supported. All cash allowances must be provided by an accredited source such as a Cost Consultant or Consultant with a costing designation, fiscal experience and authority.

The following items **may be approved** as cash allowances upon ministry review so long as the Integrated Project Team makes every effort to include them in the construction drawings and specifications:

- Architectural door hardware;
- Inspection and testing (i.e., steel, concrete and electrical);
- Hazardous material abatement including asbestos and mould remediation;
- Modifications due to final equipment selection;
- Contaminated soil conditions on the site (i.e., hydrocarbons, lead and chemical agents);
- Site servicing as required by local authorities (i.e., hydro, gas and other buried utilities); and
- Interior signage and wayfinding (all exterior signs should be identified in the general contract).

### ✓ **Ministry Attendance**

*The hospital must inform the ministry of the time, date and location of the tender opening as the ministry retains the right to observe.*

Refer to the Hospital Cost Share Agreement Guide which can be found in Appendix V for additional information.

## Opening of Bids

Once the tender period is over, the bids that have been received during the tender period are required to be opened in public and the information is documented and communicated to all present at the tender opening. In this way all interested bidders (and observers) will be aware of who bid on the project and the value of the bid. This process supports an open, fair and competitive tendering process for publicly-funded capital projects.

Opening of tenders must be conducted at a pre-determined, public location and documented by the Prime Consultant in a tender opening register. Bids that have been received after the specified closing time will be returned unopened. Single bids must be returned to the bidder UNOPENED and the Health Service Provider (HSP) must advise the ministry of the receipt of only ONE bid.

Should a hospital have questions regarding appropriate procedures to be followed regarding any aspect of the tender process, including tender opening, the ministry encourages capital planning personnel to fully review CCDC 23, *A Guide to Calling Tenders and Awarding Construction Contracts*.

## 3.3 CONSTRUCTION & SETTLEMENT

### Stage 3.1: Award of Contract

#### Overview

The objective of Stage 3.1–Award of Contract is to identify a successful bidder and obtain ministry approval of the hospital's request to award the contract. This ensures that the process to award the contract is open, fair, transparent and accountable, and aligned with the Broader Public Service (BPS) Procurement Directive.

In accordance with the submission requirements described in the Stage Submission Checklist for Stage 3.1–Award of Contract, the hospital:

- Obtains copies of the three lowest compliant bids;
- Obtains the Prime Consultant's analysis and recommendations of the successful lowest bona-fide base bidder;
- Obtains a copy of all cash allowances included in the final tender price;
- Documents the Board approved motion confirming the Prime Consultant's recommendation including the tendered value;
- Completes the Final Estimate of Cost (FEC) form; and
- Provides the ministry with a FINAL as-tendered record set of contract documents, including ALL addenda.

The hospital's Stage 3.1–Award of Contract submission must be signed by the Board chair and the hospital's CEO and enclosed with the package. The ministry's timeframe for review of the submission varies depending on the size, type and complexity of the project. Incomplete submissions are returned to the hospital.

#### **i** Final Estimate of Cost (FEC)

*The FEC form contains a breakdown of all project costs in specific cost categories. The FEC is organized to identify which costs (in full or part) will be eligible for ministry funding and those costs (in full or part) that will be the responsibility of the hospital.*

Once the review is complete, the ministry provides its agreement with the Stage 3.1-Award of Contract submission. This agreement confirms to the hospital the ministry's total grant, which is based on the ministry's share of the final bid price (that is proposed to become the contract price) and the ministry's share of all eligible costs in accordance with the ministry's Cost Share Policy. The remainder of the costs are carried by the hospital as its share, including any own funds components.

After receiving written ministry approval, the hospital can enter into a *Construction Contract* with the successful proponent. This step is commonly known as *Award of Contract*. The signed Construction Contract requires the successful General Contractor/construction company to deliver the project, and the hospital to make payments per the terms and conditions contained in the tender documents.

## Stage 3.2: Construction

### Overview

The following section provides an overview of the primary activities required to successfully manage and complete construction of an approved capital project.

From this point in the planning process, the hospital is fully responsible for completing the approved project on time, on budget and consistent with approved scope. Construction responsibility rests with the General Contractor and should be carried out in accordance with the terms and conditions of the Construction Contract. The Prime Consultant oversees the project throughout and reports directly to the hospital. For additional information, refer to Royal Architectural Institute of Canada (RAIC) Canadian Handbook of Practice (CHOP) and CCDC's suite of documents.

The ministry retains no responsibility for either construction or contract administration and limits its involvement to the terms and conditions outlined in the funding agreement for the approved ministry grant.

### Payments

Terms and conditions of ministry payments to the hospital, including the timing and required documentation, are defined in the funding agreement for the project.

For traditional projects, the hospital is required to periodically submit payment requests to the ministry with a Progress Certificate completed by the Prime Consultant which certifies the percentage of progress made with respect to hard construction. Progress certificates are used by the ministry in the funding and cash management process to calculate the amount of funding the hospital requires at a given point in time for the approved capital project. Usually, the next ministry payment can be made after the certified percentage of construction progress has exceeded the share of the grant paid by the ministry to the hospital up to that point.

During construction, hospitals are also required to submit to the ministry an updated funding forecast which contains a timeline for completion of the project, and monthly cash flow projections. The timing of these updates is defined in the funding agreement.

At substantial completion, the ministry pays to the hospital the approved grant amount excluding the holdback which is 5% of the approved grant. The size of the final payment due to the hospital

(including release of holdback) is determined once the project has been settled by the ministry based on actual project expenditures and an assessment of eligible change orders.

## Changes to the Project Scope

As the construction stage can be lengthy and complex, hidden or unforeseeable site conditions may arise on occasion and can be addressed through a Post Contract Contingency (PCC) allowance which appears as a line item in the FEC, Statement of Disbursements and Source of Funds forms for all projects. The shareable (ministry-funded) portion of a PCC allowance is a pre-determined percentage (3% for a new build and 5% for a renovation) of the shareable construction cost set aside in the construction budget for the potential unforeseeable risks to a project once construction has commenced. Hospitals are not automatically entitled to receive the full amount of a ministry share of PCC allowance indicated in the Final Estimate of Cost and included in the approved maximum ministry grant. At project settlement, the ministry will review the submitted change orders to determine their eligibility and share in the cost of eligible change orders up to the maximum approved PCC amount.

Hospitals are guided by their executed funding agreement regarding the specific requirements for implementing change orders (variations). According to the terms and conditions of the funding agreement for a project, hospitals are required to seek the ministry's consent prior to making or accepting any change order when: the change order is materially inconsistent with one or more of the approved functional program, master plan, and any design documents; the total cost of the project exceeds the approved total project cost as a result of implementing a change order; or a change order will result in an increase to the hospital's operating costs. The Prime Consultant is responsible for the documentation of change orders and providing these records to the hospital for submission to the ministry.

For more detailed information on cost eligibility of change orders, please refer to s. 3.4 "Post Contract Contingency Allowance" in the Hospital Capital Cost Share Guide.

## Substantial Completion

When the Prime Consultant determines and attests that the project is substantially complete (for its intended purpose even though there may still be some minor work remaining), a *Certificate of Substantial Completion* is issued by the Prime Consultant to the hospital in compliance with applicable laws (i.e., *Construction Act* R.S.O. 1990). This term originates in the Ontario Building Code and means compliance with all the various applicable parameters stated in the building code under Division C, Subsection 1.3.3. The term relates to a state of completion of a project primarily relating to health and life safety provisions and systems. There is no consideration of the dollar value of the work completed and is most commonly encountered where an owner or tenant desires partial occupancy of a building.

A Certificate of Substantial Completion should be submitted to the ministry within 10 days after substantial completion. Once all work is fully complete, the project is said to have achieved *Total Performance*.

## **i** *Construction Lien Holdbacks*

*The **Construction Act** at the time of publication requires a 10% hold back of every progress invoice and that the hold back amount will be identified in the progress certificate issued by the Prime Consultant. The **Construction Act** also requires the hospital to place the 10% holdback in trust until expiry of the lien period following substantial completion of the project. The purpose of holdback is to have funds available to pay sub-trades if the Contractor fails to do so. The lien period is 45 days from the date of substantial completion. Please review the **Construction Act** to confirm whether these requirements have changed and/or are still applicable.*

## Final Completion

When all outstanding and/or deficient work is corrected the project is certified by the Prime Consultant as being complete the *Certificate of Total Performance* is issued by the Prime Consultant.

An attestation of the hospital's Prime Consultant that the facility was completed in accordance with design documents and the functional program is due to the ministry within 10 days after achieving the milestone.

## Transition/Take Over Procedures

Once construction is complete, the Integrated Project Team, including Prime Consultant, facilitates orientation and training for hospital facility and maintenance staff so they can safely and efficiently operate the new space and/or equipment. Part of this transition involves the Contractor, through the Prime Consultant, providing the hospital:

- **As-built Drawings:** As-built drawings are the final, up-to-date versions of the "issued for construction" plans. The As-built drawings add any changes made to the initial working drawings and specifications during the time of construction. These drawings provide essential documentation for the ongoing maintenance and replacement of the constructed space. The ministry recommends they be retained by the hospital for reference purposes.
- **Commissioning Reports:** Whereas manuals provide instruction for hospital personnel on how to operate individual equipment, commissioning reports describe how to operate the multiple interdependent systems operating within the facility.

The hospital is encouraged to familiarize itself with all the contractual and industry standards for take-over procedures, since they often mark the start of guarantee periods, maintenance contracts, etc. that will have an impact on the long-term capital investment strategy of the facility. The CCDC suite of documents describes in detail responsibilities and rights of each of the parties under various contracts; however, a review of the related legislative (such as the *Construction Act*) or regulatory practices (such as the OAA Canadian Handbook of Practice for Architects) will help in understanding the processes in place.

For ministry-funded projects, the costs associated with transition/take over may be covered partially through PCOP start-up and transition costs (see PCOP section), and partially through commissioning costs included in the Final Estimate of Cost at approval to award contract. Hospitals should make sure

early in the planning process that the Final Estimate of Cost sufficiently captures future commissioning costs to avoid subsequent requests to the ministry for a grant increase later in the process.

Once the transition process is complete the hospital assumes legal ownership of the site.

## Claims

A claim is a request by the General Contractor for compensation above the tender amount for delays created by the hospital, labour disruptions, weather, tariffs, material price increases, etc. Claims are to be resolved between the hospital and the General Contractor with the advice of the Prime Consultant. Claims are not eligible for ministry funding.

## Guarantee Period

The guarantee period is the warranty period on all work completed by the General Contractor. The guarantee period commences as described in the CCDC 2 construction contract.

## Warranty Inspection

The Prime Consultant for the project and hospital staff must conduct a warranty inspection before the one-year warranty period expires. The Prime Consultant is to submit a report to the hospital outlining any outstanding warrantee items or latent deficiencies. The Prime Consultant must also forward a copy of the report to the General Contractor to make the necessary changes as prescribed. The requirement for a warranty inspection should be reflected in the contract between the hospital and the Prime Consultant.

## Post-Occupancy Evaluation

A Post-Occupancy Evaluation (POE) is a systematic assessment of a project to identify its strengths and weaknesses and to review potential areas for capital and operational improvements. It allows the hospital, Prime Consultant, and the ministry to determine how well the facility and its components are functioning by demonstrating how actual usage compares to planned usage as described in the Functional Program. A POE also allows lessons learned to be formally captured and disseminated which can lead to process and design improvements on similar projects in the future.

If the ministry identifies the need for a POE at the initial project planning meeting (held at Stage 1.2-Proposal Development), or at some other planning stage, the respective cost item in the Cost Share Agreement/Final Estimate of Cost will be eligible for ministry funding. In this case, the hospital will prepare and submit a report for ministry review outlining POE plans and initiate tracking of required metrics prior to construction start. The ministry will work with the hospital to determine what Performance Measures should be included in the POE such as those outlined in Table 2d: Hospital-Based Capital Projects: Performance Measures found in Chapter 2.

The post construction study should be undertaken at least 12 months after operations commence. The exact timing of the POE can depend on factors such as:

- Time required to judge the durability of interior finishes (dependent on the materials used);
- Time required for the facility to reach full operational levels (generally, more than a year);
- Time required to ascertain seasonal and operational variations (multiple years is usually required to establish trends).

## Stage 3.3: Settlement

### Overview

The purpose of Stage 3.3-Settlement is to reconcile the actual costs incurred during a capital project with the estimated costs established at Stage 3.1-Approval to Award.

Following the completion of a capital project with a provincial contribution, HCIB will undertake a settlement process to ensure that capital funding received by the hospital was used for its intended purpose and to close the financial records for the project. Within two years after the Final Completion of a capital project, the hospital submits settlement documentation to the ministry in accordance with the terms and conditions of the funding agreement and settlement submission checklist and templates.

Typically, the hospital provides its designated Senior Consultant with a *Change Order Log* that describes the types of shareable and non-shareable change orders, an audited *Statement of Expenditures (SOE)* outlining all (paid) invoices for the capital project and an audited *Statement of Disbursements & Source of Funds (SDSF)* that contains a summary of project costs and revenues. Change Order Logs may be submitted early, upon Final Completion, to “kick start” the settlement process.

The submitted Change Order Log, SDSF and SOE are compared against the approved ministry grant, as outlined in the approved FEC. A review of any new cost items is compared against the Cost Share Guide in effect at the time of FEC approval.

Following the completion of the settlement review, the ministry works with the hospital to validate findings and confirm the results of the settlement process. If the final eligible costs exceed amounts paid to date, an additional payment is provided. If final eligible costs are less than amounts paid to date, the ministry makes a recovery, in addition to retaining the holdback. A *Notice of Project Settlement* is prepared, outlining whether a payment or recovery is required. This final step signals the close of capital projects with a provincial contribution and the end of the capital planning process.

For capital projects that do not have a provincial contribution (i.e., Own Funds), the ministry requires an attestation of the Total Project Cost and Final Completion date from the CEO/CFO or other senior hospital official before projects can be closed.

# 4

## Public Private Partnership (P3) Projects

# PUBLIC-PRIVATE PARTNERSHIP (P3) PROCESS

## Purpose

To provide an overview of the P3 model, review the roles and responsibilities of key parties, and examine the process steps required to successfully plan and implement a hospital-based capital project in collaboration with IO.

## 4.1 OVERVIEW

All capital projects with planning approval follow the same path up to the end of Stage 1.3-FP. It is at this point that the government, based on the advice of the Ministry of Health, Ministry of Infrastructure and IO, will make a determination as to which procurement model will be utilized for a given project.

As explained in Chapter 2, P3 is an alternate approach for the procurement and project management of large, complex public infrastructure projects. Under the P3 model, the project sponsor (hospital) enters into one contract with a project consortium (Project Co.) that delivers the project and manages the project risks in accordance with the hospital's performance specifications as outlined in a Project Agreement. In contrast, under the traditional procurement model, the hospital is responsible for the design, construction and financing of the project, including associated project risks.

The decision regarding which P3 model is most appropriate for a given capital project is dependent on the size, scope and complexity of the project, as well as the costs, client needs, maintenance requirements, and desired degree of risk transfer. Table 4a presents an overview of how these considerations align with and ultimately inform which P3 model is selected.

**Table 4a: Considerations in P3 Model Selection\***

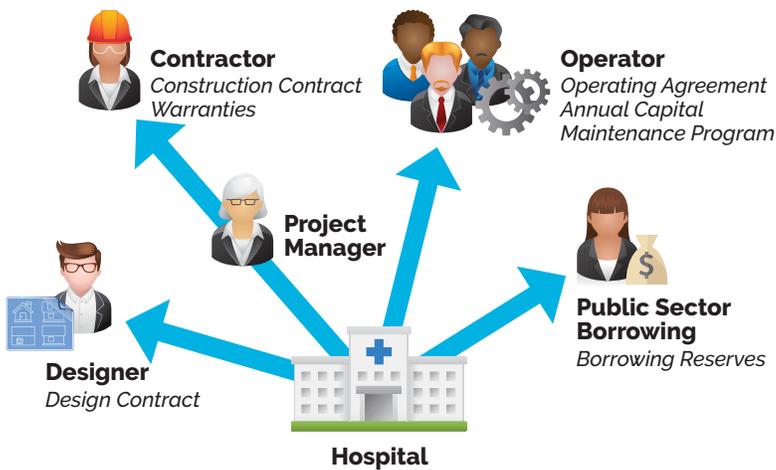
Project Considerations	Build-Finance	Design-Build Finance	Design-Build Finance-Maintain
Scope	New or Retrofit	New or Retrofit	New
Cost/Size	\$50M-\$500M	\$100M-\$500M	\$250M+
Design Requirements	Design specifications similar to traditional projects	PSOS contains design requirements	PSOS contains design requirements
Maintenance Requirements	Hospital retains responsibility for maintenance	Hospital retains responsibility for maintenance	Project Co. responsible for maintenance over fixed term (i.e., 30 years) and hospital funds this through Local Share
Risk Transfer	Fixed price, construction schedule, private financing until end of construction	Design, fixed price, construction schedule, private financing until the end of construction	Design, fixed price, construction schedule, build, maintenance, private financing (secured under a long-term agreement), asset condition

\*There may be circumstances when this is not true depending on the maturity of the design when procurement occurs.

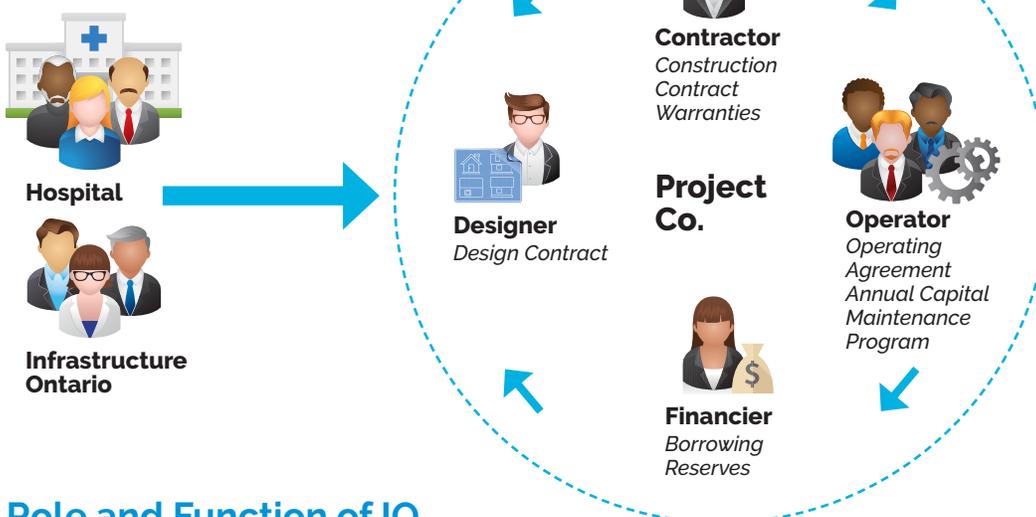
The foundational differences between the traditional and P3 procurement models are visually depicted in Figure 4b. Of note, the traditional procurement model requires the hospital, as the project sponsor, to separately coordinate each component of the capital process, whereas in the P3 (DBF/DBFM) model, the consortium of providers is established under a single entity known as Project Co. Each partner in the consortium is incentivized to work in an integrated, collaborative fashion due in large part to the financial incentives/disincentives contained in the Project Agreement.

**Figure 4b: Visual Depiction of Procurement Models**

**1. Traditional Model**



**2. P3 Model**



**Role and Function of IO**

IO plays a number of important roles on P3 projects. Its functions are agreed to with the sponsoring hospital at the outset of project planning and documented in an appropriate accountability instrument such as a *Master Agreement*, *Memorandum of Understanding*, or *Project Charter*. For most P3 projects, IO leads the procurement, construction project management, and implementation oversight functions. IO's specific responsibilities typically include:

- Undertaking due diligence and risk assessment for the P3 project;
- Developing a budget based on an independent 3<sup>rd</sup> party cost estimate;

- Leading the procurement process together with the sponsoring hospital;
- Developing project documents, and reviewing and approving the transaction structure;
- Supporting the sponsoring hospital in developing and maintaining timely capital budgets and forecasts;
- Receiving and evaluating bid submissions in conjunction with the sponsoring hospital;
- Negotiating and awarding contracts together with the sponsoring hospital;
- Managing the construction of the P3 project in accordance with the contract documents;
- Providing expertise and advice to the sponsoring hospital on procurement, commercial, financial, and market implications of P3 projects;
- Providing advice to the sponsoring hospital on requested changes to the P3 project; and
- Supporting the sponsoring hospital with contract and performance management during the design, construction and operations phases of the project.
- All other roles and responsibilities subject to Appendix xxii.

## 4.2 SUBMISSION, REVIEW AND APPROVAL PROCESS

Once the Stage 1.3-FP has been approved, a hospital with the assistance of IO is required to prepare and submit documentation to the ministry for review and approval before progressing through each of the remaining stages of the Capital Planning Process. The following sections offer a brief overview of the submission, review and approval process for each of the P3 models currently supported by IO for use in hospital-based capital projects.

Readers interested in learning more about the specific submission requirements for the remaining capital planning stages should refer to the applicable Stage Submission Checklists which can be found in the Appendix.

## 4.3 DESIGN AND CONTRACT DOCUMENT DEVELOPMENT

Design and contract document development stages differ depending on the specific P3 model utilized for a particular project. They are illustrated below.

### Build-Finance (BF)

Under the BF model, the hospital engages in preliminary design activities similar to Stage 2.1 and 2.2 for a traditionally-procured project. The hospital maintains a high degree of stewardship over the project as it retains the responsibility for developing the design and engineering specifications through its Integrated Project Team, preparing contract documents and managing the open, competitive procurement process.

- Similar to traditional projects, BF projects progress through Stages: 2.1 Block Schematic Report; and 2.2 Sketch Plan Report. As with all other P3 projects, BF projects also move through the RFQ (including requirements for clinical expertise), RFP, commercial and financial close, construction and settlement stages as discussed in the sections below.

### Figure 4c: Build-Finance

Process Flow Chart



# Design-Build-Finance (DBF) & Design-Build-Finance-Maintain (DBFM)

## Planning Design and Conformance Team

For both DBF and DBFM models, IO supports the hospital in prequalifying and competitively procuring the services of a *Planning, Design and Conformance (PDC) Team*. The PDC team is comprised of technical specialists (e.g., Architects, Engineers, etc.) that work with the hospital to prepare the PSOS in order to fulfill the needs of the Functional Program, and to report on design conformance throughout design and construction. The foundational mandate of the PDC team is to represent the interests of the hospital in contract document preparation, procurement and construction monitoring.

## DBF and DBFM Process Steps

Under the DBF and DBFM models, the hospital will prepare a Stage 2.3-Block Schematics, Project Specific Output Specifications and RFP Evaluation Criteria submission which includes a series of documents, the most important of which being the capital budget estimate and PSOS – instead of developing detailed construction drawings and specifications as in the traditional model. PSOS are a set of specifications that describe the standards to which the proposed capital project is to be built and then operated (DBFM only) throughout the life of the asset. The PSOS covers design, construction, building or asset performance, quality, regulatory, policy, or other standards that the hospital expects of the asset. It does not prescribe the design solution. The Functional Program forms the basis for preparing the PSOS.

The DBFM model follows a similar path to the DBF with the essential difference being the inclusion of long-term (i.e., 30-year) financing, building maintenance and lifecycle requirements as part of the Project Agreement. A well developed PSOS that contains comprehensive performance criteria that Project Co. must meet in maintaining the asset over the prescribed term is critically important. The hospital will be paying for the DBFM contract, including maintenance and lifecycle costs over the long-term and will expect that the asset is operating efficiently and at a reasonably low cost.

As all other P3 projects, DBF and DBFM projects progress through the RFQ, RFP stage, commercial and financial close, construction and settlement as discussed in the sections below.

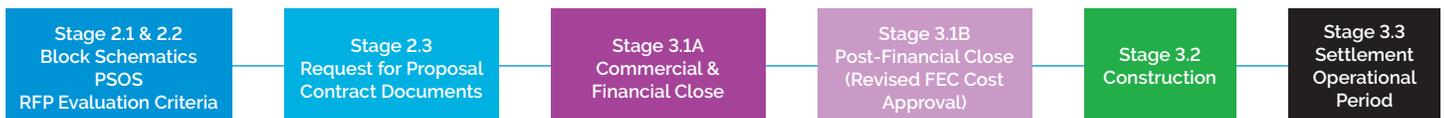
### Figure 4d: Design-Build-Finance

Process Flow Chart



### Figure 4e: Design-Build-Finance-Maintain

Process Flow Chart



## 4.4 REQUEST FOR QUALIFICATIONS

In preparation for the request for proposals stage, IO leads in prequalifying those bidders that have relevant design, construction, operations/maintenance experience (DBFM only), and financial capacity to undertake the proposed capital project. A shortlist of proponents will be selected to participate in the subsequent request for proposals.

## 4.5 REQUEST FOR PROPOSALS (RFP)

Once the formal documentation is ready to be issued, and the ministry has reviewed and provided a formal approval letter, a detailed package containing the RFP, Project Agreement and PSOS will be disseminated to the pre-qualified proponents. The level of design flexibility afforded to the proponents will be dependent on the parameters of each project. For example, Greenfield (no pre-existing building or site services) projects, completely new facilities and projects with site flexibility may offer greater design latitude to prospective proponents as opposed to projects that assume infill solutions, have prescriptive adjacencies due to existing components and/or operate under stringent municipal requirements.

Each proponent will be invited to present their developing design proposal to the hospital and IO (represented by the PDC team), and demonstrate conformance with the PSOS. After the presentations, feedback will be provided to the proponents in order to clarify hospital expectations as outlined in the PSOS. The fundamental goal of the presentations is to encourage design innovation and achieve compliant (bid) submissions for subsequent evaluation.

After the formal bids have been submitted, IO's procurement team, including PDC, will conduct a thorough review of each bid package for completeness and adherence to applicable legislative and policy requirements with respect to procurement. Complete bids will then undergo a detailed technical and financial review by an *Evaluation Committee* comprised of representatives from both the hospital and IO. The highest scoring proponent will be recommended for Award of Contract.

## 4.6 STAGE 3.1a: COMMERCIAL CLOSE

It is at this point that the hospital and IO will prepare the Stage 3.1-Commercial Close submission package in order to seek ministry approval to award the contract to the successful proponent. The Stage 3.1 submission will be provided to the ministry along with the recommendation from IO's Board of Directors.

Once the review is complete, the ministry provides its agreement with the Stage 3.1-Commercial Close submission. This agreement confirms to the hospital the ministry's capital grant which is based on the ministry's share of the successful bid price as well as the ministry's share of all eligible costs in accordance with the current Capital Cost Share Guide (see Appendix v). The remainder of the costs are carried by the hospital as its local share, including any own funds components.

Upon receipt of written ministry approval, the hospital is able to enter into the Project Agreement with the preferred proponent (Project Co.) and proceed to Commercial Close. As part of Commercial Close the first FEC form is produced which contains a detailed breakdown of all project costs in specific cost categories.

In the DBFM model, the Project Agreement will also require the successful proponent to provide maintenance of the newly constructed space for a specified time period (i.e., 30 years) after construction is finished and operations commence.

## **4.7 STAGE 3.1b: FINANCIAL CLOSE**

At Financial Close, the financial arrangements for the project are finalized with the lender. A revised FEC form, including the finalized financing costs, is generated and submitted to the ministry for review and approval within the timeframe specified by the executed funding agreement between the ministry and the hospital (i.e., three months after financial close). Readers should refer to the Stage 3.1b checklist in the Policies and Guidance Documents section of the Appendices for the complete list of documents required in this submission.

## **4.8 STAGE 3.2: CONSTRUCTION**

In Stage 3.2, the project moves through construction to substantial completion and then, as relevant, transition and occupancy. Payment(s) from the ministry to the hospital is established in the funding agreement. The funding agreement also contains the terms and conditions of the payment(s) along with associated timelines. Depending on the procurement model, payment(s) may be made over the course of the construction period, upon interim completion, and/or at substantial completion.

It is essential that the hospital notify and seek consent from the ministry regarding any material variations incurred during the construction period as per the terms of the funding agreement. As part of a consent request to the ministry, the hospital should include IO's recommendation in support of any variations.

## **4.9 STAGE 3.3: SETTLEMENT**

At substantial completion, the ministry pays to the hospital the grant amount excluding holdback which is typically 5% of the ministry grant for the BF and DBF projects and the sum of PCC and Minor Non-Depreciable (MND) cost items for DBFM projects.

Within two years after the Final Completion of a capital project, the hospital submits settlement documentation to the ministry in accordance with the terms and conditions outlined in the funding agreement and the settlement submission checklist and templates. The ministry will then undertake a settlement review to ensure that capital funding received by the hospital was used for its intended purpose and to close the financial records for the project.

The hospital initiates the process by providing its designated Senior Consultant with a Change Order Log that describes the types of shareable and non-shareable variations, an audited Statement of Expenditures (SOE) outlining all (paid) invoices for the capital project and an audited Statement of Disbursements & Source of Funds (SDSF) that contains a summary of project costs and revenues. For P3 projects, in addition to the documents described above, Infrastructure Ontario, subject to Appendix xxii, will also provide the ministry with the *Project Close-Out Report* following final completion of the project.

During the settlement review, the ministry works with the hospital to validate all expenditures and verify the hospital's settlement submission. The ministry compares the submitted SDSF and SOE

to the approved FEC and IO's close-out report and reviews the Change Order Log. The outcome of ministry settlement review is the determination of all eligible actual costs and the corresponding final ministry grant.

Once the review is complete, the ministry will share the analysis with the hospital to validate findings and confirm the results of the settlement process. If the final eligible costs exceed the amounts paid to date, an additional payment out of the holdback is provided up to the approved grant amount. If the final eligible costs are less than the amounts paid to date, the ministry makes a recovery, in addition to retaining the holdback. A Notice of Project Settlement is prepared, outlining whether a payment or recovery is required. This final step signals the close of the capital project.

For DBFM Projects, settlement requirements will focus on capital project costs incurred up to and including final completion. Project costs related to the operational/maintenance period will be monitored and settled separately by the ministry on a periodic basis.

# APPENDICES

## APPENDICES LIST

### Policies and Guidance Documents

- i. Capital Stage Submission Checklists
- ii. Pre-Capital Submission Form
- iii. Issues Comments Form
- iv. Hospital Cost Share Agreement Guide
- v. Capital Bulletins
- vi. Clinical Addenda
- vii. Space Standards
- viii. Ministry ED Benchmarks
- ix. Ministry Perioperative Care Benchmarks
- x. Program Bed Map
- xi. FEC Template
- xii. Capital Settlement Template
- xiii. Capital Variance Template
- xiv. Post Construction Operating Plan (PCOP) Policy
- xv. PCOP Submission Template
- xvi. Health Infrastructure Renewal Fund Guidelines
- xvii. Sample Project Risk Categories
- xviii. Value Analysis
- xix. IPAC Requirements for Hospital Capital Project Planning and Costing
- xx. Infrastructure Ontario Site Investigation Guidelines for Due Diligence and Design Purposes (Social and Civil Project) Final – November 2018
- xxi. Infrastructure Ontario Capital Project Policies and Procedures

### Government Directives

- xxii. Broader Public Sector Procurement Directive
- xxiii. Transfer Payment Accountability Directive
- xxiv. Ontario Realty Directive
- xxv. OPS Enterprise Risk Management Framework

### Legislation and Codes

- xxvi. Public Hospitals Act
- xxvii. Ministry of Health Act
- xxviii. Financial Administration Act
- xxix. Construction Act
- xxx. Environmental Protection Act
- xxxi. Occupational Health and Safety Act
- xxxii. Public Health Act
- xxxiii. Accessibility for Ontarians with Disabilities Act
- xxxiv. Ontario Building Code
- xxxv. Ontario Fire Code

## Industry Standards and Reference Material

- xxxvi. CAN/CSA Z8000-18 Canadian Health Care Facilities
- xxxvii. CAN/CSA Z317.2-19 Special Requirements for Heating, Ventilation, and Air-Conditioning Systems in Health Care Facilities
- xxxviii. CAN/CSA Z317.13-17 Infection Control During Construction, Renovation, and Maintenance of Health Care Facilities
- xxxix. Canadian Construction Documents Committee (CCDC)
- xl. National Fire Protection Association Standards

## Professional Associations

- xli. Infrastructure Ontario
- xlii. Canadian Contractors Association
- xlili. Ontario Association of Architects (OAA)
- xliv. Professional Engineers of Ontario (PEO)
- xlv. Ontario General Contractors Association
- xlvi. Council of Ontario Construction Associations
- xlvii. Canadian Institute of Quantity Surveyors
- xlviii. Ontario Institute of Quantity Surveyors